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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2006 114801

2006 DEC 29 PM 2:11

NOTARY PUBLIC  
LAKE COUNTY

STATE OF INDIANA )  
                                  ) SS:  
COUNTY OF LAKE )

**SURVIVORSHIP AFFIDAVIT**

On the 26 day of December, 2006, before me personally appeared ANTHONY KISZENIA, to me personally known, who being duly sworn upon oath, did say that:

1. Affiant resides at 1834 Blue Bird, Munster, IN 46321, and he is the son of OLGA KISZENIA and JOHN KISZENIA.
2. That OLGA KISZENIA died on August 9, 1998, a resident of Lake County, State of Indiana. A certified copy of her death certificate is attached hereto as Exhibit "A".
3. That at the time of her death, JOHN KISZENIA and OLGA KISZENIA, husband and wife, were the sole owners of the property commonly known as 8040 Kooy Drive, Munster, IN, and legally described as follows:  
  
Lot 3 in Lawrence Monaldi's 4<sup>th</sup> addition to Munster, as per plat thereof recorded in the Office of the Recorder in Lake County, Indiana.
4. That upon the death of OLGA KISZENIA, JOHN KISZENIA, her surviving spouse, became the sole owner of said real estate.
5. That JOHN KISZENIA and OLGA KISZENIA were never divorced, and JOHN KISZENIA was the surviving spouse of OLGA KISZENIA.
6. That, to the best of Affiant's knowledge, there is no estate or inheritance tax liability by reason of the death of said decedent; and all funeral expenses and expenses of last illness have been paid in full.



**FILED**  
DEC 29 2006  
KATONA  
LAKE COUNTY AUDITOR

*Anthony Kiszenia*  
ANTHONY KISZENIA

027105

I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law. Thomas L. Kirsch.

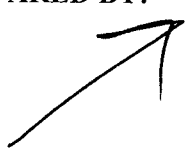
THIS AFFIDAVIT SUBSCRIBED and SWORN to before me, by the Affiant, on this 26 day of December, 2006.

*Suzette Davis-Young*  
\_\_\_\_\_, Notary Public  
Resident of LAKE County.

My Commission Expires: 6-13-07



THIS INSTRUMENT PREPARED BY: **THOMAS L. KIRSCH, 5224-45  
131 Ridge Road, Munster, IN 46321  
219-836-1384**



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23797  
*SM*

\* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 1993-98

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

265429  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>OLGA KISZENIA</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>10:20 Am</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>August 9, 1998</b>	
4. *SOCIAL SECURITY NUMBER <b>315-70-8438</b>	5a. AGE—Last Birthday (Years) <b>70</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>April 20, 1928</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Premycz, Poland</b>	8a. WAS DECEASET A U.S. VETERAN? <b>NO</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>Dyer Nursing and Rehab</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Dyer</b>	9d. COUNTY OF DEATH <b>Lake</b>		
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>John Kiszenia</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>		
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>Munster</b>	13d. STREET AND NUMBER <b>8040 Kooy Drive</b>		
13e. ZIP CODE <b>46321</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) <b>Theodore Malik</b>			
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Zarnick</b>			20a. INFORMANT'S NAME (Type/Print) <b>John Kiszenia</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8040 Kooy Drive, Munster, Indiana 46321</b>		20c. Relationship <b>Husband</b>			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>August 13, 1998 Elmwood Cemetery</b>		21c. LOCATION—City or Town, State <b>Hammond, Indiana</b>	
22a. EMBALMER'S NAME <b>Dean G. Wagner</b>		22b. EMBALMER'S LICENSE NO. <b>8800057</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b. LICENSE NUMBER (of Licensee) <b>8800057</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN. 46324</b>		
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <b>Cardio pulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF): _____ b. _____ DUE TO (OR AS A CONSEQUENCE OF): _____ c. _____ DUE TO (OR AS A CONSEQUENCE OF): _____ d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last				Approximate Interval Between Onset and Death	
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>Diabetes mellitus Hypertension Parkinson's disease</b>				27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>	
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Paik, M.D.</i>			29c. MEDICAL LICENSE NO. <b>30770</b>	29d. DATE SIGNED (Month, Day, Year) <b>August 10, 1998</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Jay C. L. Paik, M.D. 200 Monticello Drive, Dyer, Indiana 46311 865-6744</b>					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Hillman M.D.</i>			32. DATE FILED (Month, Day, Year) <b>August 11, 1998</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34f. L			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver's			

**EXHIBIT A**