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STATE OF INDIANA)
COUNTY OF LAKE 2007 } 849014

STATE OF INDIANA
LAKE COUNTY
RECORDER'S OFFICE
2007 JUN 15 AM 10:05
NOTICE: A DEED
RECORDED

AFFIDAVIT OF SURVIVORSHIP

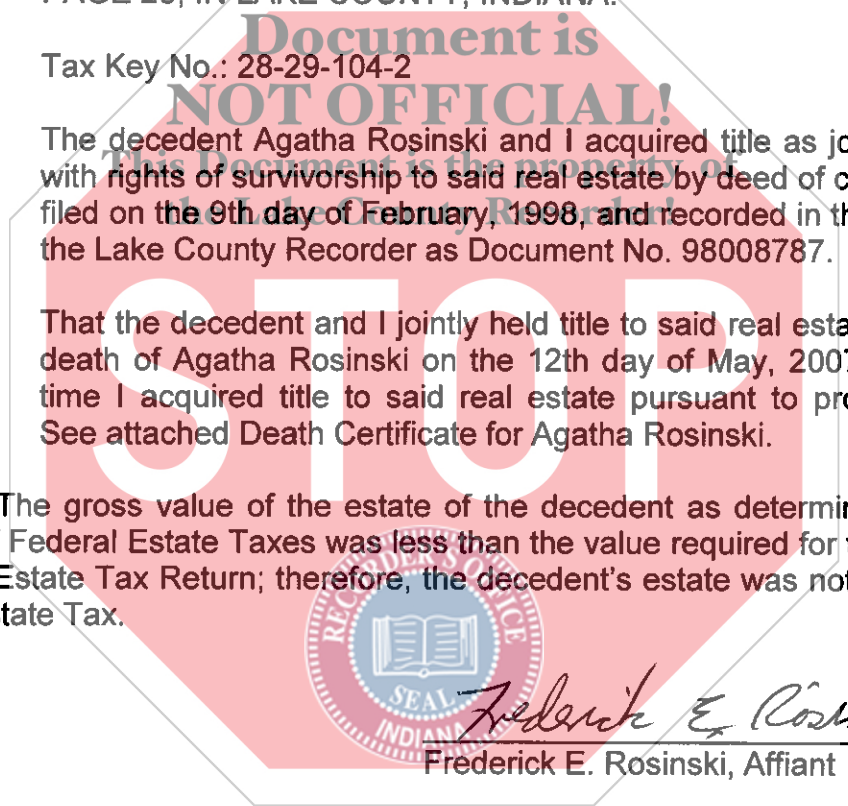
I, Frederick E. Rosinski, being duly sworn, state as follows:

1. I am over the age of eighteen (18) and suffer from no disability which would render my testimony incompetent.
2. I am the surviving owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

LOT 2, STEIBER STREET SUBDIVISION, IN THE CITY OF WHITING, AS SHOWN IN PLAT BOOK 5, PAGE 25, IN LAKE COUNTY, INDIANA.

Tax Key No.: 28-29-104-2

3. The decedent Agatha Rosinski and I acquired title as joint tenants with rights of survivorship to said real estate by deed of conveyance filed on the 9th day of February, 1998, and recorded in the Office of the Lake County Recorder as Document No. 98008787.
4. That the decedent and I jointly held title to said real estate until the death of Agatha Rosinski on the 12th day of May, 2007, at which time I acquired title to said real estate pursuant to property law. See attached Death Certificate for Agatha Rosinski.
5. The gross value of the estate of the decedent as determined for the purpose of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return; therefore, the decedent's estate was not subject to Federal Estate Tax.



Frederick E. Rosinski
Frederick E. Rosinski, Affiant

FILED

JUN 15 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

*D.D.M.
15.00
38277#*

12057

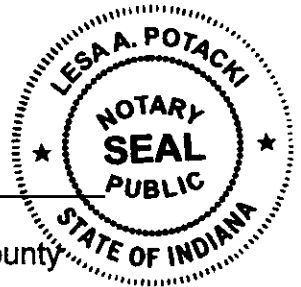
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Frederick E. Rosinski, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 12 day of June, 2007.

Lesa A. Potacki

Lesa A. Potacki
Notary Public Residing in Lake County



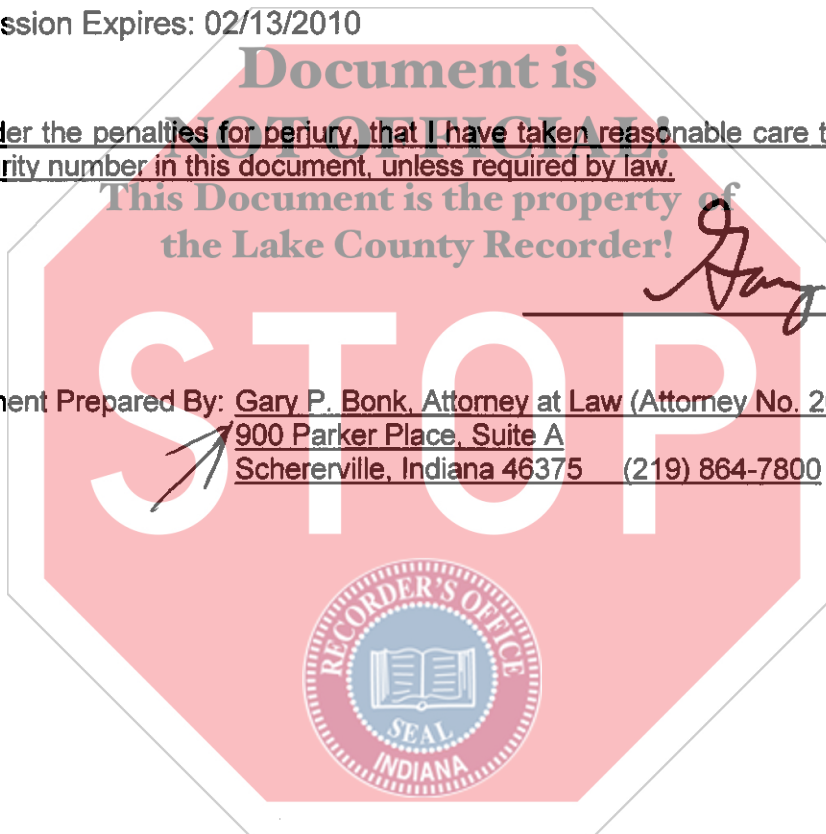
My Commission Expires: 02/13/2010

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

~~This Document is the property of the Lake County Recorder!~~

Gary P. Bonk

This Instrument Prepared By: Gary P. Bonk, Attorney at Law (Attorney No. 20519-45)
900 Parker Place, Suite A
Schererville, Indiana 46375 (219) 864-7800



* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT

MAY 14, 2007
Date issued
Hammond Health Commissioner

Local No. 302

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1 DECEASED—NAME (First, Middle, Last) AGATHA ROSINSKI				2. SEX FEMALE		3a. TIME OF DEATH 1:45A		3b. DATE OF DEATH (Month, Day, Yr.) MAY 12, 2007				
4. *SOCIAL SECURITY NUMBER 309-16-8868			5a. AGE—Last Birthday (Years) 88		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) OCT. 27, 1918		7. BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO, IND.	
8a. WAS DECEDENT A U.S. VETERAN? NO		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		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) Residence								
9b. FACILITY NAME (If not institution, give street and number) 1719 CALUMET AVENUE						9c. CITY, TOWN, OR LOCATION OF DEATH HAMMOND			9d. COUNTY OF DEATH LAKE			
10. MARITAL STATUS WIDOWED		11. SURVIVING SPOUSE (If wife, give maiden name) NONE			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) BUSINESSWOMAN			12b. KIND OF BUSINESS/INDUSTRY PAINT STORE				
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION HAMMOND (WHITING P.O.)			13d. STREET AND NUMBER 1719 CALUMET AVENUE					
13e. ZIP CODE 46394		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		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) WHITE		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		
18. FATHER'S NAME (First, Middle, Last) ELIAS CELENICA						19. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA KEKICH						
20a. INFORMANT'S NAME (Type/Print) MR. FREDERICK ROSINSKI				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 CALUMET, WHITING, IND. 46394				20c. Relationship SON				
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) MAY 16, 2007 ST. MARY CEMETERY				21c. LOCATION—City or Town, State HAMMOND, INDIANA				
22a. EMBALMER'S NAME HENRY J. BLAKE				22b. EMBALMER'S LICENSE NO. FDE01019406		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes						
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Henry J. Blake</i>				24b. LICENSE NUMBER (of Licensee) FDE01019456		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394						
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) Alzheimer's Disease Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Coronary artery disease Hypertensive cardiovascular disease										Approximate Interval Between Onset and Death		
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO				28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A						
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>Annadale Brastor MD</i>						29c. MEDICAL LICENSE NO. 01027402		29d. DATE SIGNED (Month, Day, Year) MAY 14, 2007				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26a) (Type/Print) CONRADO P. CASOR M.D., 111 FRAN-LIN PARKWAY, MUNSTER, INDIANA 46321												
31. HEALTH OFFICER'S SIGNATURE <i>R. J. ...</i>										32. DATE FILED (Month, Day, Year) May 14, 2007		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <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. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
34g. DATE PRONOUNCED DEAD (Month, Day, Year)						34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						