

**AFFIDAVIT OF SURVIVORSHIP**

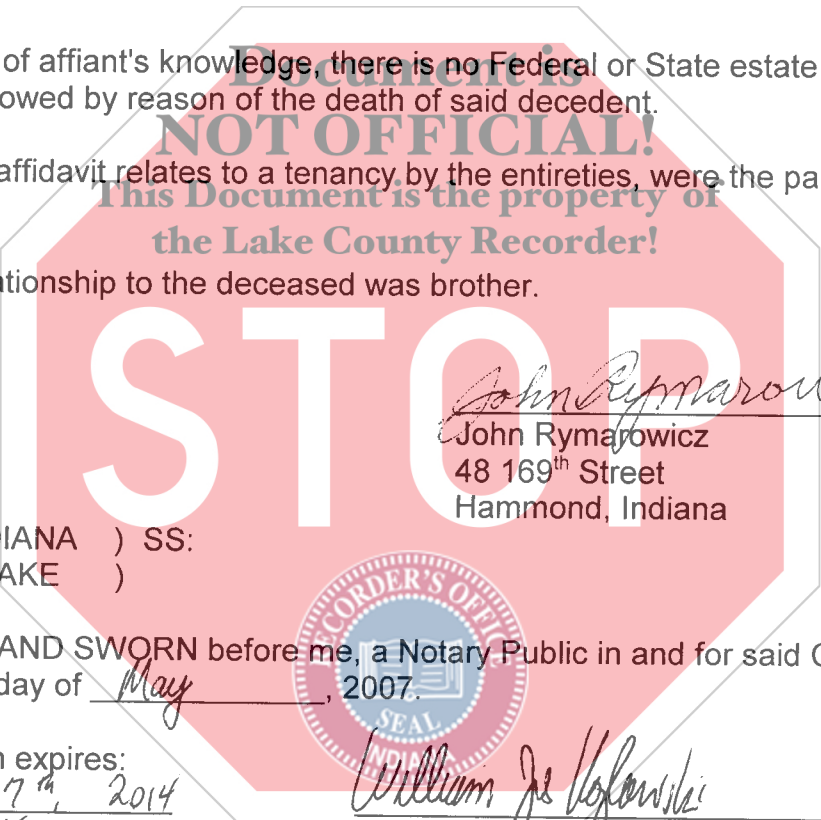
STATE OF INDIANA )  
COUNTY OF LAKE ) SS:

ON THIS 29<sup>th</sup> DAY OF May, 2007, personally appeared John F. Rymarowicz, the affiant, who being duly sworn his upon oath, did say that:

1. Affiant resides at the address given below Affiant's signature;
2. Affiant is joint owner of the premises located at 48 169<sup>th</sup> Street, Hammond, Indiana, and described below;
3. Said premises were formerly owned as joint tenants by John F. Rymarowicz and Lillian Rymarowicz.
4. Said Lillian Rymarowicz died testate on the 23<sup>rd</sup> day of May, 2005.
5. The legal description of the said premises in question is:

Lot 9, Margenaus Subdivision to the City of Hammond.  
Parcel No. 26-35-0049-0009

6. To the best of affiant's knowledge, there is no Federal or State estate or inheritance tax liability still owed by reason of the death of said decedent.
7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? N/A
8. Affiant's relationship to the deceased was brother.



John Rymarowicz  
John Rymarowicz  
48 169<sup>th</sup> Street  
Hammond, Indiana

STATE OF INDIANA ) SS:  
COUNTY OF LAKE )

SUBSCRIBED AND SWORN before me, a Notary Public in and for said County and State, this 29<sup>th</sup> day of May, 2007.

My Commission expires:  
SEPTEMBER 17<sup>th</sup>, 2014  
Resident of LAKE County.

William J. Kozlowski  
NOTARY PUBLIC  
WILLIAM J. KOZLOWSKI

008015

C:\Documents and Settings\Owner\My Documents\BMS\Rymarowicz - Est\AffSurv.wpd

**FILED**

JUN 18 2007

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

2007 049501

JUN 18 PM 3:18

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

MICHAEL A. BRONKHORST  
RECORDER

502

ch # 2527

14

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ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue 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. 146H-05

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANTS

DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Lillian M Rymarowicz</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>9:15 PM</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>May 23, 2005</b>
4. SOCIAL SECURITY NUMBER <b>310-14-7082</b>	5a. AGE—Last Birthday (Years) <b>84</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Sep 12, 1920</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>East Chicago IN</b>		8a. WAS DECEDENT 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 Center</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Dyer</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Single</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Economist</b>		12b. KIND OF BUSINESS/INDUSTRY <b>U.S. Govt</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Hammond</b>		13d. STREET AND NUMBER <b>48-169th Street</b>
13e. ZIP CODE <b>46324</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>USA</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>12</b> College (1-4 or 5+) <b>5</b>		
18. FATHER'S NAME (First, Middle, Last) <b>Casimir Rymarowicz</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Martyniec</b>		
20a. INFORMANT'S NAME (Type/Print) <b>John Rymarowicz</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>48-169th St Hammond IN 46324</b>		20c. Relationship <b>Brother</b>
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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>May 28, 2005 Holy Cross Cemetery</b>		21c. LOCATION—City or Town, State <b>Calumet City IL</b>
22a. EMBALMER'S NAME <b>James W Gholston</b>		22b. EMBALMER'S LICENSE NO. <b>1004194</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John B. Lesniak</i>		24b. LICENSE NUMBER (of Licensee) <b>1005491</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Lesniak FH 83001601 4918 Magoun E. Chicago IN 46312</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. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Acute Renal Failure</b>				
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last				
a. DUE TO (OR AS A CONSEQUENCE OF) <b>Parkinson's disease</b>				
b. DUE TO (OR AS A CONSEQUENCE OF)				
c. DUE TO (OR AS A CONSEQUENCE OF)				
d. DUE TO (OR AS A CONSEQUENCE OF)				
PART II. Other significant conditions: Conditions contributing to death but not previously stated in Part I		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>No</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>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>01042343</b>	29d. DATE SIGNED (Month, Day, Year) <b>5/25/05</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>S. Patel 9108 Columbia Ave Munster IN 46321</b>				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) <b>May 26, 2005</b>
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—Give County, Precinct, and Number or Rural Route Number, City or Town, State		34g. DATE PRONOUNCED DEAD (Month, Day, Year) <b>May 23 2005</b>		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				