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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2007 JUN 27 AM 9:26

MICHAEL A. BROWN  
RECORDER

2007 052272

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

**AFFIDAVIT OF SURVIVORSHIP**

Comes now Dorothy H. Gumulauski being duly sworn upon her oath, and states as follows:

That Dorothy H. Gumulauski is the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

Lot 197 in Northgate 3<sup>rd</sup> Addition, Unit B, to the Town of Dyer, as per plat thereof, recorded in Plat Book 41 Page 21, In the Office of the Recorder of Lake County, Indiana.  
More commonly known as 914 Harrison Place, Dyer, Indiana. Key No. 14-125-24

That the Affiant and the decedent, Robert J. Gumulauski, were married on the 10<sup>th</sup> day of October, 1964 and that they took title to the aforesaid real estate by Corporate Warranty Deed dated August 25, 1971, recorded on September 3, 1971, document number 115305.

Affiant further states that her husband, Robert J. Gumulauski died on the 17<sup>th</sup> day of April 2007, at which time she became the sole owner of the aforesaid real estate as surviving tenant by the entireties.

That Affiant makes this Affidavit of Survivorship to induce the Auditor of Lake County to show her as sole owner of said real estate on the tax records of said county.

Further, Affiant sayeth not.

*Dorothy H. Gumulauski*  
Dorothy H. Gumulauski, Affiant

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Before me, the undersigned, a Notary Public in and for Lake County and State of Indiana, personally appeared Dorothy H. Gumulauski and being first duly sworn upon her oath, says that the facts alleged in the following Affidavit are true. Signed and sealed this 20 day of JUNE, 2007.

My Commission Expires: 8.15.08

Notary Public, *[Signature]*  
County of Residence: LAKE

This instrument prepared by: **JOSEPH E. MORRISON**  
Attorney No. 21024-37  
ATTORNEY AT LAW  
P.O. BOX 262  
ROSELAWN, INDIANA 46372

**SHARLENE SAYRE**  
NOTARY PUBLIC, Lake County, Indiana  
My Commission Expires August 15, 2008  
Resident of Lake County, Indiana

***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. Joseph E. Morrison***

#13  
CS  
CA

**FILED**

12314

JUN 27 2007  
PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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. (059-01) .....

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) <b>ROBERT J. GUMULAUSKI</b>				2. SEX <b>Male</b>	3a. TIME OF DEATH <b>7:17 AM</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>April 17, 2007</b>	
4. *SOCIAL SECURITY NUMBER <b>316-36-6142</b>		5a. AGE—Last Birthday (Years) <b>69</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Sept. 27, 1937</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>East Chicago, Indiana</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>yes</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1966</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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) <b>914 Harrison Pl.</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>Dorothy Jerzak</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Expeditor</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Inland Steel Co</b>	
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Dyer</b>		13d. STREET AND NUMBER <b>914 Harrison Pl.</b>	
13e. ZIP CODE <b>46311</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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></b>					
18. FATHER'S NAME (First, Middle, Last) <b>John A. Gumulauski</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Laska</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Dorothy H. Gumulauski</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>914 Harrison Pl., Dyer, Indiana 46311</b>			20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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>April 20, 2007 SOLAN-PRUZIN CREMATORY</b>			21c. LOCATION—City or Town, State <b>Schererville, Indiana</b>	
22a. EMBALMER'S NAME <b>Dean G. Wagner</b>			22b. EMBALMER'S LICENSE NO. <b>FD# 08800057</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John A. Pruzin</i>			24b. LICENSE NUMBER (of Licensee) <b>FD# 01007231</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>SOLAN-PRUZIN FUNERAL HOME FH#10200037 14 Kennedy Ave., Schererville, IN 46375</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. <b>Prostate Cancer</b>							
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death <b>Yes</b> THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. <b>APR 20 2007</b>			
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		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>na</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>na</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>01038072</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 17, 2007</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Erwin L. Robin M.D., 801 McArthur, Munster, Indiana 46321</b>							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>							32. DATE FILED (Month, Day, Year) <b>April 20, 2007</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. 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.			