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STATE OF INDIANA )  
COUNTY OF LAKE )

2007 075010

) SS:

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2007 SEP 18 AM 9:49

MICHAEL A. BROWN  
RECORDER

**FILED**

SEP 18 2007

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

**AFFIDAVIT OF SURVIVORSHIP**

Donald Kurcz, being duly sworn upon his oath and states as follows:

1. Donald Kurcz is the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

Lot No. Seventeen in Block Six (6) as marked and laid down on the recorded plat of West Park Addition to Hammond, Lake County, Indiana.

Key No: 26-36-0310-0017

Commonly known as: 2042 Lincoln Avenue, Whiting, Indiana 46394.

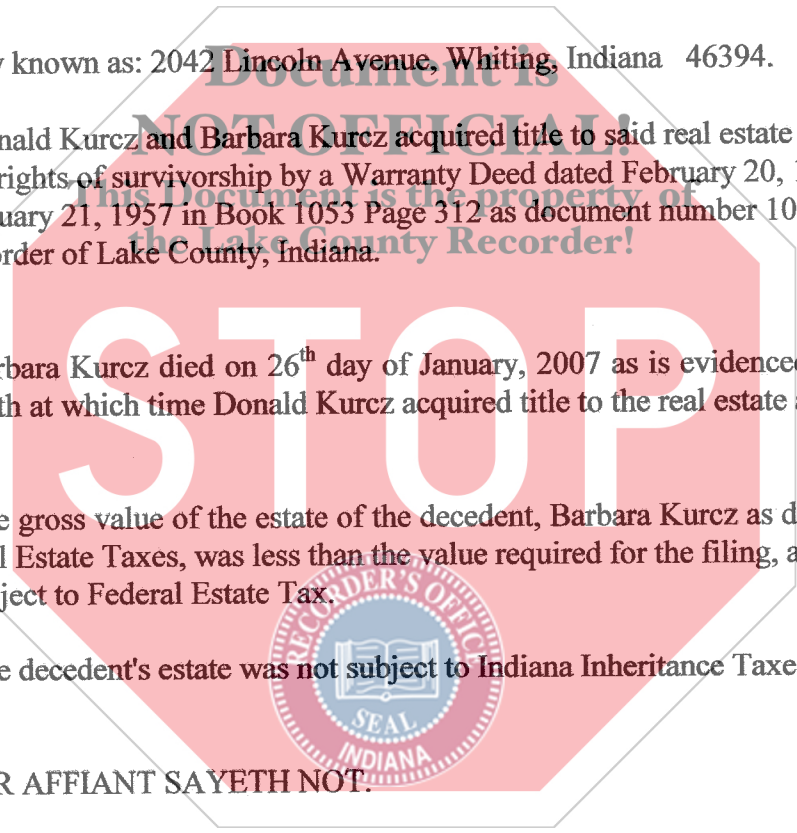
2. Donald Kurcz and Barbara Kurcz acquired title to said real estate as joint tenants with rights of survivorship by a Warranty Deed dated February 20, 1957 and recorded February 21, 1957 in Book 1053 Page 312 as document number 10264 in the Office of the Recorder of Lake County, Indiana.

3. Barbara Kurcz died on 26<sup>th</sup> day of January, 2007 as is evidenced by the attached Certificate of Death at which time Donald Kurcz acquired title to the real estate as surviving joint tenant.

4. The gross value of the estate of the decedent, Barbara Kurcz as determined for the purpose of Federal Estate Taxes, was less than the value required for the filing, and the decedent's estate was not subject to Federal Estate Tax.

5. The decedent's estate was not subject to Indiana Inheritance Taxes.

FURTHER YOUR AFFIANT SAYETH NOT.



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3117

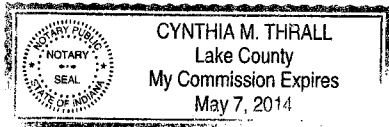
014883

x Donald Kurcz  
Donald Kurcz

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

Before me, a Notary Public in and for the State of Indiana, personally appeared Donald Kurcz, who acknowledged the execution of the foregoing Affidavit of Survivorship.

Witness my hand and Notarial Seal this 10th day of July, 2007.

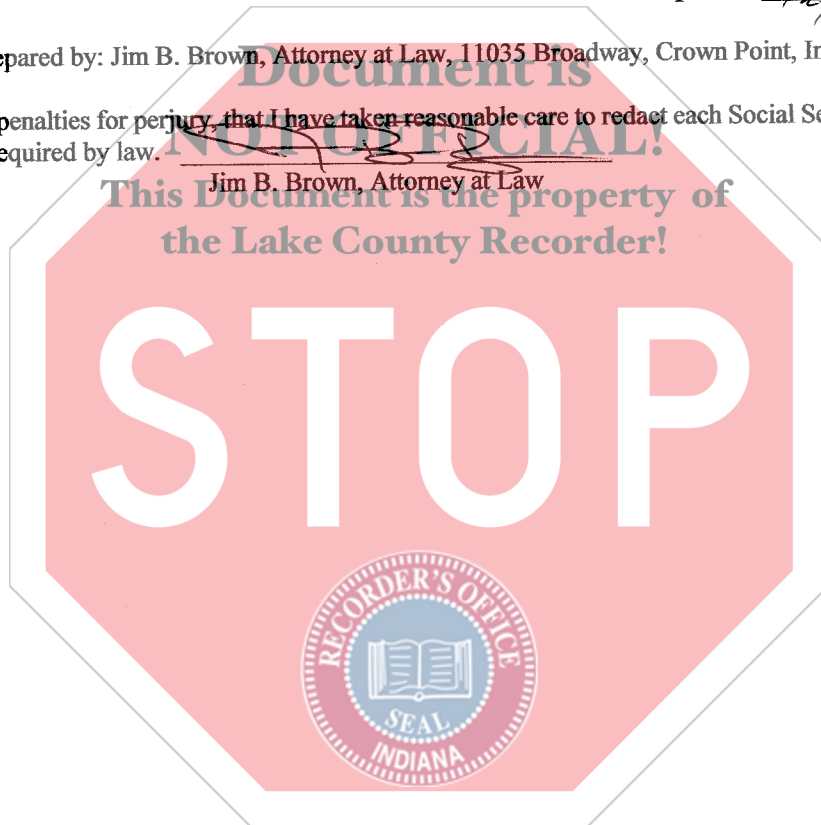


Cynthia M Thrall  
Notary Public  
Cynthia M Thrall  
Printed  
County of Residence: Lake  
Commission Expires: May 7, 2014

→ This instrument prepared by: Jim B. Brown, Attorney at Law, 11035 Broadway, Crown Point, Indiana 46307

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.

Jim B. Brown, Attorney at Law



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

Jan 29 2007 Date Issued  
Hammond Health Commissioner

Local No. 42

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>BARBARA A. KURCZ</b>			2. SEX <b>FEMALE</b>		3a. TIME OF DEATH <b>9:55P M</b>		3b. DATE OF DEATH (Month, Day, Yr) <b>JANUARY 26, 2007</b>								
4. *SOCIAL SECURITY NUMBER <b>317-38-4982</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>FEB. 1, 1937</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>BERWYN, ILLINOIS</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 checked="" type="checkbox"/> Residence											
9b. FACILITY NAME (If not institution, give street and number) <b>2042 LINCOLN AVENUE</b>					9c. CITY, TOWN, OR LOCATION OF DEATH <b>HAMMOND</b>			9d. COUNTY OF DEATH <b>LAKE</b>							
10. MARITAL STATUS (Specify) <b>NEVER MARRIED/</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>CLERICAL</b>				12b. KIND OF BUSINESS/INDUSTRY <b>BANK</b>							
13a. RESIDENCE—STATE <b>INDIANA</b>		13b. COUNTY <b>LAKE</b>		13c. CITY, TOWN, OR LOCATION <b>HAMMOND (WHITING P.O.)</b>			13d. STREET AND NUMBER <b>2042 LINCOLN AVENUE</b>								
13e. ZIP CODE <b>46394</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>12</b> College (1-4 or 5+) <b></b>					
18. FATHER'S NAME (First, Middle, Last) <b>WALTER KURCZ</b>					19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CATHERINE DVORSCAK</b>										
20a. INFORMANT'S NAME (Type/Print) <b>MR. DONALD KURCZ</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10855 PARK AVE., CROWN POINT, IN 46307/</b>				20c. Relationship <b>BROTHER</b>							
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>XX Cremation</b>			21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>JANUARY 30, 2007 HERITAGE CREMATORY</b>				21c. LOCATION—City or Town, State <b>PORTAGE, INDIANA</b>								
22a. EMBALMER'S NAME <b>HENRY J. BLAKE</b>			22b. EMBALMER'S LICENSE NO. <b>FDE01019406</b>			23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes									
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>			24b. LICENSE NUMBER (of Licensee) <b>FDE01019456</b>			25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BARAN &amp; SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394</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>Natural Causes</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:  PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I. <b>Hypertension, Type II Diabetes, Smoker, Polycythemia</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>[Signature]</i>								29c. MEDICAL LICENSE NO. <b>02061515A</b>		29d. DATE SIGNED (Month, Day, Year) <b>JAN. 29, 2007</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print) <b>CHRISTOPHER MCINTIRE, D.O., 3831 HOHMAN AVE., HAMMOND, INDIANA 46327</b>															
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>										32. DATE FILED (Month, Day, Year) <b>January 29, 2007</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 (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.											