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Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

BT701107

On this 11/27/07 before me personally appeared Julia IZAK
(insert date)

CHICAGO TITLE INSURANCE COMPANY

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:

2. Affiant is owner
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Stefan IZAK and Julia IZAK

4. Said Stefan IZAK
(fill in name of co-tenant who died)
died on JANUARY 8, 1995
leaving a will;
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:

Beutin's ADD. W 1/2, LOT 8

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? Yes No

If yes, then estimated taxes due are \$

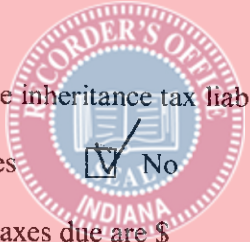
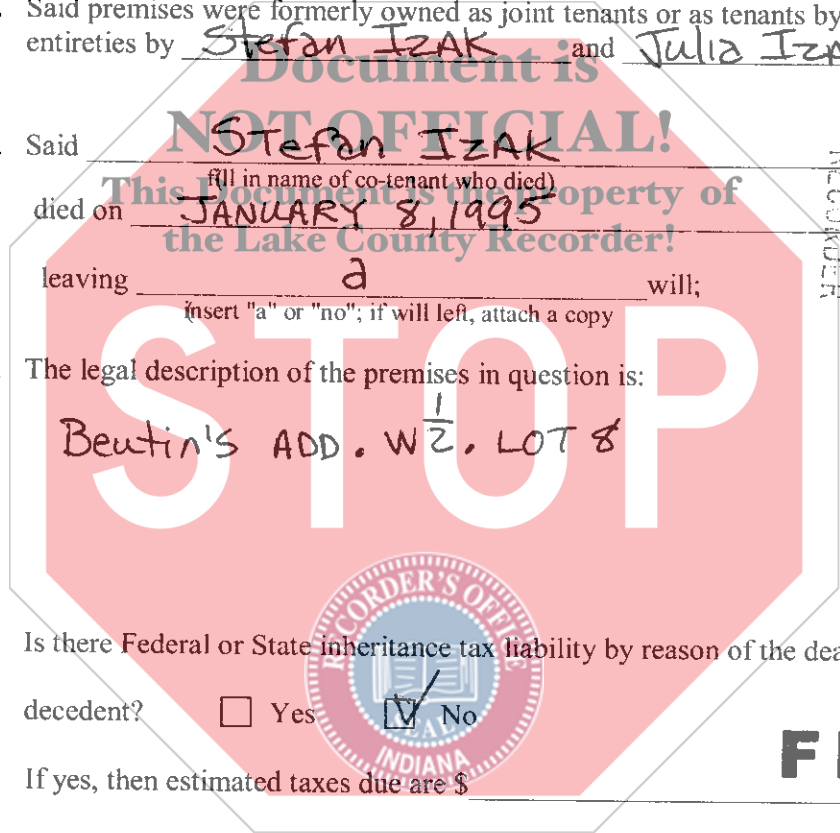
The taxes due are paid or unpaid..

2007 096786

MICHAEL A. BROWN
RECORDER

2007 DEC 11 AM 9:19

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDS



FILED

16507

DEC 10 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

024258

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? no

(If answer is "Yes" , identify the divorce proceedings:

8. Affiant's relationship to the deceased was wife

* Signature: Julia Izak

Printed Name Julia IZAK

Address: 400 Cranesbill Drive

West Chicago, IL 60185

Subscribed and sworn to before me by the affiant

c/o Michael S. Pylupczak

This 11/27/07
(insert date)

Elizabeth V. Federoff
Notary Public

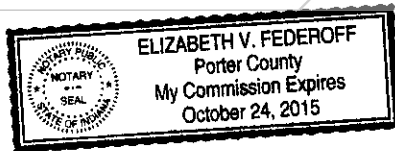
Printed Name Elizabeth V. Federoff

My County of Residence is: Porter

In the State of IN

My Commission Expires 10/24/15

This instrument prepared by Julia Izak



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. Vivan Federoff

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities 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.

Local No. 28

Date Issued Jan 12, 1995
Hammond Health Commissioner

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED—NAME (First, Middle, Last) Stefan Izak		2. SEX Male	3a. TIME OF DEATH 5:45 a.m.	3b. DATE OF DEATH (Month, Day, Year) January 8, 1995	
4. *SOCIAL SECURITY NUMBER [REDACTED]-3427	5a. AGE—Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day, Yr) May 6, 1913	
7. BIRTHPLACE (City and State or Foreign Country) Ukraine	8a. WAS DECEDENT A U.S. VETERAN? no				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? no		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) St. Margaret Mercy-North Campus		9c. CITY, TOWN, OR LOCATION OF DEATH Hammond	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Julia Zaluckyj	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Mechanic		12b. KIND OF BUSINESS/INDUSTRY Inland Steel	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond		13d. STREET AND NUMBER 1037-167th Street	
13e. ZIP CODE 46323	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) 8th College (1-4 or 5+) ---		18. FATHER'S NAME (First, Middle, Last) John Izak			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Anastasia Zaluckyj		20a. INFORMANT'S NAME (Type/Print) Julia Izak			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1037-167th Street, Hammond, Indiana 46323		20c. Relationship Wife			
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) January 11, 1995 St. Nicholas Cemetery		21c. LOCATION—City or Town, State Hammond, Indiana	
22a. EMBALMER'S NAME Dean G. Wagner		22b. EMBALMER'S LICENSE NO. 8800057	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24. SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b. LICENSE NUMBER (of licensee) 8800057	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Solan Funeral Home #83002893 7109 Calumet Avenue, Hammond, In. 46323		
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. Coronary Disease DUE TO (OR AS A CONSEQUENCE OF):					
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)		28a. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
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>S. Makam</i>		29c. MEDICAL LICENSE NO. 31764	29d. DATE SIGNED (Month, Day, Year) January 11, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) S. Makam, M. D. 9122 Columbia Avenue, Munster, Indiana					
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Remuda, M.D.</i>				32. DATE FILED (Month, Day, Year) JAN 11 1995	
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.			