2

HEIRSHIP AFFIDAVIT

2007 098840

CYNTHIA J. BADOWSKI, being first duly sworn upon oath, deposes and says:

1. That your Affiant is the daughter of HELEN L. STANEK.

2. That HELEN L. STANEK reserved a Life Estate to the following described real estate:

LOT 36 AND THE SOUTH HALF OF LOT 37 IN BLOCK 9 AS MARKED AND LAID DOWN ON THE RECORDED PLAT OF DOUGLAS PARK MANOR, A SUBDIVISION IN THE CITY OF HAMMOND, LAKE COUNTY, INDIANA, AS THE SAME APPEARS OF RECORD IN PLAT BOOK 17 PAGE 26 IN THE RECORDER'S OFFICE OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS: 3844 TORRENCE AVENUE, HAMMOND, IN 46327

3. That said HELEN L. STANEK DIED ON THE 27TH DAY OF DECEMBER, 1999.

FURTHER AFFIANT SAITH NOT.

I AFFIRM UNDER THE PENALTIES FOR PERJURY, that the above and foregoing representations are true and correct to the best of my knowledge and belief.

B

x Cynthia J Badowski

CYNTHIA J. BADOWSKI

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.

STATE OF INDIANA

COUNTY OF PORTER

Before me a Notary Public in and for said County and State this 12th day of December 2007 personally appeared Cynthia J. Badowski and acknowledged the execution of the Above and foregoing to be her voluntary act and deed.

My Commission Expires:

NOTARY PUBLIC

County of Residence:

THIS INSTRUMENT PREPARED BY: RICHARD A. ZUNICA, ATTORNEY AT LAW, 162 Washington Street, Lowell, In 46356

FILE NO. 07-16614

RICHARD A. ZUNICA
Porter County
My Commission Expires
August 31, 2014

FILED

DEC 17 2007

PEGGY
LAKE COUNTY

1441
14 DC

025231

* **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.

Local No. 1017

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

Feb 23, 2007 — Date Issued — Hammond Health Commissioner

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
HELEN L. STANEK	FEMALE	7:04 A M	DECEMBER 27, 1999

4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
[redacted]	77			DECEMBER 12, 1922	WHITING, INDIANA

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
NO	- N/A	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
3844 TORRENCE AVENUE	HAMMOND	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	PETER A. STANEK	HOMEMAKER	OWN HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	3844 TORRENCE AVENUE

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46327	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	9	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN KAMINSKY	ANNA KUHAR

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
PETER A. STANEK	3844 TORRENCE AVE., HAMMOND, INDIANA 46327	HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____	DECEMBER 30, 1999 CHAPEL LAWN MEMORIAL GARDENS	SCHERERVILLE, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
KEITH D. ANTHONY	01011911	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Keith D Anthony	01011911	ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327

CAUSE OF DEATH

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)	a atherosclerotic cardiovascular disease	
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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	NO	NO	NO

CERTIFIER

29a CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated

☐ 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

☐ 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
	01051272	DECEMBER 27, 1999

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

SONA KAMMULA M.D. 5500 HOHMAN AVENUE, HAMMOND, INDIANA 46320

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Grenuda M.D.	December 29, 1999

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

SDH06-004, State Form 10110 (R5/1-99)