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# TICOR TITLE INSURANCE

2008 044352

2008 JUN 16 10:51:14

## AFFIDAVIT

NOTARY PUBLIC  
LAKE COUNTY

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

Kathleen M. Pilackas, being first duly

Sworn upon oath, deposes and says:

1. That Peter A. Pilackas  
died on August 17, 2000 at \_\_\_\_\_

2. That Peter A. Pilackas and Kathleen M. Pilackas  
were duly and legally married at the time they acquired title as husband and wife  
to the following described real estate:

See attached . . .

3. That the marital relationship which existed between them at the time they acquired  
title to said real estate remained in effect and unbroken until the date of his/her death.

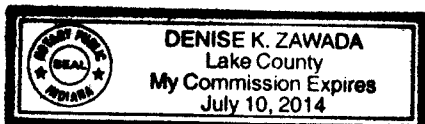
4. That all funeral expenses in connection with the death of said decedent have been  
paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate  
tax purposes, including joint bank accounts and life insurance on decedent's life were  
Not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

*Kathleen M. Pilackas*  
Kathleen M. Pilackas

Subscribed and sworn to before me, a Notary Public, this 12th day of  
June, 2008.



*Denise K. Zawada*  
Notary Public:  
Denise K. Zawada

My commission expires: 3/14/15

County of Residence: Lake

"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." Janet McDonald.

"Aff only"

This Instrument prepared by: Kathleen M. Pilackas

928-2123 SOTIO  
TICOR TITLE INSURANCE  
(PLEASE PRINT MAILING ADDRESS)

009867

No: 920082123

## LEGAL DESCRIPTION

Part of the Northwest 1/4 of Section 19, Township 35 North, Range 9 West of the 2nd Principal Meridian, more particularly described as follows: Commencing at a point 1,239.80 feet East of the Southwest corner of said Northwest 1/4 and running thence North 444.49 feet; thence East 245 feet; thence South 444.49 feet; thence West 245 feet to the place of beginning, in Lake County, Indiana.



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. 1909-00

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

ALTHICER

1 DECEASED--NAME (First, Middle, Last) Peter Allen Pilackas				2 SEX Male		3a TIME OF DEATH 1:30 P.M.		3b DATE OF DEATH (Month, Day, Yr) August 17, 2000	
4 *SOCIAL SECURITY NUMBER 340-30-8359		5a AGE--Last Birthday (Years) 59		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) December 29, 1940	
7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana		8a WAS DECEDENT A U.S. VETERAN? No							
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" 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) Methodist Hospital-Southlake				9c CITY, TOWN, OR LOCATION OF DEATH Merrillville			9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Kathleen M. Brown		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Bricklayer			12b KIND OF BUSINESS/INDUSTRY Union Local 4		
13a RESIDENCE--STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Dyer			13d STREET AND NUMBER 14000 W. 81st Ave		
13e ZIP CODE 46311		13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		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) 12 College (1-4 or 5 +)		18 FATHER'S NAME (First, Middle, Last) Edward Pilackas				19 MOTHER'S NAME (First, Middle, Maiden Surname) Irene Wojchiewski			
20a INFORMANT'S NAME (Type/Print) Kathleen M. Pilackas				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14000 W. 81st Ave Dyer, Indiana 46311				20c Relationship Wife	
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) August 21, 2000 Chapel Lawn Memorial Gardens				21c LOCATION--City or Town, State Schererville, Indiana		
22a EMBALMER'S NAME Edward F. Mullaney				22b EMBALMER'S LICENSE NO. FDO 1007176		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullaney</i>			24b LICENSE NUMBER (of licensee) FDO 1007176		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Homes Inc FH83001504 1920 Hart St Dyer, Indiana 46311				
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 <i>Sudden cardiac death</i> DUE TO (OR AS A CONSEQUENCE OF) b <i>Coronary artery disease</i> 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.						27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) 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>Conrado P. Castor MD</i>						29c MEDICAL LICENSE NO. 01027402		29d DATE SIGNED (Month, Day, Year) 8/18/2000	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 911 FRAN-LIN PKWY MUNSTER, IN 46321 CONRADO P. CASTOR, M.D.									
31 HEALTH OFFICER'S SIGNATURE <i>Alexander A. Hillman MD</i>						32 DATE FILED (Month, Day, Year) August 18, 2000			
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.						