STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2008 066839

2008 SEP 25 AM 8:55

MICHAEL A. BROWN
RECORDER

STATE OF WISCONSIN)
) SS:
COUNTY OF DANE)

AFFIDAVIT

Stephen J. Sramek, Personal Representative of the Estate of Anna M. Sramek, deceased, being first duly sworn upon oath, deposes and says:

1. That I am the son of Stephen Sramek a/k/a Stephan Sramek, who died on April 4, 1994, and Anna M. Sramek, who died on September 29, 2006, both residents of Lake County, Indiana.

2. That the deaths of my above-described parents are evidenced by Certificates of Death of both of them, which are attached hereto and made a part hereof, and that although the Certificate of Death of my father shows his Christian name as "Stephan," his correct legal Christian name was "Stephen."

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the Lake County Recorder!

3. That Anna M. Sramek and Anna Sramek were one and the same person.

4. That my father was legally married to my mother at the time they acquired title, as husband and wife, to the following described real estate:

Lot 45 in Innsbrook Unit 4, as per plat thereof, recorded in Plat Book 37, page 93, in the Office of the Recorder of Lake County, Indiana.
45-12-08-176-008.000-030

5. That the marital relationship which existed between my parents at the time they acquired title to said real estate remained in effect and unbroken until the date of death of my father.

STOP

Stephen J. Sramek, Personal Representative of the Estate of Anna M. Sramek, deceased, under Cause No. 45C01-0611-EU-0190 in the Lake County, Indiana Circuit Court

920084919

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SEP 23 2008

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

015813

STATE OF WISCONSIN)
) SS:
COUNTY OF DANE)

Before me, the undersigned, a Notary Public in and for said County and State, this 2 day of September, 2008, personally appeared Stephen J. Sramek, Personal Representative of the Estate of Anna M. Sramek, deceased, who acknowledged the execution of the foregoing document. In witness whereof, I have hereunto subscribed my name and affixed my official seal.

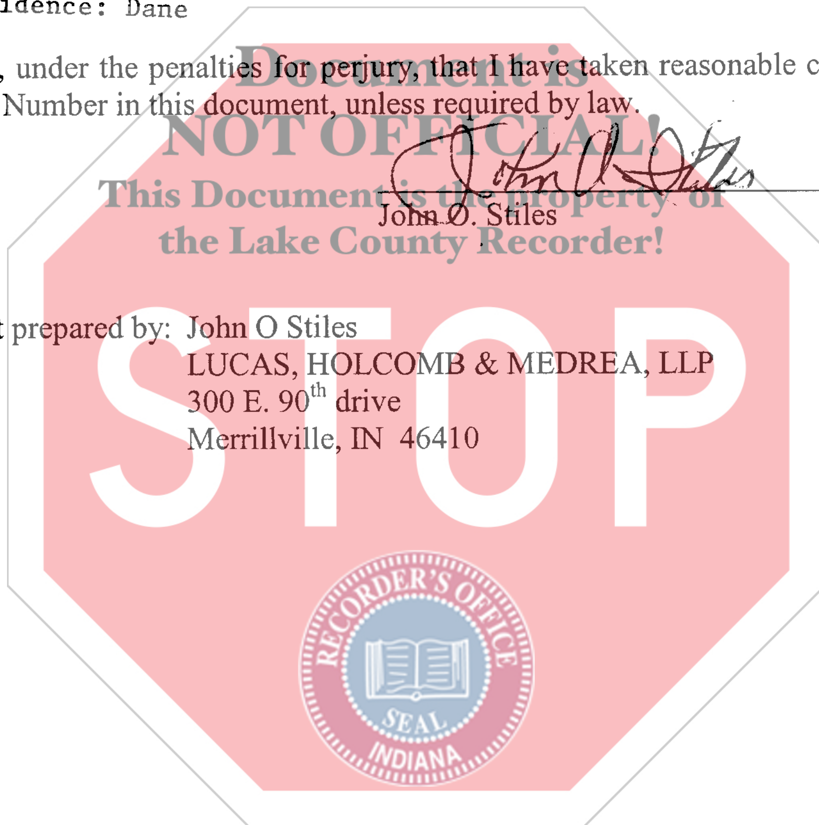
Notary Public

My Commission Expires: 12-6-09

County of Residence: Dane

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.

John O. Stiles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This instrument prepared by: John O Stiles
LUCAS, HOLCOMB & MEDREA, LLP
300 E. 90th drive
Merrillville, IN 46410

TTENTION ESTATE: Disclosure of the S# we need to pursue our responsibilities voluntary and there will be no penalty for fusal.*

ocal No. 0800-94

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED—NAME (First, Middle, Last): STEPHAN SRAMEK
- 2. SEX: MALE
- 3a. TIME OF DEATH: 2:45 AM
- 3b. DATE OF DEATH (Month, Day, Yr): APRIL 4, 1994
- 4. *SOCIAL SECURITY NUMBER: [redacted]-0368
- 5a. AGE—Last Birthday (Years): 86
- 5b. UNDER 1 YEAR: Months / Days
- 5c. UNDER 1 DAY: Hours / Minutes
- 6. DATE OF BIRTH (Mo, Day, Yr): JAN.14,1908
- 7. BIRTHPLACE (City and State or Foreign Country): PIKE CREEK, OHIO
- 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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)
- 9b. FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL SOUTHLAKE CAMPUS
- 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): ANNA MAYERIK
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MILLWRIGHT FOREMAN
- 12b. KIND OF BUSINESS/INDUSTRY: YOUNGSTOWN SHEET & TU
- 13a. RESIDENCE—STATE: INDIANA
- 13b. COUNTY: LAKE
- 13c. CITY, TOWN, OR LOCATION: MERRILLVILLE
- 13d. STREET AND NUMBER: 6420 ELLSWORTH PLACE
- 13e. ZIP CODE: 46410
- 13f. INSIDE CITY LIMITS: [ ] No [X] Yes
- 13g. ON A FARM?: [X] No [ ] Yes
- 14. CITIZEN OF WHAT COUNTRY?: USA
- 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes
- 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+):

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): STEPHAN SRAMEK
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): MARY WADINA

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): ROSEMARY ZOLEZZI
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6420 ELLSWORTH PL., MERRILLVILLE, IN 46410
- 20c. Relationship: DAUGHTER

DISPOSITION

- 21a. METHOD OF DISPOSITION: [XXX] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 7, 1994 CHAPEL LAWN MEMORIAL GARDENS
- 21c. LOCATION—City or Town, State: SCHERERVILLE INDIANA
- 22a. EMBALMER'S NAME: GORDON L. JONES
- 22b. EMBALMER'S LICENSE NO.: 1010711
- 23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Terrence P. Burns
- 24b. LICENSE NUMBER (of Licensee): 1013890
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home,10101 Broadway Crown Point,IN 46307 FDH83002445

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

	Cause	Approximate Interval Between Onset and Death
a.	Anoxic Encephalopathy	
b.	DUE TO (OR AS A CONSEQUENCE OF) Ventricular Dysrhythmia	
c.	DUE TO (OR AS A CONSEQUENCE OF) Congestive Cardiomyopathy	
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): 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): N/A

CERTIFIER

29a. CERTIFIER (Check only one)
- [XXX] 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: Richard Buyer MD
- 29c. MEDICAL LICENSE NO.: 01025233
- 29d. DATE SIGNED (Month, Day, Year): April 6, 1994
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Richard Buyer, 8895 Broadway, Merrillville, IN 46410

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
- 32. DATE FILED (Month, Day, Year): April 6, 1994

- 33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
- 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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 2330-06

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last): Anna M. Sramek
2. SEX: Female
3a. TIME OF DEATH: 3:41AM
3b. DATE OF DEATH (Month, Day, Yr.): September 29, 2006
4. *SOCIAL SECURITY NUMBER: [redacted]-1539
5a. AGE - Last Birthday (Years): 93
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): July07,1913
7. BIRTHPLACE (City and State or Foreign Country): New Brighton Pennsylvania
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 6420 Ellsworth Place
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: At Home
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Merrillville
13d. STREET AND NUMBER: 6420 Ellsworth Place
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): Stephen Mayerik
19. MOTHER'S NAME (First, Middle, Maiden Surname): Sophie Linet

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Stephen Sramek
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2834 Waunona Way, Madison, WI 53713
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 2, 2006 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION - City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: TERRENCE P. BURNS
22b. EMBALMER'S LICENSE NO.: 1013890
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F. Burns
24b. LICENSE NUMBER (of Licensee): FD01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. CHF pneumonia
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

Approximate Interval Between Onset and Death:

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): 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: A. Kawamleh
29c. MEDICAL LICENSE NO.: 01052395A
29d. DATE SIGNED (Month, Day, Year): 10-10-06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)(Type/Print): DR. ABDUL KAWAMLEH 8895 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.
32. DATE FILED (Month, Day, Year): October 11, 2006

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): September 29, 2006
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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