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SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA) **2009 061926**
)SS:
COUNTY OF LAKE)

2009 SEP -9 AM 10: 39

**MICHAEL A. BROWN
RECORDER**

On this 28TH day of AUGUST 2009, before me personally appeared JOHN P. LEDZIUS A/K/A JOHN D. LEDZIUS who being duly sworn on his/her oath states the following:

1. That the Affiant is the owner of the real estate located in Lake County, State of Indiana, more particularly described as follows:

LOT 619, LAKES OF THE FOUR SEASONS, UNIT NO. 2, AS SHOWN ON PLAT IN PLAT BOOK 37 PAGE 76 IN THE RECORDER'S OFFICE IN LAKE COUNTY, INDIANA.

2. That said premises were formerly owned as tenants by the entireties by JOHN P. LEDZIUS A/K/A JOHN D. LEDZIUS and JUDITH M. LEDZIUS, husband and wife.

3. That said JUDITH M. LEDZIUS died on MAY 13, 2009 a resident of Lake County, Indiana, leaving no Will.

4. That by reason of the death of JUDITH M. LEDZIUS, there are no Federal Estate Taxes nor Indiana Inheritance Taxes due and payable by reason of the death of said Decedent.

5. That on the date of the death of JUDITH M. LEDZIUS said parties, namely, JOHN P. LEDZIUS A/K/A JOHN D. LEDZIUS and JUDITH M. LEDZIUS, were husband and wife, and have not been divorced.

FURTHER AFFIANT SAITH NOT.

NORTHWEST INDIANA TITLE
162 WASHINGTON STREET
LOWELL, IN 46356
219-696-0100



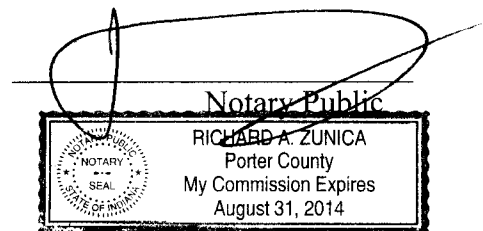
John P. Ledzius
JOHN P. LEDZIUS A/K/A
JOHN D. LEDZIUS

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said County and State, this 28TH day of AUGUST, 2009 personally appeared JOHN P. LEDZIUS A/K/A JOHN D. LEDZIUS and acknowledged the execution of the foregoing affidavit. IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal.

My Commission Expires:

County of Residence:



THIS INSTRUMENT PREPARED BY: RICHARD A. ZUNICA, Attorney at Law
162 Washington Street, Lowell IN 46356

FILE NO. 09-17701

FILED

SEP 09 2009

**PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR**

015394

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.

Blues Caputo

1400
1922
RM

RESNO



INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No. 1886-09

State No.

1. Decedent's Legal Name (First, Middle, Last) JUDITH M. LEDZIUS				2. Maiden Last Name (If Female) DANIEL		3. Sex FEMALE	4. Time of Death 8:06 PM	5. Date of Death (Month/Day/Year) MAY 13, 2009		
6. Social Security Number [REDACTED]	8a. Age - Yrs 69	8b. Under 1 Year Months	8c. Under 1 Month Days	8d. Under 1 Day Hours	8e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) NOVEMBER 8, 1939		8. Birthplace (City, State, and Country) CHICAGO, ILLINOIS		
9. Entered U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (Unknown)		10. If Death Occurred in a Hospital <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Department/Outpatient <input type="checkbox"/> Dead On Arrival		10a. If Death Occurred Somewhere Other Than a Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long Term Care Facility <input type="checkbox"/> Other (Specify)						
11. Facility Name, Address, City, State, and Zip Code ST. ANTHONY MEDICAL CENTER										
12. City or Town, State and Zip Code CROWN POINT, IN 46307				13. County of Death LAKE		14. Marital Status At Time of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married - Not Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
15. Surviving Spouse's Name JOHN DONALD LEDZIUS		15a. Relationship to Decedent N/A		16. Decedent's Usual Occupation FLORIST		17. Kind of Business/Industry FLOWERS				
18. Residence - State INDIANA		18a. County LAKE		18b. City or Town CROWN POINT		15b. Zip Code 46307		18c. Single City Name <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
18c. Street and Number 3655 KINGSWAY DRIVE										
19. Decedent's Education SOME COLLEGE CREDIT NO DEGREE		20. Decedent Of (Immigrant Origin) NO		21. Decedent's Race WHITE						
22. Father's Name (First, Middle, Last) ALBERT DANIEL				23. Mother's Name (First, Middle, Last) EVELYN ABRAM		24. Mother's Maiden Last Name OLANDER				
25. Relationship to Decedent HUSBAND		26. Relationship to Decedent HUSBAND		27. Mailing Address (Street and Number, City, State, and Zip Code) 3655 KINGSWAY DRIVE CROWN POINT, IN 46307						
28. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)										
29. Place of Disposition SERVICE		29a. Location (City, Town, and State) CROWN POINT, INDIANA								
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name and Complete Address of Funeral Home BURNS FUNERAL HOME 10101 BROADWAY CROWN POINT, IN 47307				29c. Funeral Home License Number 83002445				
27a. Signature of Licensed Funeral Service Licensee <i>James E. Burns</i>		27b. License Number of Licensee 01009461								
20. Part I. Enter the Chain of Events - Diseases, Injuries, or Complications That Directly Caused the Death. Do Not Enter Terminal Events Such as Cardiac Arrest, Respiratory Arrest, or Ventricular Fibrillation Without Stating the Etiology. Do Not Abbreviate. Enter Only One Cause on Line A. Add Additional Lines if Necessary. Immediate Cause (Final Disease or Condition Resulting in Death) A. Probable Acute Myocardial Infarction Minutes B. Myocardial Ischemia C. Myocardial Ischemia D. Myocardial Ischemia Approximate Interval of Onset to Death Years										
Part II. Enter the Underlying Cause (Disease or Injury That Initiated the Events Resulting in Death) Last Chronic Obstructive Pulmonary disease										
29. Was Air Rescue Potentially Available to Transport the Decedent to a Hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
30. Were Adequate Facilities Available to Complete the Death Certificate? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
31. Did Tobacco Use Contribute to Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time of Death <input type="checkbox"/> Not Pregnant, Not Pregnant/Within 42 Days of Death <input type="checkbox"/> Unknown: Pregnant Within Past Year		33. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined		34. Date of Injury (Month/Day/Year)		35. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
36. Location of Injury - State		36a. City or Town		36b. Street & Number		36c. Zip Code		36d. ZIP Code		
37. Date of Injury Reported		38. Date of Injury Reported		39. Date of Injury Reported		39. Date of Injury Reported		39. Date of Injury Reported		
41. Signature of Person Reporting Cause of Death <i>[Signature]</i>				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer						
43. Name, Address and Zip Code of Person Certifying Cause of Death MICHAEL KOVACICH, M.D. 200 E. 80TH PLACE MERRILLVILLE, IN 46410				44. License Number 01033371		45. Date Certified 5-26-09				
46. Signature of Local Health Officer <i>Susan J. Best DO</i>				47. Date Certified June 5, 2009						

