

4

AFFIDAVIT OF MORTGAGE SATISFACTION

Comes now LEE J. MILAZZO, being duly sworn upon his oath, and states as follows:

1. That the affiant is the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

Lot 22 in Homestead Heights 2nd Addition to the Town of St. John, Lake County, Indiana, as shown in Plat Book 64, page 43, in the Recorder's Office of Lake County, Indiana.

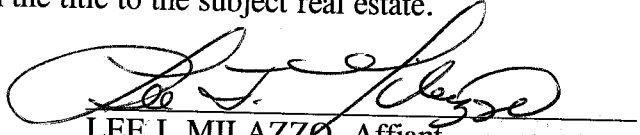
Commonly known as: 11735 Homestead Heights Drive, St. John, IN 46373

2. That the undersigned executed a mortgage for said property in the amount of One Hundred Eighty Five Thousand Dollars (\$185,000), which was recorded as **Document Number 071916** on December 4, 1989 and said mortgage's holder was the undersigned's father Leo J. Milazzo, Sr., who died on March 9, 1995. (See Certificate of Death, attached as **Exhibit "A"**).

3. That prior to his passing, Leo J. Milazzo, Sr. executed a Release of the subject mortgage, which was inadvertently not notarized or recorded (See Release of Mortgage attached as **Exhibit "B"**).

4. That the undersigned's mother, Catherine Milazzo, died on May 16, 2005, leaving the undersigned, Lee J. Milazzo as her only child and heir to all assets including the subject real estate mortgage. (See Certificate of Death, attached as **Exhibit "C"**).

5. That as a result of the foregoing, the subject mortgage has been fully satisfied and should be released and removed as a cloud on the title to the subject real estate.


LEE J. MILAZZO, Affiant

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

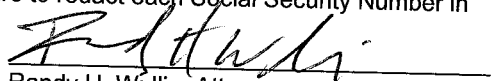
Subscribed and sworn to before me, a Notary Public, this 19th day of May, 2010.


Notary Public

Beth A. Tague

My Commission Expires: June 19, 2010

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.


Randy H. Wyllie, Attorney

This instrument prepared by: RANDY H. WYLLIE, Atty # 17621-64, 429 West Lincoln Hwy, Schererville, IN 46375,
Atty at Law

2010 03 28 03 54
STATE OF INDIANA
LAKE COUNTY
RECORDER
APR 10 2 22
NOTARY PUBLIC
MAN

\$19
CIA
Ch#
5453
CM

COMMUNITY TITLE COMPANY
FILE NO L43252

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

Local No. 0603-95

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) LEO J MILAZZO
2. SEX MALE
3a. TIME OF DEATH 4:30 P M
3b. DATE OF DEATH (Month, Day, Yr) MARCH 9, 1995
4. *SOCIAL SECURITY NUMBER 352-01-1043
5a. AGE—Last Birthday (Years) 74
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo, Day, Yr) JAN. 10, 1921
7. BIRTHPLACE (City and State or Foreign Country) ITALY
8a. WAS DECEDENT A U.S. VETERAN? YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL [X] Inpatient [] ER/Outpatient [] DOA OTHER [] Nursing Home [] Other (Specify) [] Residence

DECEDENT

9b. FACILITY NAME (If not institution, give street and number) ST MARGARET MERCY
9c. CITY, TOWN, OR LOCATION OF DEATH DYER
9d. COUNTY OF DEATH LAKE
10. MARITAL STATUS (Specify) MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name) CATHERINE NIELSEN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) OWNER
12b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) PERM MACHINE & TOOL CO
13a. RESIDENCE—STATE INDIANA
13b. COUNTY LAKE
13c. CITY, TOWN, OR LOCATION DYER
13d. STREET AND NUMBER 11351 CALUMET AVE
13e. ZIP CODE 46311
13f. INSIDE CITY LIMITS [] No [X] Yes
13g. ON A FARM? [X] No [] Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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) unk College (1-4 or 5+) unk

PARENTS

18. FATHER'S NAME (First, Middle, Last) VINCENZO MILAZZO
19. MOTHER'S NAME (First, Middle, Maiden Surname) SALVATRICE TORABENE

INFORMANT

20a. INFORMANT'S NAME (Type/Print) CATHERINE MILAZZO
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11351 CALUMET AVE, DYER, IN 46311
20c. Relationship WIFE

DISPOSITION

21a. METHOD OF DISPOSITION [] Entombment [X] Burial [] Cremation [] Removal from State [] Donation [] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) MARCH 11, 1995 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State SCHERERVILLE IND.

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 [Signature]
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) THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CAUSE OF DEATH ON FILE WITH THE HEALTH DEPT. a. Sudden cardiac death b. Hypertrophic Cardiomyopathy
Approximate Interval Between Onset and Death 20 hours
Lifelong
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
MAR 15 1995
DUE TO (OR AS A CONSEQUENCE OF)

PART II. Other significant conditions, conditions contributing to death but not previously stated in Part I. LAKE COUNTY HEALTH COMMISSIONER
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) [X] 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 [Signature]
29c. MEDICAL LICENSE NO. 02000573B
29d. DATE SIGNED (Month, Day, Year) 3-15-95

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Robert Litchfield, 24 Joliet, Dyer, IN 46311
31. HEALTH OFFICER'S SIGNATURE [Signature]
32. DATE FILED (Month, Day, Year) March 16, 1995

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

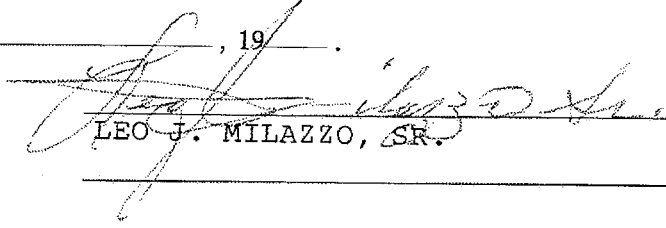
THIS FORM HAS BEEN APPROVED BY THE INDIANA STATE BAR ASSOCIATION FOR USE BY LAWYERS ONLY. THE SELECTION OF A FORM OF INSTRUMENT, FILLING IN BLANK SPACES, STRIKING OUT PROVISIONS AND INSERTION OF SPECIAL CLAUSES, CONSTITUTES THE PRACTICE OF LAW AND SHOULD BE DONE BY A LAWYER.

RELEASE OF MORTGAGE

For a valuable consideration, it is hereby certified that a certain mortgage executed by _____
LEE J. MILAZZO

_____, on the 2nd
day of May 19 89, securing the principal sum of ONE HUNDRED EIGHTY-FIVE
THOUSAND and 00/100----- Dollars (\$ 185,000.00)
which mortgage was duly recorded as Document Number 071916 or in Mortgage Record
_____ at pages _____ in the office of the Recorder of LAKE
County, Indiana, on 4th day of December, 1989, and subsequently assigned on the
_____ day of _____, 19____ to the _____
_____, said assignment being duly recorded as Document
Number _____ or in Mortgage and Assignment Record _____ at page
_____ in the Office of the Recorder of _____ County, State of Indiana on the
_____ day of _____, 19____, is hereby Released and Satisfied.

Dated this _____ day of _____, 19____.



LEO J. MILAZZO, SR.

STATE OF _____, COUNTY OF _____ SS:

Before me, the undersigned, a Notary Public in and for said County and State this _____ day of _____, 19____, personally appeared

and acknowledged the execution of the foregoing instrument. In witness whereof, I have hereunto subscribed my name and affixed my official seal.

My commission expires: _____ NOTARY PUBLIC

STATE OF _____, COUNTY OF _____, SS:

Before me, the undersigned, a Notary Public in and for said County and State, personally appeared

_____, President and _____, Secretary known

to me to be such Officers of _____ and acknowledged the execution of the foregoing Release of Mortgage, as such officers, for and on behalf of said Corporation and by authority of its Board of Directors.

Witness my hand and notarial seal this _____ day of _____, 19____.

My commission expires: _____ NOTARY PUBLIC

This instrument was prepared by _____, Attorney At Law

* 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

Local No. 1394-05
691297

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED - NAME (First, Middle, Last) Catherine Milazzo		2. SEX Female		3a. TIME OF DEATH 12:45 PM		3b. DATE OF DEATH (Month, Day, Yr.) May 16, 2005	
4. *SOCIAL SECURITY NUMBER 343-14-2932		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.) June 14, 1923		7. BIRTHPLACE (City and State or Foreign Country) Roseland, Illinois					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		PLACE OF DEATH (Check only one See instructions)			
HOSPITAL: <input checked="" type="checkbox"/> Inpatient				OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
<input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				<input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) St. Margaret Mercy Hospital South Campus				9c. CITY, TOWN, OR LOCATION OF DEATH Dyer		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		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.) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Saint John		13d. STREET AND NUMBER 11415 West 95th Pl.	
13e. ZIP CODE 46373-		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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)		College (1-4 or 5+) 11					
18. FATHER'S NAME (First, Middle, Last) Harry Nielsen				19. MOTHER'S NAME (First, Middle, Maiden Surname) Olene Thompson			
20a. INFORMANT'S NAME (Type/Print) Leo J. Milazzo Jr.				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11735 Homestead Heights Drive Saint John IN 46373-		20c. Relationship	
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) May 21, 2005 Chapel Lawn Memorial Gardens		21c. LOCATION - City or Town, State Schererville, Indiana			
22a. EMBALMER'S NAME Kevin Knaga		22b. EMBALMER'S LICENSE NO. FD20400005		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Michelle L. Tracy</i>		24b. LICENSE NUMBER (of Licensee) FD29700007		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home FH19900060 109 N. East St., Crown Point, Indiana 46307-			
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. <u>Gastrointestinal Bleeding</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
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	
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>Leslie F. Stork</i>				29c. MEDICAL LICENSE NO. 01040407		29d. DATE SIGNED (Month, Day, Year) 5-18-05	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (HEM 26) (Type/Print) Leslie Stork, M.D. 9660 Wicker Ave, Saint John, IN 46373							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>						32. DATE FILED (Month, Day, Year) MAY 18, 2005	
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 THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.		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) MAY 18 2005			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.					