4

AFFIDAVIT OF MORTGAGE SATISFACTION

2010 038824

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
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.

Beth A. Tague
Notary Public

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

$19
CA
Ch# 5453
CM

COMMUNITY TITLE COMPANY
FILE NO L 43252

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

Local No. 06003-95

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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
LEO J MILAZZO	MALE	4:30 PM	MARCH 9, 1995

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)
352-01-1043	74			JAN.10,1921	ITALY

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.)
YES	1945	HOSPITAL: [X] 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
ST MARGARET MERCY	DYER	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	CATHERINE NIELSEN	OWNER	PERM MACHINE & TOOL CO

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	DYER	11351 CALUMET AVE

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+)
46311	[X] No [ ] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	WHITE	unk	unk

PARENTS

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

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
CATHERINE MILAZZO	11351 CALUMET AVE, DYER, IN 46311	WIFE

DISPOSITION

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

22a. EMBALMER'S NAME:	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
GORDON L. JONES	1010711	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Terrence P Burns	1013890	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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Sudden Cardiac death DUE TO (OR AS A CONSEQUENCE OF):	20 hours
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. Idiopathic Hypertrophic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):	Lifetime
	c. MAR 15 1995 DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE ORIGINAL DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I

Ronald D. Nelson, M.D. LAKE COUNTY HEALTH COMMISSIONER

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	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Robert Litchfield	02000573B	3-15-95

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

Dr. Robert Litchfield, 24 Joliet, Dyer, IN 46311

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Ronald D. Nelson, M.D.	March 16, 1995

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.

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.

Local No. 1394-05
691297

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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.)
Catherine	Milazzo	Female	12:45 PM	May 16, 2005

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)
343-14-2932	81			June 14,1923	Roseland, Illinois

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	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
St. Margaret Mercy Hospital South Campus	Dyer	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
Widowed		Homemaker	Own Home

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Saint John	11415 West 95th Pl.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	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+)
46373-	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	White	11	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Harry Nielsen	Olene Thompson

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
Leo J. Milazzo Jr.	11735 Homestead Heights Drive Saint John IN 46373-	Son

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION - City or Town, State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) Burial	May 21, 2005 Chapel Lawn Memorial Gardens	Schererville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Kevin Knaga	FD20400005	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Michelle L. Tracy	FD29700007	Geisen Funeral Home FH19900060 109 N. East St., Crown Point, Indiana 46307-

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. Gastrointestinal Bleeding
DUE TO (OR AS A CONSEQUENCE OF):
b. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last
c. Myocardial Infarction
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)	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)
Leslie J Stork	01040407	5-18-05

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Leslie Stork, M.D.
9660 Wicker Ave, Saint John, IN 46373

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
Susan W Burt D.O.

32. DATE FILED (Month, Day, Year)
MAY 18, 2005

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.

MAY 18 2005

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)