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STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

2010 074617

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2010 DEC 16 PM 2:14
MICHELLE R. FAJMAN
RECORDER

IN RE: WALTER KASPRZYCKI, Sr, decedent

AFFIDAVIT OF SURVIVORSHIP

Comes now MARY KASPRZYCKI being first duly sworn upon his oath, and states as follows:

1. That the above-named decedent, WALTER KASPRZYCKI, Sr., died intestate on November 14, 2007 . (See death certificate attached hereto as Exhibit "1.")
2. That I am the spouse of the decedent.
3. That forty-five (45) days have elapsed since the death of the decedent.
4. No other probate proceeding or asset estate was commenced for or on behalf of the assets of Walter Kaprzycki, Sr. in Lake County, Indiana, or elsewhere.
5. No Indiana Inheritance taxes, inheritance taxes from other states or countries, federal estate taxes, or other death taxes are outstanding by reason of the death of Walter Kasprycki, Sr..
6. No claims were made.
7. That decedent was the co-titled owner of the following described real property, commonly known as:

- a. 735 Gostlin Street, Hammond, Indiana - Legal description known as:
POINT MIDDLE POINT SOUTHWEST NORTHEAST 8.25 T.37 R.10.06A (22 x 125 FT)., IN THE CITY OF HAMMOND, LAKE COUNTY, INDIANA AS RECORDED IN A PLAT BOOK IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.
- b. 419 Gostlin Street, Hammond, Indiana - Legal description known as:
HUEHNS 2ND ADDITION WEST 4 FEET LOT 1, IN THE CITY OF HAMMOND, LAKE COUNTY, INDIANA AS RECORDED IN A PLAT BOOK IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.
- c. 735 Gostlin Street, Hammond, Indiana - Legal description known as:
SCHRUM'S RESUB. LOTS 19 TO 24 BLOCK 24 ROLLING MILL ADDITION L.A WEST 27.25FEET L.B., IN THE CITY OF HAMMOND, LAKE COUNTY, INDIANA AS RECORDED IN A PLAT BOOK IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

FILED

DEC 16 2010

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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- d. 739 Gostlin Street, Hammond, Indiana - Legal description known as:
SCHRUM'S RESUB. LOTS 19 TO 24, BLOCK 4 ROLLING MILL ADDITION.
L.C., IN THE CITY OF HAMMOND, LAKE COUNTY, INDIANA AS
RECORDED IN A PLAT BOOK IN THE OFFICE OF THE RECORDER OF
LAKE COUNTY, INDIANA.
- e. 743 Gostlin Street, Hammond, Indiana - Legal description known as:
SCRUM'S RESUM. LOTS 19 TO 24, BLOCK 4 ROLLING MILL ADDITION.
L.D., IN THE CITY OF HAMMOND, LAKE COUNTY, INDIANA AS
RECORDED IN A PLAT BOOK IN THE OFFICE OF THE RECORDER OF
LAKE COUNTY, INDIANA.
- f. 417 Gostlin Street, Hammond, Indiana - Legal description known as:
POINT MID. POINT SOUTHWEST, NORTHEAST, SOUTH 25 T.37 R.10 .06A.
(22 x 125 FT.), IN THE CITY OF HAMMOND, LAKE COUNTY, INDIANA AS
RECORDED IN A PLAT BOOK IN THE OFFICE OF THE RECORDER OF
LAKE COUNTY, INDIANA

8. Upon the death of Walter Kasprzycki, Sr., the above property became vested in the following as tenants in common:

- a. Mary Kaprzycki - Spouse

9. The Affiant requests that the Lake County Auditor complete the transfer of title for the real property located at 735 Gostlin Street, Hammond, Indiana; 419 Gostlin Street, Hammond, Indiana; 735 Gostlin Street, Hammond, Indiana; 739 Gostlin Street, Hammond, Indiana; 743 Gostlin Street, Hammond, Indiana; 417 Gostlin Street, Hammond, Indiana

FURTHER YOUR AFFIANT SAYETH NAUGHT.



MARY KASPRZYCKI, Affiant

* 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. 708

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) Walter J. Kasprzycki Sr.		2. SEX Male	3a. TIME OF DEATH 5:44A. M	3b. DATE OF DEATH (Month, Day, Year) November 14, 2007	
4. *SOCIAL SECURITY NUMBER 308-18-7148	5a. AGE—Last Birthday (Years) 91	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo, Day, Yr) APRIL 19, 1916	
7. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS		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 checked="" type="checkbox"/> Inpatient <input 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) ST. MARGARET MERCY HOSPITAL		9c. CITY, TOWN, OR LOCATION OF DEATH HAMMOND	9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) MARY CHRAPONSKI	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 RESTAURANT	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HAMMOND	13d. STREET AND NUMBER 735 GOSTLIN STREET		
13e. ZIP CODE 46327	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) 8 College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) JOSEPH KASPRZYCKI			
19. MOTHER'S NAME (First, Middle, Maiden Surname) AGNES ZIEBA		20a. INFORMANT'S NAME (Type/Print) MARY KASPRZYCKI			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 735 GOSTLIN STREET, HAMMOND, INDIANA 46327		20c. Relationship WIFE			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) NOVEMBER 19, 2007 HOLY CROSS MAUSOLEUM		21c. LOCATION—City or Town, State CALUMET CITY, ILLINOIS	
22a. EMBALMER'S NAME: KEITH D. ANTHONY		22b. EMBALMER'S LICENSE NO. 01011911	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24b. LICENSE NUMBER (of Licensee) 01011911	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327		
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>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): _____		Approximate Interval Between Onset and Death	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. <u>CVA</u> DUE TO (OR AS A CONSEQUENCE OF): _____			
		c. _____ DUE TO (OR AS A CONSEQUENCE OF): _____			
		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) 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>[Signature]</i>		29c. MEDICAL LICENSE NO. 01063801A	29d. DATE SIGNED (Month, Day, Year) NOVEMBER 15, 2007		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. FAROOQUI 3454 Johnson Ave Hammond IN 46320					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) NOVEMBER 15, 2007			
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 DEC 16 2010
		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.			