

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

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2010 DEC 30 PM 1:00

MICHAEL J. HAN  
RECORDER

Mail Future Tax Statements to:

PARCEL #45-11-27-377-006.000-035

Grantee's Address:

**Ms. Maria Ossanna et al**  
**9114 Lancer Dr.**  
**St. John, IN 46373**

STATE OF INDIANA )

) SS:

IN RE: DECEDENT,  
CHRISTOPHER OSSANNA a/k/a  
CHRISTOPHER E. OSSANNA

COUNTY OF LAKE )

**AFFIDAVIT FOR TRANSFER OF REAL PROPERTY**

The undersigned Affiant, Maria Ossanna, being first duly sworn upon her oath, hereby states:

1. That the CHRISTOPHER OSSANNA a/k/a CHRISTOPHER E. OSSANNA died intestate on the 13th day of July, 2008, while domiciled in Lake County, Indiana and that a redacted copy of his death certificate is attached hereto and made a part hereof, marked as Exhibit "A".

2. That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction.

3. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of the allowance provided by I.C. 29-1-4-1, the costs and expenses of administration and reasonable funeral expenses.

4. That among the decedent's probate assets is a parcel of real estate which was owned by the decedent located in Lake County, Indiana, more particularly described as follows:

LOT 58, LANCER ESTATES SECOND ADDITION TO THE TOWN OF ST. JOHN, AS SHOWN IN PLAT BOOK 46, PAGE 96, IN LAKE COUNTY, INDIANA.

Commonly known as: 9114 Lancer Dr., St. John, IN 46373

5. That the following named persons are the only heirs, legatees or devisees of the decedent according to the laws

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PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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of intestate succession as stated in the Indiana Probate Code, therefore, they are the only individuals entitled to the real estate as a result of the decedent's death in the percentages shown below:

- A) Ms. Maria Ossanna (Surviving Spouse): 50%
- B) Minor Children:
  - i) Lucas C. Ossanna (DOB: 08/21/1994) 16.66%
  - ii) Zachary J. Ossanna (DOB: 08/27/1995) 16.66%
  - iii) Matthew M. Ossanna (DOB: 09/12/2001) 16.67%

and said decedent left no other child or children nor descendants of any predeceased child or children.

6. That more than nine (9) months have expired since the date of the decedent's death and pursuant to Indiana Code, I.C. 29-1-14-1, all all claims against the decedent's estate are forever barred.

7. That the estate of the decedent, CHRISTOPHER OSSANNA a/k/a CHRISTOPHER E. OSSANNA, was not subject to Federal Estate Tax, and therefore, no Federal Estate Tax Return was filed.

8. That the decedent's estate was not subject to Indiana Inheritance Tax.

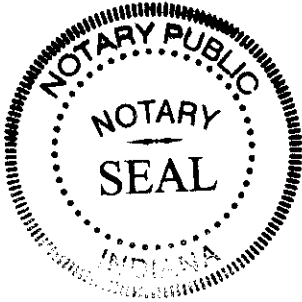
9. That the statements made in this Affidavit are true and complete insofar as the Affiant knows and are made for the purposes of establishing the heirship of CHRISTOPHER OSSANNA a/k/a CHRISTOPHER E. OSSANNA, deceased, and transferring title to his real estate to his legal heirs-at-law.

Affiant further sayeth not.

  
Maria Ossanna, Affiant

STATE OF INDIANA            )  
  ) SS:  
COUNTY OF LAKE            )

Before me, the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared MARIA OSSANNA, who acknowledged the execution of this instrument this 30th day of December, 2010.



Theresa L. Clements  
NOTARY PUBLIC SIGNATURE

Theresa L. Clements  
Notary Public, State of Indiana  
Lake County  
My Commission Expires:  
07/07/2016

THIS INSTRUMENT PREPARED BY:  
**MICHAEL D. DOBOSZ, ATTORNEY AT LAW (#14539-45)**  
HILBRICH CUNNINGHAM SCHWERD DOBOSZ & VINOVICH, LLP  
2637-45TH ST., HIGHLAND, IN 46322  
PH: 219/924-2427 - FAX: 219/924-2481

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.

Michael D. Dobosz Attorney at Law



# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No. 2524-08

State No. \_\_\_\_\_

1. Decedent's Legal Name (First, Middle, Last) <b>Christopher E. Ossanna</b>				10. Maiden Last Name (if Female)		2. Sex <b>M Male</b>	3. Time Of Death <b>6:36 AM</b>	4. Date Of Death (Month/Day/Year) <b>July 13, 2008</b>
5. Social Security Number [REDACTED]	6a. Age, Yrs <b>43</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date Of Birth (Month/Day/Year) <b>April 10, 1965</b>		8. Birthplace (City And State Or Foreign Country) <b>Hammond, IN</b>
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input 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 checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (if Not Institution, Give Street And Number) <b>9114 Lancer Dr.</b>								
12. City Or Town, State, And Zip Code <b>St. John, IN 46373</b>				13. County Of Death <b>Lake</b>		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name <b>Maria Ossanna</b>			15a. (if Wife) Give Maiden Last Name <b>Sojka</b>		16. Decedent's Usual Occupation <b>Pipefitter</b>		17. Kind Of Business/Industry <b>Local #597</b>	
18. Residence - State <b>IN</b>		18a. County <b>Lake</b>		18b. City Or Town <b>St. John</b>			18c. Apt. No.	18d. Zip Code <b>46373</b>
18c. Street And Number <b>9114 Lancer Dr.</b>				18e. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
19. Decedent's Education <b>12</b> Please select education level:		20. Decedent Of Hispanic Origin <b>No</b> Please select Hispanic origin, if any:		21. Decedent's Race <b>White</b> Please select race:		21a. Mother's Maiden Last Name <b>Dorris</b>		
22. Father's Name (First, Middle, Last) <b>James Ossanna</b>			23. Mother's Name (First, Middle, Last) <b>Gloria Ossanna</b>					
24. Informant's Name <b>Maria Ossanna</b>		24a. Relationship To Decedent <b>Wife</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>9114 Lancer Dr. St. John, IN 46373</b>				
25a. Method Of Disposition: <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Crematory, Cemetery, Other Place) <b>Kelly-Carroll Crematory</b>		25c. Location - City, Town, And State <b>Gary, IN</b>			27a. Funeral Home License Number: <b>3004968</b>	
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>Burns-Kish Funeral Home 8415 Calumet Munster, IN 46321</b>					27c. License Number (Of Licensee) <b>1045184</b>	
27b. Signature Of Indiana Funeral Service Licensee <i>Thomas J. Burns</i>								
28. 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 Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) <b>A. Vascular collapse</b> Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last <b>B. Pending further study</b> C. _____ D. _____								Approximate Interval: Onset To Death <b>Unknown</b>
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I						29. Was An Autopsy Performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year		33. Manner Of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined		37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			38. Location Of Injury - State	
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Apt. No.	38d. Zip Code	
39. Describe How Injury Occurred								40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)
41. Signature Of Person Certifying Cause Of Death: <i>[Signature]</i>				42. Coroner (Check Only One) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Coroner <input type="checkbox"/> Health Officer <input type="checkbox"/> Deputy				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>Donna Melyon, Deputy Coroner 2900 West 93rd Avenue, Crown Point, Indiana 46307</b>						44. License Number <b>N/A</b>	45. Date Certified <b>July 15, 2008</b>	
46. Additional Funeral Service Provider:						47. "A" box		
48. Signature Of Local Health Officer: <i>Susan W. Butts D.O.</i>				49. For Registrar Only - Date Filed (Month/Day/Year): <b>July 14, 2008</b>				

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. Michael D. Dobsz, Attorney at Law

State Form 10110 (R7/8-07) ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to process its statutory responsibility. Disclosure of this information and those of the policy for redaction. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 36-3-1-2

Exhibit "A"