

3

FIDELITY NATIONAL TITLE INSURANCE COMPANY

AFFIDAVIT

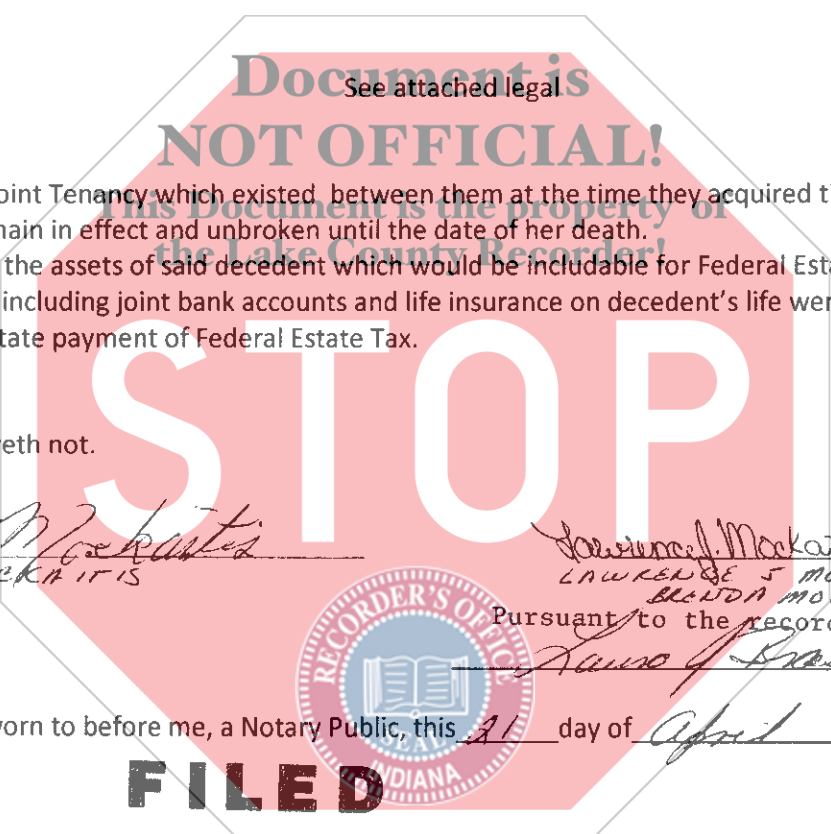
2011 024343

STATE OF INDIANA)
)
COUNTY OF PORTER)

Lawrence J. Mockaitis and Donald A Mockaitis, being duly sworn upon oath, deposes and says:

- 1. That Sophia V Mockaitis died on Sept 20⁰⁵, 2011 at 1:00 AM.
- 2. That Sophia V Mockaitis, Lawrence J Mockaitis and Donald A Mockaitis were duly Joint Tenants with rights of survivorship at the time they acquired the following described real estate.

2011 MAR -2 AM 5:38
 76⁰⁰
 FN
 ✓ Non Com
 PB



- 3. That the Joint Tenancy which existed between them at the time they acquired title to said real estate remain in effect and unbroken until the date of her death.
- 4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Donald A. Mockaitis
 DONALD A. MOCKAITIS

Lawrence J. Mockaitis by Brenda Mockaitis
 LAWRENCE J. MOCKAITIS BY
 BRENDA MOCKAITIS POA P.O.A.

Pursuant to the recorded Power of Attorney
Laura J. Brasovan as Doc
 No. 2011024342

Subscribed and sworn to before me, a Notary Public, this 21 day of April 2011.

FILED

APR 27 2011

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

052463



**FIDELITY NATIONAL TITLE
INSURANCE COMPANY.**

Prepared by Donald A. Mockaitis

920110873

Legal Description

Lot 12 in Block 2 in Greater Riverview Addition to East Gary, in
the City of Lake Station, as per plat thereof, recorded in Plat
Book 15 page 7 in the Office of the Recorder of Lake County,
Indiana.

PARK FK

45-09-17-405-004.000-021



2

This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

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) SOPHIE V MOCKAITIS				2. SEX Female		3a. TIME OF DEATH 1:00 AM		3b. DATE OF DEATH (Month, Day, Yr) September 20, 2005	
4. *SOCIAL SECURITY NUMBER ██████-1890		5a. AGE—Last Birthday (Years) 87		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) November 1, 1917	
7. BIRTHPLACE (City and State or Foreign Country) South Bend Indiana		8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OCA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residences <input checked="" type="checkbox"/> Other (Specify) Residence			
9b. FACILITY NAME (If not institution, give street and number) 342 W. 300 S				9c. CITY, TOWN, OR LOCATION OF DEATH Valparaiso			9d. COUNTY OF DEATH Porter		
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) N/A		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 Home		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Lake Station			13d. STREET AND NUMBER 2521 Orange St.		
13a. ZIP CODE 46405		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		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	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+)		18. FATHER'S NAME (First, Middle, Last) Frank Radzwill		19. MOTHER'S NAME (First, Middle, Maiden Surname) Elnora Jenczewski			
20a. INFORMANT'S NAME (Type/Print) Donald Mockaitis				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 W. 300 S., Valparaiso, IN 46385				20c. Relationship Son	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify) Calvary Cemetery			21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Sep 23, 2005			21c. LOCATION—City or Town, State Portage IN			
22a. EMBALMER'S NAME James J. Krause				22b. EMBALMER'S LICENSE NO. FD01006463		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>				24b. LICENSE NUMBER (of Licensee) FD01006463		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488			
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. Respiratory failure Congestive Heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. Conditions, if any, which gave rise to the immediate cause stating the underlying cause last 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		Approximate Interval Between Onset and Death			
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>John Dolatowski MD</i>						29c. MEDICAL LICENSE NO. 01046155A		29d. DATE SIGNED (Month, Day, Year) 9-21-05	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John Dolatowski MD 1441 S. Lake Park Avenue, Hobart, IN 46342									
31. HEALTH OFFICER'S SIGNATURE <i>Henry A. Bobenka MD</i>							32. DATE FILED (Month, Day, Year) September 21, 2005		
33. MANNER OF DEATH <input checked="" 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		
34a. 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)						
35a. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						