

4

AFFIDAVIT OF SURVIVING SPOUSE OR JOINT SURVIVOR

State of INDIANA
County of Lake

Nick S. Summa, being first duly sworn,

- 1) That Augusto Flores and Robert Flores are joint owners of property under a duly recorded survivorship or tenancy by entireties deed.
- 2) That the property is known as 9025 Bryan St ^{Crown Point} IN, Lake County, State of IN and also known as Permanent Parcel Number * on the records of the County Auditor. The original Survivorship Deed is recorded in the records of the Lake County Recorder in Document Number 2006-094854

I have included the descriptive information requested below and have attached a full legal description as an attachment hereto.

"SEE EXHIBIT "A" ATTACHED"

- 3) That Dora Garkovich died on or about October, 3, 2007, at the Regency Hospital in East Chicago, IN. (date)
- 4) That by virtue of the death of the party listed in Item #3 above, Augusto Flores is the fee simple owner of the above described property and requests that this fact be reflected on the land and tax records of the county.

[Signature]
Witness

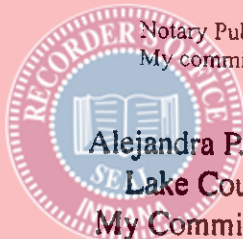
State of INDIANA
County of Lake

Sworn to before me and subscribed in the my presence this 14th day of April, 2005. 2011

Notary Public
My commission expires: 09/03/16

This document prepared by & Return to:
AUGUSTO FLORES
9025 BRYAN ST
CROWN POINT, IN 46307

Return To:
Southwest Financial Services, LTD.
P.O. Box 306
Cincinnati, OH 45273-8043
DF474949



Alejandra P. Lizarde, Notary Public
Lake County, State of Indiana
My Commission Expires 09/03/16

AMOUNT \$ 1.80
 CASH _____ CHARGE _____
 CHECK # 0000463182
 OVERAGE 1 0000465192
 COPY _____
 NON-COM
 CLERK [Signature]

2011 025773

2011 MAY -9 AM 10:00

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

FILED

MAY 6 2011

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

052523

Chicago Title Insurance Company

Commitment Number: 23-14857328REVISED

**SCHEDULE A CONTINUATION
PROPERTY DESCRIPTION**

The land referred to in this Commitment is described as follows:

Situated in Lake County, Indiana:

Lot numbered 45 High Point Acres Unit 3 as shown in Plat Book 35, page 36, Lake County, Indiana.

Parcel No. 45-11-26-304-008.000-032



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

City Of East Chicago
East Chicago, In 46312

CERTIFICATE OF DEATH

State No.

Local No. 231

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

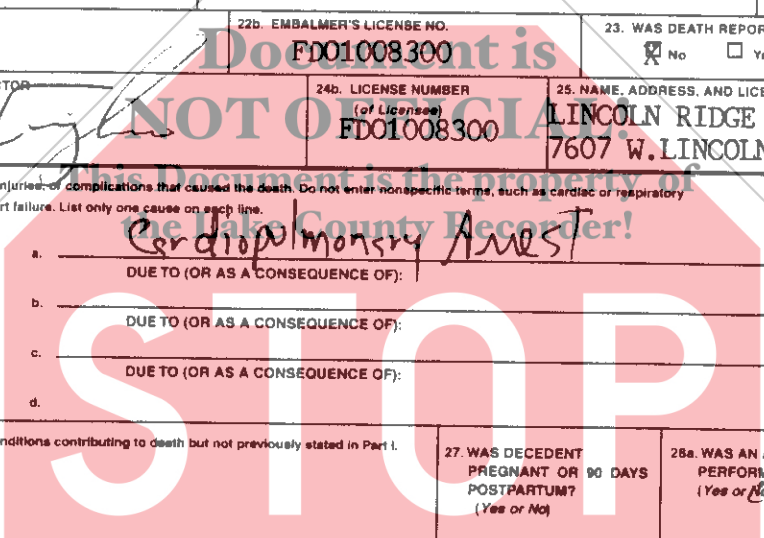
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

| | | | | | | | | | |
|--|--|---|--|---|---------------------|--|--|--|--|
| 1. DECEASED-NAME (First, Middle, Last) DARA GRKINICH | | | | 2. SEX FEMALE | | 3a. TIME OF DEATH | | 3b. DATE OF DEATH (Month, Day, Year) OCTOBER 3, 2007 | |
| 4. SOCIAL SECURITY NUMBER | | 5a. AGE - Last Birthday (Years) 81 | | 5b. UNDER 1 YEAR Months Days | | 5c. UNDER 1 DAY Hours Minutes | | 8. DATE OF BIRTH (Mo, Day, Yr) OCT. 14, 1925 | |
| 6a. WAS DECEDENT A U.S. VETERAN? NO | | 6b. 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"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | | | | 7. BIRTHPLACE (City and State or Foreign Country) YUGOSLAVIA | |
| 9b. FACILITY NAME (If not institution, give street and number) REGENCY HOSPITAL | | | | 9c. CITY, TOWN, OR LOCATION OF DEATH EAST CHICAGO | | | 9d. COUNTY OF DEATH LAKE | | |
| 10. MARITAL STATUS (Specify) WIDOWED | | 11. SURVIVING SPOUSE (If wife, give maiden name) NONE | | 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 DOMESTIC | | |
| 13a. RESIDENCE - STATE INDIANA | | 13b. COUNTY LAKE | | 13c. CITY, TOWN, OR LOCATION CROWN POINT | | | 13d. STREET AND NUMBER 9025 BRYAN ST. | | |
| 13e. ZIP CODE 46307 | | 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 (1-4 or 5+) _____ | | 18. FATHER'S NAME (First, Middle, Last) LAZAR BACKO | | | 19. MOTHER'S NAME (First, Middle, Maiden Surname) SAMONA LAZIC | | |
| 20a. INFORMANT'S NAME (Type/Print) BOSKO GRKINICH | | | | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 9025 BRYAN ST. CROWN POINT, IND. 46307 | | | | 20c. Relationship SON | |
| 21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) OCTOBER 8, 2007 ST. SAVA CEMETERY | | | | 21c. LOCATION—City or Town, State LIBERTYVILLE, ILLINOIS | |
| 22a. EMBALMER'S NAME: ELI VUKO | | | | 22b. EMBALMER'S LICENSE NO. FD01008300 | | 23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR <i>Eli Vuko</i> | | | | 24b. LICENSE NUMBER (of License) FD01008300 | | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 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. Approximate Interval Between Onset and Death | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): _____ | | | | | | | | | |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last b. 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 POSTPARTUM? (Yes or No) | | 28a. WAS AN AUTOPSY PERFORMED? (Yes or 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>Elliot Stokar MD</i> | | | | | | 29c. MEDICAL LICENSE NO. 1030852 | | 29d. DATE SIGNED (Month, Day, Year) 10-09-07 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Elliot Stokar, MD 7610 45th St. Munster, IN. 46322 | | | | | | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>Gabe Bonhuk Attorney MD</i> | | | | | | | 32. DATE FILED (Month, Day, Year) 10/10/07 | | |
| 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 | | |
| | | | | | | | | | |
| | | | 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. | | | | | |
| | | | | | | | | | |



I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

Mary L. Meek
Name of Declarant

