

**SURVIVORSHIP AFFIDAVIT**

2012 057192

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

<sup>m</sup>  
Doris Galinski, being first duly sworn upon oath, deposes and says:

- 1 That Robert Galinski died on June 18, 2012 in Crown Point, Indiana.
- 2 That Doris Galinski and Robert Galinski were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 33 in Clearwater Cove, a planned unit development, as per plat thereof Recorded in Plat Book 92 page 52, in the Office of the Recorder of Lake County, Indiana

Parcel #: 45-16-16-277-013.000-042

Commonly known as: 885 Clearwater Cove East, Crown Point, IN 46307

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. 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.

*Doris M Galinski*  
Doris Galinski  
<sup>m</sup>

STATE OF INDIANA )  
 ) SS: **ACKNOWLEDGEMENT**  
COUNTY OF LAKE )

Before me, a Notary Public in and for said County and State, personally appeared Doris Galinski who acknowledged the execution of the foregoing instrument, and who, having been duly sworn, stated that any representations therein contained are true. Witness my hand and Notary Seal this 20<sup>th</sup> day of August 2012.

Resident of Porter County, Indiana.

Signature Jessica R. Colburn My Commission Expires: 10-25-2015 Printed

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.

*Aly Wodorhanyj*  
[Name]

This instrument prepared by:



**FILED**

AUG 23 2012

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No 001943

EDR No 00000266039

State No 027962

1 Decedent's Legal Name (First, Middle, Last) <b>ROBERT JOHN GALINSKI</b>				1a Maiden Name (If female)		2 Sex <b>MALE</b>		3 Time Of Death <b>07 25 AM</b>		4 Date Of Death (Month/Day/Year) <b>06/18/2012</b>			
5 Social Security Number <b>328-30-9874</b>		6a Age - Yrs <b>75</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>03/18/1937</b>				8 Birthplace (City and State or Foreign Country) <b>CHICAGO, IL</b>									
9 Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				10 If Death Occurred In A Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department <input type="checkbox"/> 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>885 CLEARWATER COVE EAST</b>													
12 City Or Town, State, And Zip Code <b>CROWN POINT, IN, 46307</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>DORIS GALINSKI</b>				15a (If Wife) Give Maiden Last Name <b>ELLER</b>				16 Decedent's Usual Occupation <b>CRANE OPERATOR</b>		17 Kind Of Business/Industry <b>STEEL</b>			
18 Residence - State <b>INDIANA</b>				18a County <b>LAKE</b>				18b City Or Town <b>CROWN POINT</b>					
18c Street And Number <b>885 CLEARWATER COVE EAST</b>						18d Apt No		18e Zip Code <b>46307</b>		18f Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
19 Decedent's Education <b>8TH GRADE OR LESS</b>				20 Decedent Of Hispanic Origin <b>NOT HISPANIC</b>				21 Decedent's Race <b>White</b>					
22 Father's Name (First Middle Last) <b>WALTER GALINSKI</b>				23 Mother's Name (First, Middle, Last) <b>DOROTHY GALINSKI</b>				23a Mother's Maiden Last Name <b>KOZLOWSKI</b>					
24 Informant's Name <b>DORIS GALINSKI</b>				24a Relationship To Decedent <b>WIFE</b>				24b Mailing Address (Street And Number, City, State, Zip Code) <b>885 CLEARWATER COVE EAST, CROWN POINT, IN 46307</b>					
25a Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <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 Cemetery, Crematory, Other Place) <b>NORTHWEST INDIANA CREMATION SERVICE CROWN POINT, IN</b>				25c Location - City, Town, And State					
26 Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				27 Name And Complete Address Of Funeral Facility <b>BURNS FUNERAL HOME (CROWN POINT), 10101 BROADWAY, CROWN POINT, IN 46307</b>				27a Funeral Home License Number <b>FH83002445</b>					
27b Signature Of Indiana Funeral Service Licensee <b>JAMES E BURNS, BY ELECTRONIC SIGNATURE</b>						27c License Number (Of Licensee) <b>FD20700059</b>							
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.													
Cause Of Death (See Instructions And Examples)													
Immediate Cause (Final Disease Or Condition Resulting In Death) A <b>LEFT VENTRICLE HEART FAILURE, SECONDARY TO CORONARY ARTERY DISEASE</b> 1 MONTH													
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>DIABETES, INSULIN DEPENDENT</b> 10 YEARS													
C <b>OBSTRUCTIVE LUNG DISEASE</b> 10 YEARS													
D <b>OBESITY</b> 20 YEARS													
Part II Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I													
HYPERLIPIDEMNIA													
31 Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input 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 checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined					
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)					
37 Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				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 <b>WILLIAM J PIERCE, BY ELECTRONIC SIGNATURE</b>						42 Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer							
43 Name, Address And Zip Code Of Person Certifying Cause Of Death <b>WILLIAM J PIERCE, 210 E 90TH DRIVE, MERRILLVILLE, IN 46410</b>						44 License Number <b>01025010A</b>		45 Date Certified <b>06/25/2012</b>					
46 Additional Funeral Service Provider						47 *Akas							
48 Signature of Local Health Officer <b>SUSAN W BEST, VIA ELECTRONIC SIGNATURE</b>						49 For Registrar Only - Date Filed (Month/Day/Year) <b>JUN 26 2012</b>							
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)													