1202496

B

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

On this 8/10/12 (insert date) before me personally appeared Rose A. Szablewski

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:

2. Affiant is OWNER (state interest of affiant in the above premises as "owner," son of owner", etc.

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Michael W. Szablewski and Rose A. Szablewski

4. Said Michael W. Szablewski (fill in name of co-tenant who died) died on 8-29-09 leaving A (insert "a" or "no"; if will left, attach a copy) will;

5. The legal description of the premises in question is:

16924 White Oak Ave
Lowell, IN 46356

Lot 1 in Hickory Lane Estates, as Recorded in Plat Book 65, Page 47, in the Office of the Recorder of Lake County, Indiana.

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? ☐ Yes ☒ No

If yes, then estimated taxes due are $

The taxes due are ☐ paid or ☐ unpaid..

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2012 SEP 17 AM 9:50
JOHN E. BRUMAN
RECORDER

2012 064991

DULY ENTERED FOR TAXATION SUBJECT
FINAL ACCEPTANCE FOR TRANSFER
SEP 12 2012
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

26065

#14
CT
CA
NON COMF

D

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? NO

(If answer is "Yes" , identify the divorce proceedings:

_____):

8. Affiant's relationship to the deceased was SPOUSE

Signature: Rose A. Szablewski

Printed Name ROSE A. SZABLEWSKI

Address: 16924 WHITE OAK AVE

LOWELL, IN 46356

Subscribed and sworn to before me by the affiant

This 10TH DAY OF AUGUST 2010

(insert date)

Notary Public

Printed Name DENISE ROBINSON

My County of Residence is: COOK

In the State of ILLINOIS

My Commission Expires 09/12/2012

OFFICIAL SEAL
DENISE R ROBINSON
Notary Public - State of Illinois
My Commission Expires Sep 12, 2012

This instrument prepared by ROSE A. SZABLEWSKI

#45 19-18-400-013.000-037

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3061-09 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
MICHAEL W. SZABLEWSKI .		M	1:22 PM	AUGUST 29, 2009

5. Social Security Number	5a. Age Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)
357-48-7781	54	Months	Days	Hours	Minutes	SEPTEMBER 30, 1954	CHICAGO, IL

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No Unknown ☐

10. If Death Occurred In A Hospital: ☐ Inpatient ☒ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): ST. ANTHONY MEDICAL CENTER

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
CROWN POINT	LAKE	☒ Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
ROSE SZABLEWSKI	HIRSCH	PRESIDENT	BEST BUILT FABRICATING CO.

18. Residence – State	18a. County	18b. City Or Town	18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
INDIANA	LAKE	LOWELL	16924 WHITE OAK AVE.		46356	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
Some college credit, but no degree	No, not Spanish/Hispanic/Latino	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
FRANK SZABLEWSKI SR.	.N/A	N/A

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
ROSE SZABLEWSKI	WIFE	16924 WHITE OAK AVE. LOWELL, IN 46356

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	REGIONAL CREMATION	MUNSTER, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number
☒ Yes ☐ No	ELMWOOD CHAPEL 11300 W. 97TH LN.; ST.JOHN, INDIANA 46373	19900052

27b. Signature Of Indiana Funeral Service Licensee: Janet Beldsworth

27c. License Number (Of Licensee): FD09200077

Cause Of Death (See Instructions And Examples)

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.

Approximate Interval: Onset To Death

Immediate Cause (Final Disease Or Condition Resulting In Death): A. VASCULAR COLLAPSE — UNKNOWN

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. DUE TO ARTERIOSCLEROTIC HEART AND VASCULAR DISEASE (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. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☒ No

31. Did Tobacco Use Contribute To Death?	32. If Female:	33. Manner Of Death:
☐ Yes ☐ Probably ☐ No ☒ Unknown	☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ 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?
			☐ Yes ☐ 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: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death:

42. Certifier (Check Only One): ☐ Certifying Physician ☒ Coroner ☐ Health Officer

AUG 31 2009

43. Name, Address And Zip Code Of Person Certifying Cause Of Death: DONNA MELYON, DEPUTY CORONER, 2900 WEST 93RD AVENUE, CROWN POINT, INDIANA 46307

44. License Number: N/A

45. Date Certified: AUG. 31, 2009

46. Additional Funeral Service Provider:

47. "Akas:

48. Signature of Local Health Officer: Susan M Best D.O.

49. For Registrar Only – Date Filed (Month/Day/Year): August 31, 2009