

2

2012 068421

AFFIDAVIT

STATE OF INDIANA )  
COUNTY OF LAKE ) SS:

Tax I.D. No. 45-12-04-205-014.000-031

DEBRA A. TASSI, being first duly sworn upon oath, depose(s) and say(s):

1. That EMILY L. GRABEK a/k/a EMILY GRABEK, died without leaving a will on April 8, 2005 at, Lowell Health Care, in Lake County, Indiana.
2. That at the time of her death, EMILY L. GRABEK a/k/a EMILY GRABEK individually owned an undivided 1/2 interest and was a joint tenant with DEBRA A. TASSI as to an undivided 1/2 interest, and also held a Life Estate interest, in the following described real estate:  
LOT 11, BLOCK "R" MEADOWLAND ESTATES, UNIT NO. THREE (3), AS SHOWN IN PLAT BOOK 31, PAGE 34, IN LAKE COUNTY, INDIANA.
3. That the following person (s) are the true and lawful heir(s) of EMILY L. GRABEK a/k/a EMILY GRABEK: DEBRA A TASSI (daughter).
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 included 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.

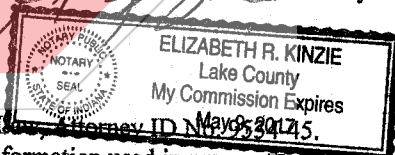
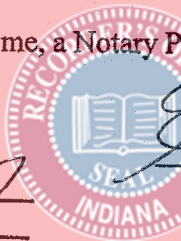
FURTHER, Affiant saith naught.

*Debra A. Tassi*  
Debra A. Tassi

COMMUNITY TITLE COMPANY  
FILE NO 122673

Subscribed and sworn to before me, a Notary Public this 19 day of Sept, 2012.

My Commission Expires: 5/9/17  
County of Residence: Lake



This instrument prepared by PATRICK J. McMANAMA, Attorney-at-Law, Attorney ID No. 934175.

No legal opinion given or rendered. All information used in preparation of document was supplied by title company.

FILED

SEP 26 2012

004052  
PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

\$14  
CM  
Cox  
NON  
CONF

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

CERTIFICATE OF DEATH

State No. ....

Local No. .... 1040-05 .....

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

TYPE/PRINT IN PERMANENT BLACK INK

PRECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>EMILY GRABEK</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>6:30 P.M.</b>	3b. DATE OF DEATH (Month, Day, Year) <b>April 8, 2005</b>	
4. *SOCIAL SECURITY NUMBER <b>307-20-1364</b>	5a. AGE—Last Birthday (Years) <b>79</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>August 31, 1925</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? -----		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) <b>Lowell Health Care</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Lowell</b>	9d. COUNTY OF DEATH <b>Lake</b>		
10. MARITAL STATUS (Specify) <b>Widowed</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>		
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Merrillville</b>	13d. STREET AND NUMBER <b>5484 Monroe Street</b>		
13e. ZIP CODE <b>46410</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>12</b>		15. FATHER'S NAME (First, Middle, Last) <b>Michael Pietrzyk</b>			
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Cielak</b>			20. INFORMANT'S NAME (Type/Print) <b>Debbie Tassi</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3147 Tremont Lane, Crown Point, IN 46307</b>		20c. Relationship <b>Daughter</b>			
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) <b>April 12, 2005 Calvary Cemetery</b>		21c. LOCATION—City or Town, State <b>Portage, Indiana</b>	
22a. EMBALMER'S NAME <b>Jonathon R. Christiansen</b>		22b. EMBALMER'S LICENSE NO. <b>FD20200095</b>	22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) <b>1009893</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>PRUZIN BROTHERS FUNERAL SERVICE 6360 Broadway Merrillville, IN 46410 #83002453</b>		
25. PART I Enter the disease, 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) <b>a. Subarachnoid Hemorrhage</b>					
b. DUE TO IOR AS A CONSEQUENCE OF: <input checked="" type="checkbox"/> THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT					
c. DUE TO IOR AS A CONSEQUENCE OF:					
d. DUE TO IOR 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 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>		
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>[Signature]</i> - <b>Physician</b>		29c. MEDICAL LICENSE NO. <b>02-001002</b>	29d. DATE SIGNED (Month, Day, Year) <b>4-12-05</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) <b>Dr. Richard Kwejsa 317 W. Commercial Ave., Lowell, IN 46356 (219)696-6258</b>					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				31. DATE FILED (Month, Day, Year) <b>April 13, 2005</b>	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		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)			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			