STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 MAR 12 AM 11:04

MICHAEL B. BROWN
RECORDER

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

2013 018287

AFFIDAVIT OF SURVIVORSHIP

Comes now Robert Nowak, and upon being duly sworn does attest and say:

1. That the affiant is the son of Stanley C. Nowak, a/k/a Stanley Nowak, and Adela Nowak, deceased.

2. That Stanley C. Nowak and Adela Nowak were the owners as Tenants by the Entirety of real property located in Lake County, Indiana, more particularly described as:

   Lots Numbered 1,2 and 3 in Block 8, in Matthai's Addition to Liverpool Heights, New Chicago, as per plat thereof recorded in Plat Book 3, page 59, in the Office of the Recorder of Lake County, Indiana.

   Commonly known as: 3630 Michigan Ave., Hobart, IN 46342
   Parcel No.: 45-09-19-358-020.000-022

3. That Stanley C. Nowak and Adela Nowak acquired the property during the term of their marriage.

4. That Adela Nowak died on the 28th day of June, 2004.

5. That Stanley C. Nowak died on the 5th day of June, 2010.

6. That Robert Nowak is a surviving child of Stanley C. Nowak and Adela Nowak.

I affirm under the penalties for perjury that the foregoing statements are true.

Robert Nowak

FILED
MAR 07 2013
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

STATE OF INDIANA/ COUNTY OF PORTER)ss:

Subscribed and sworn to before me this 5 day of February, 2013

My Commission
Expires: 10/30/16

Susan R. Colunga, Notary Public
Resident of Porter County

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.

Patricia A. Rees.

This Instrument Prepared by: Patricia A. Rees, Attorney at Law, 5341 Central Ave., Portage, IN 46368 (219) 947-1692.

13-1350 HOLD FOR MERIDIAN TITILE CORP

13 M

11174

* 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.

Local No. 1582-04

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ADELA J. NOWAK
2. SEX: Female
3a. TIME OF DEATH: 8:50 AM M
3b. DATE OF DEATH (Month, Day, Yr.): June 28, 2004
4. *SOCIAL SECURITY NUMBER: 304-22-8186
5a. AGE—Last Birthday (Years): 79
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): October 9, 1924
7. BIRTHPLACE (City and State or Foreign Country): New Chicago Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 3630 Michigan Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Stanley Nowak
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: Hobart
13d. STREET AND NUMBER: 3630 Michigan Street
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Bieniek
19. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Sudut

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Stanley C. Nowak
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3630 Michigan Street, Hobart, IN 46342
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jul 1, 2004 Calvary Cemetery
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?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
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

CAUSE OF DEATH

28. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Vascular collapse — Approximate Interval Between Onset and Death: Unknown
DUE TO (OR AS A CONSEQUENCE OF)
b. Due to arteriosclerotic heart and vascular disease
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)

CERTIFIER

29a. CERTIFIER (Check only one): Chief Deputy
☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☒ 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
29c. MEDICAL LICENSE NO.: N/A
29d. DATE SIGNED (Month, Day, Year): June 29, 2004

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): Jeffrey R. Wells Chief Deputy, 2900 West 93rd Avenue, Crown Point, Indiana 46307
31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): 6/30/04

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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
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): June 28, 2004
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

SDH06-004 State Form 10110 (R5/1-99)