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### AFFIDAVIT TO TERMINATE LIFE ESTATE

Tax ID #45-10-13-401-002.000-034

BT 1300421

On this 6/28/13 before me personally appeared Janice Marie Sokolowski  
(insert date)

2013 049181

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

- Affiant resides at the address given below affiant's signature:
- Affiant is \_\_\_\_\_  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
- Said RAYMOND FOLLMER  
(fill in name of life estate tenant who died)  
died on FEBRUARY 3, 2010

- Said PHYLLIS FOLLMER  
(fill in name of life estate tenant who died)  
died on MARCH 2, 2013

- The legal description of the premises in question is:

LOT 30 IN BLOCK 5 IN PHEASANT HILLS ADDITION, UNIT 1, BOTH TOWNSHIP OF DYER, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 39 PAGE 36, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

- 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..

- Where this affidavit relates to a Life Estate Interest only.

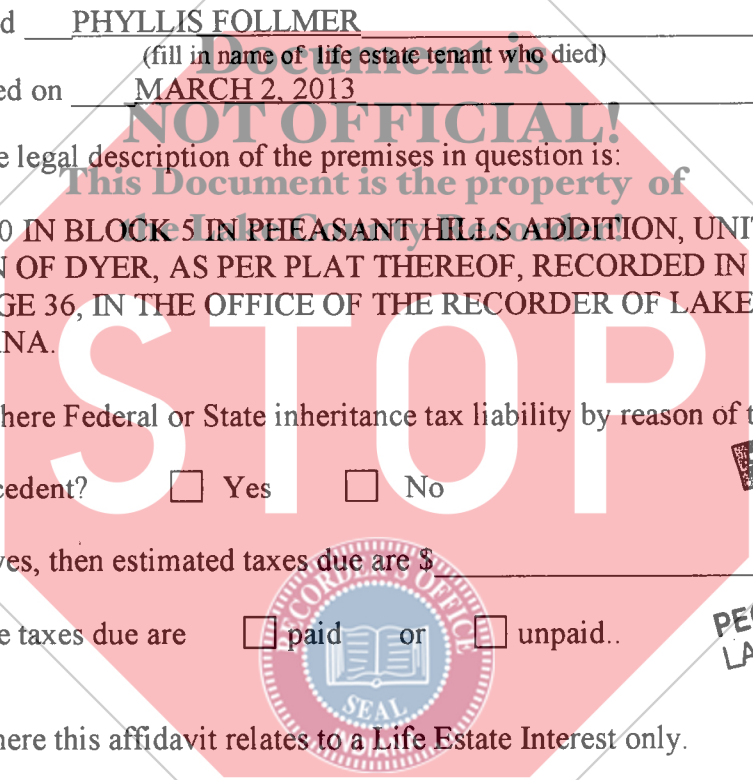
- Affiant's relationship to the deceased was daughter

①

Signature: Janice Marie Sokolowski

Printed Name Janice Marie Sokolowski

CHICAGO TITLE INSURANCE COMPANY



2013 JUL -8 AM 10:01  
MICHAEL B. BOGGS  
RECORDER

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

FILED  
JUL 03 2013

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

17  
CT  
CS

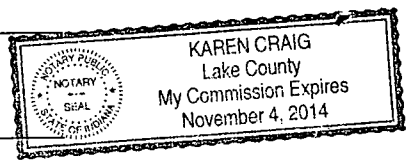
003991

Address: \_\_\_\_\_

Subscribed and sworn to before me by the affiant

This 6/28/13  
(insert date)

Karen Craig  
Notary Public



Printed Name \_\_\_\_\_

My County of Residence is: \_\_\_\_\_

In the State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_



This instrument prepared by Janice Marie Sokolowski

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. J Sokolowski



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tax ID #45-10-13-401-002.000-034

Local No. **375-10**

State No.

1. Decedent's Legal Name (First, Middle, Last) <b>RAYMOND S. FOLLMER</b>		1a. Maiden Last Name (If Female) <b>-</b>		2. Sex <b>MALE</b>	3. Time Of Death <b>1:45 PM</b>	4. Date Of Death (Month/Day/Year) <b>FEBRUARY 3, 2010</b>	
5. Social Security Number <del>XXXXXXXXXX</del>	6a. Age - Yrs <b>83</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>MAY 19, 1926</b>	8. Birthplace (City And State Or Foreign Country) <b>CHICAGO, ILLINOIS</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 checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival		10a. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input 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>ST. MARGARET MERCY HOSPITAL</b>							
12. City Or Town, State, And Zip Code <b>DYER, INDIANA 46311</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>PHYLLIS FOLLMER</b>		15a. (If Wife) Give Maiden Last Name <b>STAJKOWSKI</b>		16. Decedent's Usual Occupation <b>ROLL TENDER</b>		17. Kind Of Business/Industry <b>PRINTING</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>DYER</b>		18d. Apt. No. <b>-</b>	18e. Zip Code <b>46311</b>
18c. Street And Number <b>449 ASPEN DRIVE</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
19. Decedent's Education <b>10TH GRADE, NO DIPLOMA</b>		20. Decedent Of Hispanic Origin <b>NO</b>		21. Decedent's Race <b>WHITE</b>			
22. Father's Name (First, Middle, Last) <b>PETER FOLLMER</b>		23. Mother's Name (First, Middle, Last) <b>LOTTIE FOLLMER</b>		23a. Mother's Maiden Last Name <b>ADAMSKI</b>			
24. Informant Name <b>PHYLLIS FOLLMER</b>		24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>449 ASPEN DRIVE, DYER, INDIANA 46311</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>FEBRUARY 6, 2010 COMMUNITY CREMATION SERVICE</b>		25c. Location - City, Town, And State <b>SCHERERVILLE, INDIANA</b>		27a. Funeral Home License Number <b>83002916</b>	
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>ANTHONY &amp; DZIADOWICZ FUNERAL HOME 9445 CALUMET AVENUE MUNSTER, INDIANA 46321</b>		27b. License Number (Of Licensee) <b>01001447</b>			
27c. Signature Of Indiana Funeral Service Licensee <i>Anthony J. Anthony</i>		27d. the Lake County Recorder		27e. License Number (Of Licensee) <b>01001447</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. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Atherosclerotic heart disease</u> Due To (Or As A Consequence Of) B. _____ Due To (Or As A Consequence Of) C. _____ Due To (Or As A Consequence Of) D. _____ Due To (Or As A Consequence Of) 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 <u>Osteomyelitis of the left heel</u>							
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
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		37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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) <b>CITY OF DYER OFFICE ON DEATH ON FILE WITH THE LAKE COUNTY RECORDER</b>		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		38e. City Or Town		38f. Street & Number		38g. Apt. No.	
39. Describe How Injury Occurred <b>FEB 05 2010</b>		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: <i>J. Paik, M.D.</i>				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>JAY C.L. PAIK, M.D., 800 MACARTHUR BLVD., MUNSTER, INDIANA 46321</b>				44. License Number <b>01030770A</b>		45. Date Certified <b>FEBRUARY 4, 2010</b>	
46. Additional Funeral Service Provider:				47. Area			
48. Signature Of Local Health Officer: <i>Susan W. Best, SO</i>				49. For Registrar Only - Date Filed (Month/Day/Year) <b>February 5, 2010</b>			



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tax ID #45-10-13-401-002.000-034

Local No 000799

EDR No 00000310557

State No 010689

1. Decedent's Legal Name (First, Middle, Last) <b>PHYLLIS FOLLMER</b>				1a. Maiden Name (If Female) <b>STAJKOWSKI</b>		2. Sex <b>FEMALE</b>		3. Time Of Death <b>06:10 PM</b>		4. Date Of Death (Month/Day/Year) <b>03/02/2013</b>			
5. Social Security Number <b>██████████</b>		6a. Age - Yrs <b>83</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>03/11/1929</b>				8. Birthplace (City and State or Foreign Country) <b>CHICAGO, IL</b>									
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred in A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input checked="" type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)											
11. Facility Name (If Not Institution, Give Street and Number) <b>DYER NURSING AND REHABILITATION CENTER</b>													
12. City Or Town, State, And Zip Code <b>DYER, IN, 46311</b>						13. County Of Death <b>LAKE</b>			14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
15. Surviving Spouse's Name				15a. (If Wife) Give Maiden Last Name				16. Decedent's Usual Occupation <b>HOMEMAKER</b>		17. Kind Of Business/Industry <b>OWN HOME</b>			
18. Residence - State <b>INDIANA</b>			18a. County <b>LAKE</b>			18b. City Or Town <b>DYER</b>			18c. Apt. No.		18d. Zip Code <b>46311</b>		
18e. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
18f. Street And Number <b>1000 ROANOKE COURT</b>													
19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</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>JOHN STAJKOWSKI</b>				23. Mother's Name (First, Middle, Last) <b>CECELIA STAJKOWSKI</b>				23a. Mother's Maiden Last Name <b>GRUSZKOWSKI</b>					
24. Informant's Name <b>NANCY WEST</b>				24a. Relationship To Decedent <b>DAUGHTER</b>				24b. Mailing Address (Street And Number, City, State, Zip Code) <b>1000 ROANOKE COURT, DYER, IN 46311</b>					
25. Place Of Disposition													
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>COMMUNITY CREMATION SERVICE</b>				25c. Location - City, Town, And State <b>SCHERERVILLE, IN</b>					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>ANTHONY &amp; DZIADOWICZ FUNERAL HOME, INC. - MUNSTER, 9445 CALUMET AVE, MUNSTER, IN 46321</b>						27a. Funeral Home License Number <b>EH83002916</b>					
27b. Signature Of Indiana Funeral Service Licensee <b>LARRY D. ANTHONY, BY ELECTRONIC SIGNATURE</b>													
27c. License Number Of Decedent On File With The Department <b>FD01001447</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>RUPTURED AORTIC ANEURYSM</b> Due to (Or As A Consequence Of)													
B. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (Or As A Consequence Of)													
C. <b>ATRIAL FIBRILLATION</b> Due to (Or As A Consequence Of)													
D.													
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													
Approximate Interval: Onset To Death <b>10 MINUTES</b>													
<b>15 YEARS</b>													
<b>2 YEARS</b>													
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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" 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>FRED ADLER, BY ELECTRONIC SIGNATURE</b>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			44. License Number <b>01019251A</b>			45. Date Certified <b>03/04/2013</b>	
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>FRED ADLER, 800 MAC ARTHUR BLVD STE 2, MUNSTER, IN 46321</b>						46. *Alias:			47. *Alias:				
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>MAR 05 2013</b>							
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)													