

4

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2014 008758  
AFFIDAVIT

2014 FEB 14 AM 9:06

MICHAEL B. BROWN  
RECORDER

On this 2/6/2014 before me personally appeared \_\_\_\_\_  
(insert date)

John E. Lubash

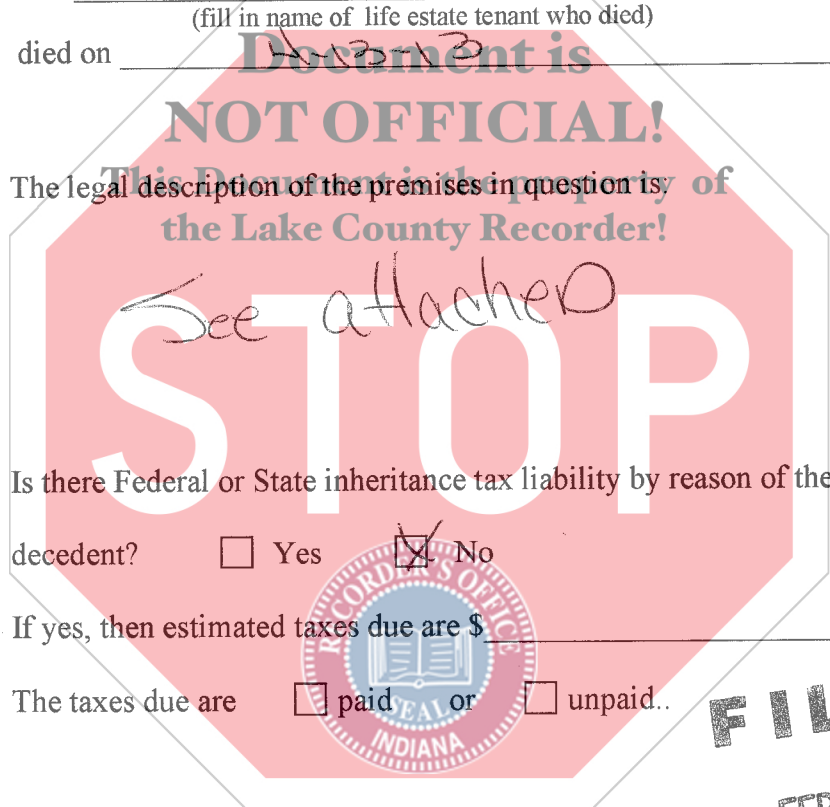
to me personally known, who being duly sworn on oath did say that:

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

2. Affiant is Son of Florence Lubash  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said Florence Lubash  
(fill in name of life estate tenant who died)  
died on 12-13-13

4. The legal description of the premises in question is \_\_\_\_\_  
of \_\_\_\_\_  
the Lake County Recorder!



5. 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..

**FILED**

FEB 11 2014

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

6. Where this affidavit relates to a Life Estate Interest on \_\_\_\_\_  
7. Affiant's relationship to the deceased was son

FIDELITY NATIONAL  
TITLE COMPANY

92014-0081

920140081  
**FIDELITY HBT**

20797  
non conf

# 18<sup>00</sup>  
FN  
SP

Signature: [Handwritten Signature]  
Printed Name John E. Lubash  
Address: 10350 W. Lake Street  
Crown Point, IN 46307

Subscribed and sworn to before me by the affiant

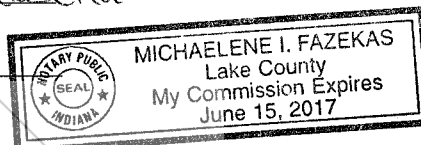
This 2/10/2014  
(insert date)  
[Handwritten Signature]  
Notary Public

Printed Name Michaelene J. Fazekas

My County of Residence is: Lake

In the State of Indiana

My Commission Expires 6-15-2017



This Document is the property of  
the Public Records Office

This instrument prepared by Michaelene J. Fazekas



Dalanna Tarlton



920140081

**EXHIBIT A**

Lot 17 in Block 5 in "Corrected Plat" as of August 21, 1959 in Wright Manor Addition to Gary, as per plat thereof, recorded in Plat Book 33 page 62, correcting plat recorded in Plat Book 32 page 26, in the Office of the Recorder of Lake County, Indiana.





**INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH**

Local No **001352**

EDR No **00000318463**

State No **018237**

1. Decedent's Legal Name (First, Middle, Last) <b>FLORENCE LUBASH</b>				1a. Maiden Name (If female) <b>WYSOCKI</b>		2. Sex <b>FEMALE</b>	3. Time Of Death <b>06:25 AM</b>	4. Date Of Death (Month/Day/Year) <b>04/13/2013</b>	
5. Social Security Number [REDACTED]	6a. Age - Yrs <b>90</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>09/12/1922</b>		8. Birthplace (City and State or Foreign Country) <b>GARY, IN</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 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 ANTHONY MEDICAL CENTER OF CROWN POINT</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 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>WAITRESS</b>		17. Kind Of Business/Industry <b>RESTAURANT</b>		
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>MERRILLVILLE</b>					
18c. Street And Number <b>5960 MCKINLEY STREET</b>						18d. Apt. No.	18e. Zip Code <b>46410</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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>JOSEPH WYSOCKI</b>				23. Mother's Name (First, Middle, Last) <b>KAZIMIERA WYSOCKI</b>		23a. Mother's Maiden Last Name <b>RYBINSKA</b>			
24. Informant's Name <b>JOHN E LUBASH</b>		24a. Relationship To Decedent <b>SON</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>1038 WEST LAKESHORE DRIVE, CROWN POINT, IN 46307</b>					
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input 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>CALUMET PARK CEMETERY</b>		25c. Location - City, Town, And State <b>MERRILLVILLE, IN</b>					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>PRUZIN BROTHERS-MERRILLVILLE, 6360 BROADWAY, MERRILLVILLE, IN 46410</b>					27a. Funeral Home License Number: <b>FH83002453</b>		
27b. Signature Of Indiana Funeral Service Licensee: <b>THOMAS G. PRUZIN, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD01009893</b>			
28. Part I. Enter The <u>Chain Of Events</u> - 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. <b>GASTRIC VOLVULUS DUE TO LARGE HIATAL HERNIA</b> 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				B. _____ 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
ADVANCED DEMENTIA		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>ASRAR AHMED SHEIKH, 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>ASRAR AHMED SHEIKH, 17648 MORSE STREET, LOWELL, IN 46356</b>						44. License Number <b>01060322A</b>		45. Date Certified <b>04/13/2013</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>APR 16 2013</b>			
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)									
<p>020140081</p> <p><b>FIDELITY HBT</b></p>									