

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

1401083

Tax ID #45-07-21-360-003.000-026

On this 4/24/2014 before me personally appeared Stanley T. Wasiak (insert date)

2014 024602

CHICAGO TITLE INSURANCE COMPANY

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 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 Eva Wasiak and

4. Said Eva Wasiak (fill in name of co-tenant who died) died on 11/9/2013 leaving no will; (insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is: Lot Six (6) Block Two (2), Auwerda's Second Addition to the Town of Highland, as shown in plat book 29 page 73 in Lake County, Indiana

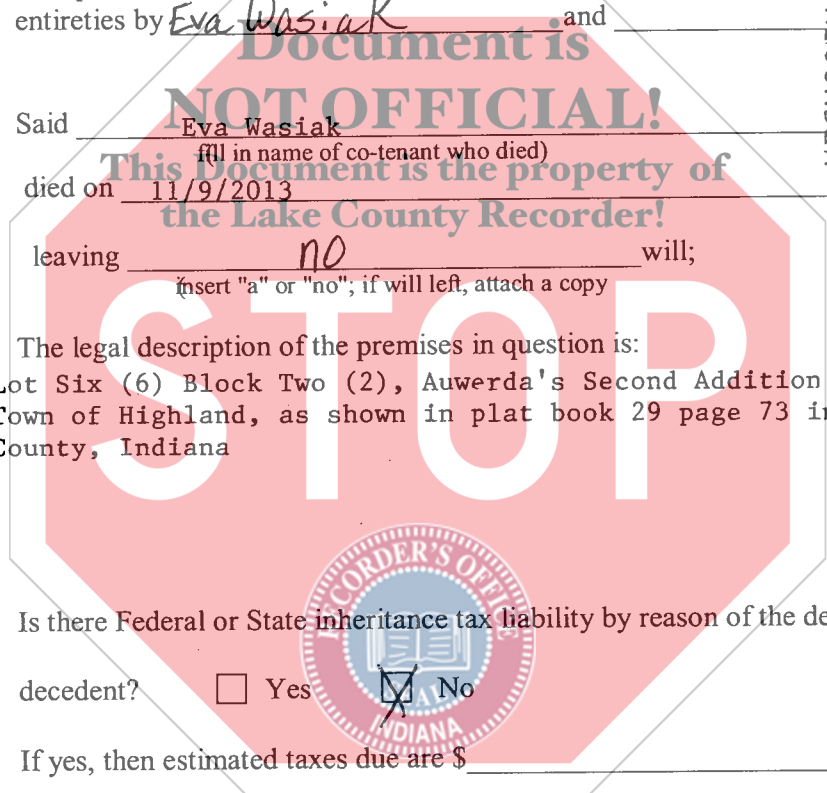
6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? [] Yes [X] No

If yes, then estimated taxes due are \$

The taxes due are [] paid or [] unpaid..

2014 MAY -2 AM 10:24 MICHAEL B. BROWN RECORDER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD



FILED

APR 29 2014

01558

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

164 non cm CT RM

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 SON

Signature: Stanley T. Wasiak

Printed Name Stanley T. Wasiak

Address: 708 Northgate Dr.
Dyer, IN 46311

Subscribed and sworn to before me by the affiant

This 4/24/2014
(insert date)

Karen Craig
Notary Public

Printed Name _____

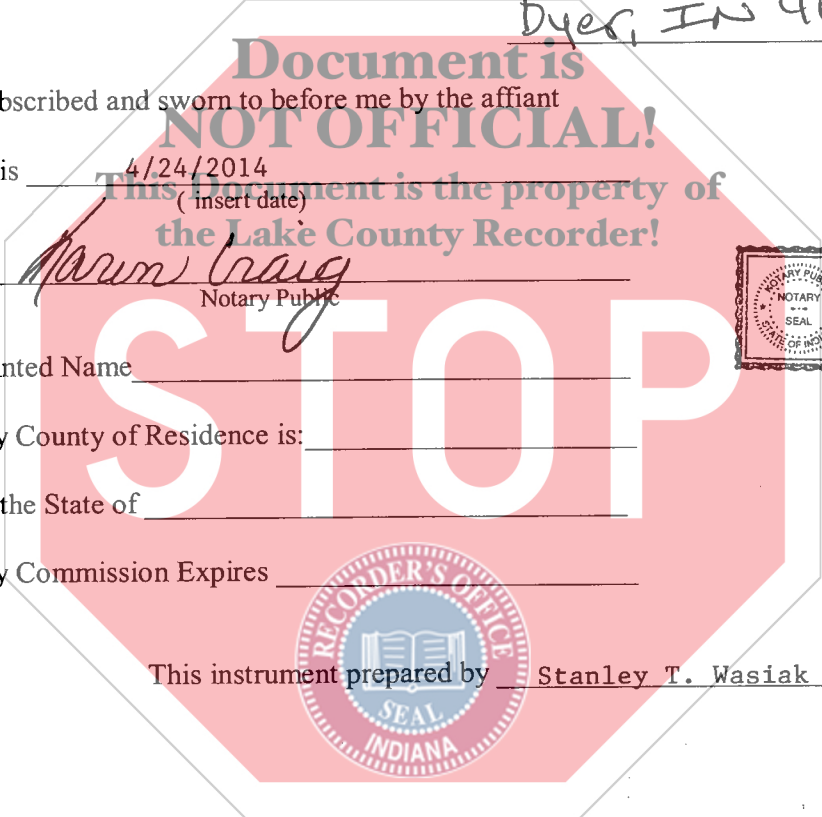
My County of Residence is: _____

In the State of _____

My Commission Expires _____

This instrument prepared by Stanley T. Wasiak

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. S.T. WASIAK





INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

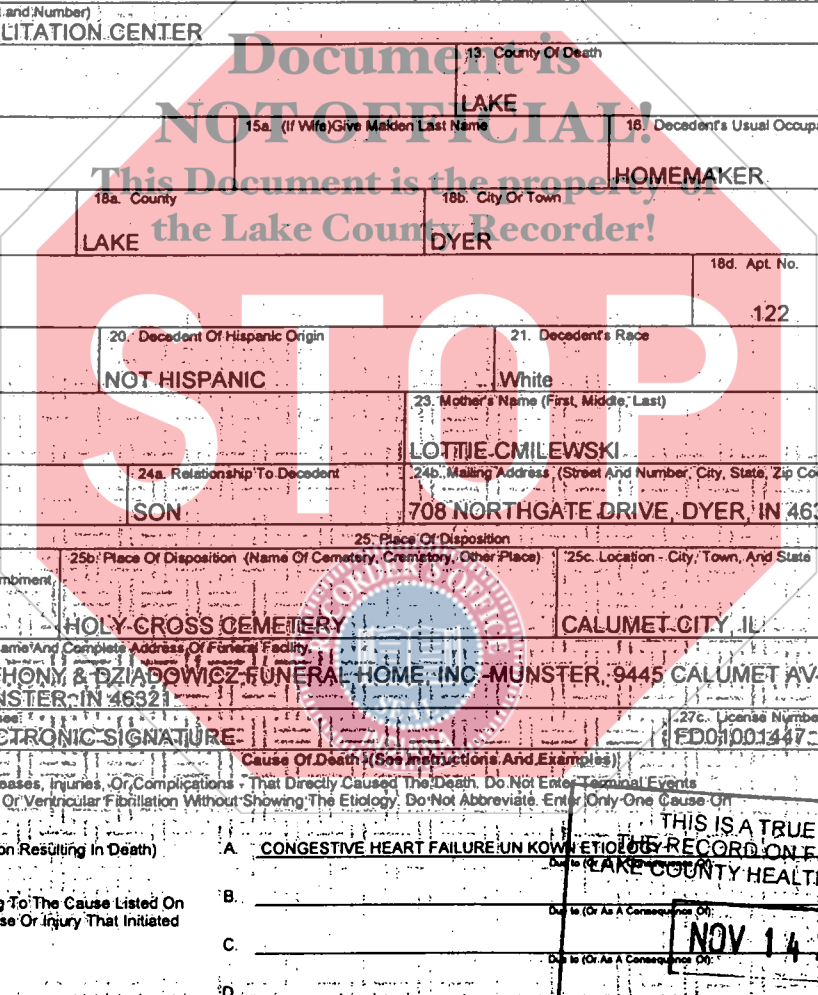
Tracking No. 00813

Local No 003697

EDR No 00000352572

State No

1. Decedent's Legal Name (First, Middle, Last) EVA WASIAK				1a. Maiden Name (If female) CMILEWSKI		2. Sex FEMALE	3. Time Of Death 01:00 AM	4. Date Of Death (Month/Day/Year) 11/09/2013			
5. Social Security Number 093-00-2007	6a. Age - Yrs 97	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) 06/10/1916		8. Birthplace (City and State or Foreign Country) CHICAGO, IL			
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				10a. If Death Occurred Somewhere Other Than A Hospital: <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) DYER NURSING AND REHABILITATION CENTER				12. City Or Town, State, And Zip Code DYER, IN, 46311		13. County Of Death LAKE		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 HOMEMAKER		17. Kind Of Business/Industry OWN HOME			
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town DYER		18d. Apt. No. 122		18e. Zip Code 46311			
18c. Street And Number 601 SHEFFIELD AVENUE		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		19. Decedent's Education 8TH GRADE OR LESS		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White			
22. Father's Name (First, Middle, Last) STANLEY CMILEWSKI				23. Mother's Name (First, Middle, Last) LOTTIE CMILEWSKI		23a. Mother's Maiden Last Name MACKIEWICZ					
24. Informant's Name STANLEY T WASIAK		24a. Relationship To Decedent SON		24b. Mailing Address (Street And Number, City, State, Zip Code) 708 NORTHGATE DRIVE, DYER, IN 46311							
25a. Method Of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) HOLY CROSS CEMETERY		25c. Location - City, Town, And State CALUMET CITY, IL							
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility ANTHONY & DZIADOWICZ FUNERAL HOME INC - MUNSTER, 9445 CALUMET AVE, MUNSTER, IN 46321				27a. Funeral Home License Number FH83002916					
27b. Signature Of Indiana Funeral Service Licensee LARRY D. ANTHONY - BY ELECTRONIC SIGNATURE		27c. License Number (Of Licensee) ED01001447		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. CONGESTIVE HEART FAILURE UNKOWN ETIOLOGY B. _____ C. _____ 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							
28. 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No		30. Were Any Records Available To Complete The Cause Of Death? <input checked="" type="checkbox"/> Yes <input 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 checked="" 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)	
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					
36. Location Of Injury - State		36a. City Or Town		36b. Street & Number		36c. Apt. No.		36d. 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: RAJARAJESWARI MAJETY, BY ELECTRONIC SIGNATURE				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		44. License Number 01055426A		45. Date Certified 11/13/2013			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: RAJARAJESWARI MAJETY, 2050 N. MAIN STREET SUITE F, CROWN POINT, IN 46307				47. Address		48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE		49. For Registrar Only - Date Filled (Month/Day/Year) NOV 14 2013			



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.

RAISED SEAL AFFIXED