

4

AFFIDAVIT TO TERMINATE LIFE ESTATE

On this 7/25/14 before me personally appeared _____
(insert date)

VIRGINIA F. MISTARZ

2014 048595

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 OWNER
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said Joseph G. MISTARZ
(fill in name of life estate tenant who died)

died on 7/23/2013

4. The legal description of the premises in question is:

ATTACHED

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..

6. Where this affidavit relates to a Life Estate Interest on _____

7. Affiant's relationship to the deceased was Spouse

Signature: Peggy Holmgren
PEGGY HOLMGREN
LAKE COUNTY AUDITOR

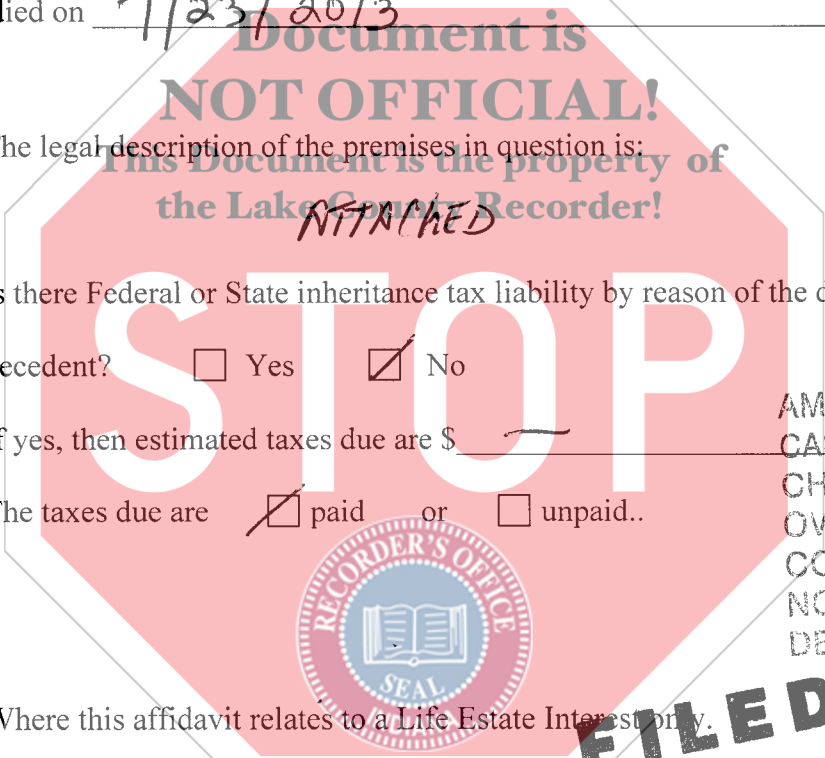
25468

BT1400280

CHICAGO TITLE INSURANCE COMPANY

2014 AUG 13 AM 10:35
MICHAEL B. BROWN
RECORDER

STATE OF ILLINOIS
LAKE COUNTY
FILED FOR RECORD



AMOUNT \$ 18
CASH _____ CHARGE CF
CHECK# _____
OVERAGE _____
COPY _____
NON-CONF ✓
DEPUTY RR

FILED

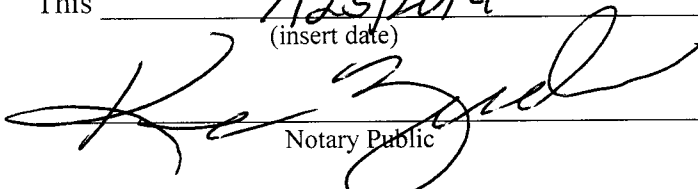
AUG 08 2014

Printed Name Virginia F. Mistrarz

Address: 70 Wingate Rd
Providence, RI. ~~02909~~
02906

Subscribed and sworn to before me by the affiant

This 7/25/2014
(insert date)


Notary Public

Printed Name _____

My County of Residence _____

In the State of _____

My Commission Expires _____

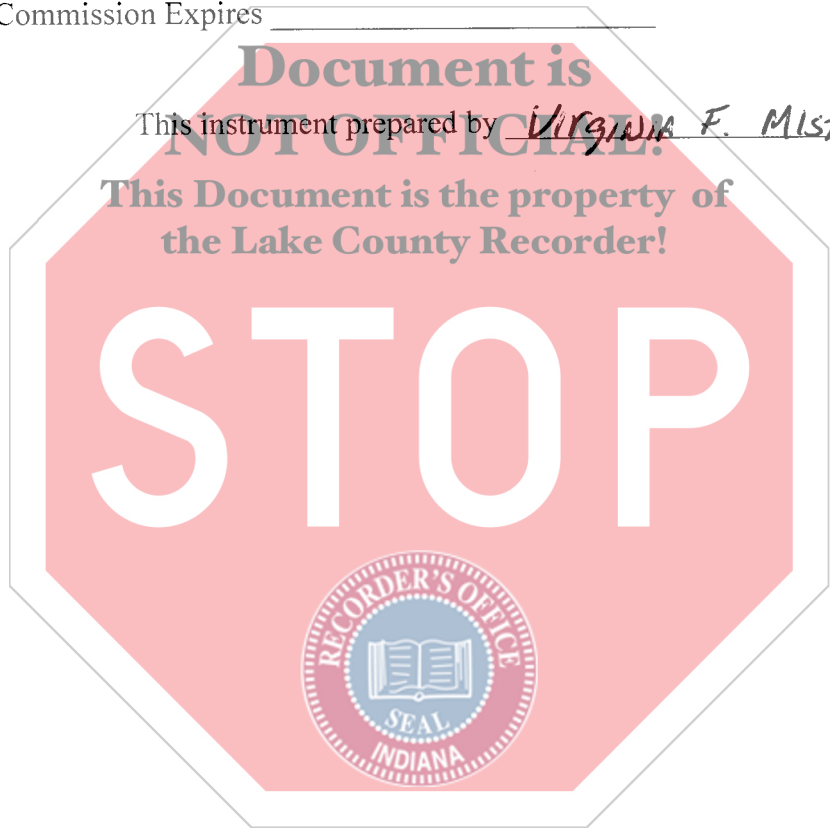
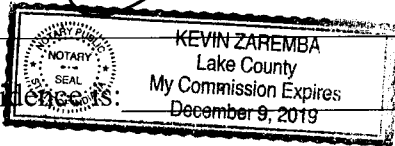


EXHIBIT A

LEGAL DESCRIPTION

THE WEST 46.0 FEET OF LOT 37, BY PARALLEL LINES AS MEASURED ALONG THE NORTH LINE THEREOF, IN AUBURN MEADOW SUBDIVISION PHASE 1, AN ADDITION TO THE TOWN OF SCHERERVILLE, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 90, PAGE 98, AND AS AMENDED BY PLAT OF CORRECTION RECORDED IN PLAT BOOK 91 PAGE 6, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.





Local No 002486

EDR No 000000335045

State No 034365

1. Decedent's Legal Name (First, Middle, Last) JOSEPH G MISTARZ				1a. Maiden Name (If female)		2. Sex MALE	3. Time Of Death 10:00 PM	4. Date Of Death (Month/Day/Year) 07/23/2013	
5. Social Security Number [REDACTED]	6a. Age - Yrs 86	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) 03/03/1927		8. Birthplace (City and State or Foreign Country) WHITING, IN	
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 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 checked="" 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) WILLIAM J. RILEY MEMORIAL RESIDENCE, HOSPICE								12. City Or Town, State, And Zip Code MUNSTER, IN, 46321	
13. County Of Death LAKE				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 VIRGINIA F MISTARZ			15a. (If Wife) Give Maiden Last Name KUZMINSKI		16. Decedent's Usual Occupation INSULATOR		17. Kind Of Business/Industry UNILEVER		
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town SCHERERVILLE			18d. Apt. No.	18e. Zip Code 46375	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
18c. Street And Number 1257 BLUEBELL TRAIL		19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED			20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White		23a. Mother's Maiden Last Name STOLARZ
22. Father's Name (First, Middle, Last) FRANK A MISTARZ			23. Mother's Name (First, Middle, Last) MARYANNA MISTARZ			23a. Mother's Maiden Last Name STOLARZ			
24. Informant's Name VIRGINIA F MISTARZ		24a. Relationship To Decedent WIFE		24b. Mailing Address (Street And Number, City, State, Zip Code) 1257 BLUEBELL TRAIL, SCHERERVILLE, IN 46375					
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) SOLAN PRUZIN CREMATORY			25c. Location - City, Town, And State SCHERERVILLE, IN				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	27. Name And Complete Address Of Funeral Facility SOLAN-PRUZIN FUNERAL SERVICE INC. DBA SOLAN-PRUZIN, 14 KENNEDY AVENUE, SCHERERVILLE, IN 46375						27a. Funeral Home License Number: FH10200037		
27b. Signature Of Indiana Funeral Service Licensee: PAUL P. GONZALEZ, BY ELECTRONIC SIGNATURE		27c. License Number (Of Licensee): FD21100035		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 On ONE LINE. Add Additional Lines If Necessary. THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT JUL 30 2013 From J Best, do LAKE COUNTY HEALTH OFFICER					Approximate Interval: Onset To Death UNKNOWN
Immediate Cause (Final Disease Or Condition Resulting In Death) A. T CELL LYMPHOMA		Due to (Or As A Consequence Of):		UNKNOWN					
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. MYCOSIS FUNGOIDES OF BODY		Due to (Or As A Consequence Of):		UNKNOWN					
C. DIARRHEA, SEPSIS, HYPOTENSION, HYPERNATREMIA		Due to (Or As A Consequence Of):		FEW DAYS					
D. DO NOT RESUSCITATE, CORONARY ARTERY DISEASE, PROSTATE CANCER, MEMORIAL LOSS, SHORT TERM, DIABETES, HYPERTENSION		Due to (Or As A Consequence Of):		UNKNOWN					
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I HOSPICE								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 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: LIZA R PARIKH, BY ELECTRONIC SIGNATURE				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: LIZA R PARIKH, 2727 HWY AVENUE, HIGHLAND, IN 46322				44. License Number 01061275A		45. Date Certified 07/26/2013			
46. Additional Funeral Service Provider:				47. *Akas:					
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year): JUL 29 2013			

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency to permit us to determine if the measure is voluntary and there will be no penalty for refusal.

I affirm, under the penalties to perjury that I have taken reasonable care to redact each Social Security number in this document, unless required by law.