3

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

2014 0487955

On this 8-07-2014 (insert date) before me personally appeared Beverly J Watson BEVERLY J. WATSON

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

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2014 AUG 13 PM 2:45
MICHAEL B. BROWN
RECORDER

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by FLORENCE KOLAT and BEVERLY J. WATSON

4. Said FLORENCE KOLAT (fill in name of co-tenant who died)
died on AUGUST 08-2006
leaving YES (insert "a" or "no"; if will left, attach a copy) will;

5. The legal description of the premises in question is: 45-02-25-151-005-000 623
Lot 7 in Block 15 in J. William Eschenburgs State Line Addition to Hammond, as per plat thereof, recorded in Plat Book 2, page 2, in the office of the recorder of Lake County Indiana, Commonly known as 4315 STATE LINE AVENUE, HAMMOND, INDIANA 46327.

6. 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 $ N/A

The taxes due are ☒ paid or ☐ unpaid..

FILED
AUG 13 2014
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

25671

16- CASH DP

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? N/A

(If answer is "Yes" , identify the divorce proceedings: —):

8. Affiant's relationship to the deceased was DAUGHTER

Signature: Beverly J Watson

Printed Name BEVERLY J. WATSON

Address: 4315 STATELINE

HAMMOND - IN

46327

Subscribed and sworn to before me by the affiant

This AUGUST 7th 2014
(insert date)

Raquel Orduna
Notary Public

RAQUEL ORDUNA
NOTARY PUBLIC
State of Indiana, Lake County
My Commission Expires June 29, 2019

Printed Name RAQUEL ORDUNA

My County of Residence is: LAKE

In the State of INDIANA

My Commission Expires JUNE 29th, 2019

This instrument prepared by Beverly J Watson

* 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. 531

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Stat Date Issued Aug 9, 2006 — Hammond Health Commissioner

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)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
FLORENCE F. KOLAT	FEMALE	8:35 A M	AUGUST 8, 2006

4. *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
[redacted]	91			NOVEMBER 1, 1914	HAMMOND, INDIANA

8a A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
NO	N/A	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
HAMMOND-WHITING CARE CENTER	HAMMOND/WHITING P.O.	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
WIDOWED	NONE	HOMEMAKER	OWN HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	4315 STATELINE AVENUE

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46327	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	WHITE	9	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
FREDERICK BORMAN	MATILDA HOLDORF

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
GERALDINE FALUCSKAI	3028-41ST STREET, HIGHLAND, INDIANA 46322	DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	AUGUST 11, 2006 HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
KEITH D. ANTHONY	01011911	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Keith D Anthony	01011911	ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327

CAUSE OF DEATH

25. 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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a Hypertensive Heart Disease With CHF	6 months
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause 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 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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
COPD CHF HTN Anemia	NO	NO	NO

CERTIFIER

29a CERTIFIER (Check only one)

☒ 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	29d DATE SIGNED (Month, Day, Year)
M. Patel	01034865	AUGUST 8, 2006

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

M. PATEL M.D. 835 - 169TH STREET, HAMMOND, INDIANA 46324

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Keith D Anthony MD	August 9, 2006

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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