

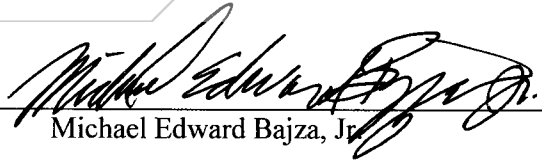


5. Michael E. Bajza died testate July 24, 2011, a resident of Porter County, Indiana. A certified copy of the Indiana Department of Health Certificate of Death of Michael E. Bajza is attached to this Survivorship Affidavit as Exhibit "A" and made a part of this Survivorship Affidavit by reference.
6. The Last Will and Testament of Michael E. Bajza, under which Margaret L. Bajza, his surviving spouse, was the sole devisee, was spread of record by the Order of Probate of Will Without Administration (Will Spread of Record), entered on December 23, 2011, by the Porter Superior Court, Probate Division, sitting at Valparaiso, Indiana, under Cause No. 64D02-1112-EM-12244. A scrivener's error in said Will states Margaret L. Bajza's name as Margaret B. Bajza; however, her correct name is Margaret L. Bajza.
7. The probate value of Michael E. Bajza's probate estate does not exceed the sum of \$50,000.00.
8. There were no Federal Estate or State Inheritance taxes due by reason of Michael E. Bajza's death.
9. All funeral expenses and the expenses of the last illness of Michael E. Bajza have been paid.
10. As a result of Michael E. Bajza's death, Margaret L. Bajza, as his surviving spouse, became the sole owner of said real estate.
11. On October 23, 2011, Margaret L. Bajza, a resident of Porter County, Indiana, died a widow, having never been remarried. A certified copy of the Indiana State Department of Health Certificate of Death of Margaret L. Bajza is attached to this Survivorship Affidavit as Exhibit "B" and made a part of this Survivorship Affidavit by reference.
12. Margaret L. Bajza died intestate, her estate administered in the Porter Superior Court, Probate Division, sitting at Valparaiso, Indiana, under cause number 64D02-1112-EU-12245. Letters Testamentary were issued to Michael Edward Bajza to act Personal Representative of the estate of Margaret L. Bajza without court supervision.
13. There were no Federal Estate taxes due by reason of the death of Margaret L. Bajza and State Inheritance Taxes are being paid through the administration of her estate.
14. All funeral expenses and the expenses of the last illness of Margaret L. Bajza have been paid.
15. The purpose of this Survivorship Affidavit is to place of record with the Auditor's and Recorder's Offices of Lake County, Indiana, proof of the deaths of Michael E. Bajza and Margaret L. Bajza and so that a deed will be accepted for transfer of title from Michael Edward Bajza, as Personal Representative of the estate of Margaret L. Bajza, deceased.

Further Affiant saith not.

Dated: April 16, 2014

Signature: \_\_\_\_\_

  
Michael Edward Bajza, Jr.

(Survivorship Affidavit – Page 2 of 3)





INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No 000792

EDR No 00000210849

State No 032784

1. Decedent's Legal Name (First, Middle, Last) <b>MICHAEL E BAJZA</b>				1a. Maiden Name (if female)		2. Sex <b>MALE</b>	3. Time Of Death <b>09:19 PM</b>	4. Date Of Death (Month/Day/Year) <b>07/24/2011</b>	
5. Social Security Number [REDACTED]	6a. Age - Yrs <b>63</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>11/21/1947</b>		8. Birthplace (City and State or Foreign Country) <b>GARY, IN</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 type="checkbox"/> Inpatient <input checked="" 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>PORTER, VALPARAISO HOSPITAL</b>									
12. City Or Town, State, And Zip Code <b>VALPARAISO, IN, 46383</b>					13. County Of Death <b>PORTER</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>MARGARET BAJZA</b>			15a. (If Wife) Give Maiden Last Name <b>ROLLETT</b>		16. Decedent's Usual Occupation <b>ELECTRICIAN</b>		17. Kind Of Business/Industry <b>LOCAL 697 IBEW</b>		
18. Residence - State <b>INDIANA</b>		18a. County <b>PORTER</b>		18b. City Or Town <b>VALPARAISO</b>		18d. Apt. No.	18e. Zip Code <b>46383</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
18c. Street And Number <b>78 EAST 55 SOUTH</b>		19. Decedent's Education <b>SOME COLLEGE CREDIT, BUT NOT A DEGREE</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>MICHAEL BAJZA</b>			23. Mother's Name (First, Middle, Last) <b>ANNA BAJZA</b>			23a. Mother's Maiden Last Name <b>TUHY</b>			
24. Informant's Name <b>MARGARET BAJZA</b>		24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>78 EAST 55 SOUTH, VALPARAISO, IN 46383</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>WOODLAWN CREMATORY</b>			25c. Location - City, Town, And State <b>FOREST PARK, IL</b>				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>KUIPER FUNERAL HOME, 9039 KLEINMAN ROAD, HIGHLAND, IN 46322</b>					27a. Funeral Home License Number. <b>FH10300021</b>		
27b. Signature Of Indiana Funeral Service Licensee: <b>CORNELIUS KUIPER, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD01014511</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. <b>PULMONARY ARREST</b> Due to (Or As A Consequence Of): <b>MINUTES</b>  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. <b>BRAIN CANCER, METASTATIC FROM LUNG</b> Due to (Or As A Consequence Of): <b>WEEKS</b>  C. _____ Due to (Or As A Consequence Of): _____  D. _____ Due to (Or As A Consequence Of): _____									Approximate Interval: Onset To Death
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			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)			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>WILLIAM A. ZATO, 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>WILLIAM A. ZATO, 12800 MISSISSIPPI PARKWAY, STE. B201, CROWN POINT, IN 46307</b>						44. License Number <b>02000629A</b>		45. Date Certified <b>07/28/2011</b>	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: <b>MARIA L STAMP, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>JUL 29 2011</b>			

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

Survivorship Affidavit  
Exhibit  
A



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

Local No 001119

EDR No 00000225701

State No 047235

1. Decedent's Legal Name (First, Middle, Last) <b>MARGARET L BAJZA</b>				1a. Maiden Name (If female) <b>ROLLETT</b>		2. Sex <b>FEMALE</b>	3. Time Of Death <b>02:17 PM</b>	4. Date Of Death (Month/Day/Year) <b>10/23/2011</b>			
5. Social Security Number	6a. Age - Yrs <b>64</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>04/22/1947</b>		8. Birthplace (City and State or Foreign Country) <b>HAMMOND, 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 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 checked="" 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>78 EAST 55 SOUTH</b>											
12. City Or Town, State, And Zip Code <b>VALPARAISO, IN, 46583</b>					13. County Of Death <b>PORTER</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>PORTER</b>		18b. City Or Town <b>VALPARAISO</b>			18c. Street And Number <b>78 EAST 55 SOUTH</b>	18d. Apt. No.	18e. Zip Code <b>46583</b>	18f. Inside City Limits? <input type="checkbox"/> Yes <input checked="" 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>EDWARD ROLLETT</b>				23. Mother's Name (First, Middle, Last) <b>ELAINE ROLLETT</b>			23a. Mother's Maiden Last Name <b>NOVAK</b>				
24. Informant's Name <b>MICHAEL BAJZA</b>			24a. Relationship To Decedent <b>SON</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>631 FOREST AVENUE, GRIFFITH, IN 46319</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>WOODLAWN CREMATORY</b>			25c. Location - City, Town, And State <b>FOREST PARK, IL</b>					
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>KUIPER FUNERAL HOME, 9039 KLEINMAN ROAD, HIGHLAND, IN 46322</b>					27a. Funeral Home License Number: <b>FH10300021</b>				
27b. Signature Of Indiana Funeral Service Licensee: <b>DAVID R. PETERSON, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD08601585</b>					
<b>STOP</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. <b>CORONARY THROMBOSIS</b> Due to (Or As A Consequence Of): <b>2 HOURS</b>											
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 <b>ARTHEROSCLEROSIS, DIABETES</b>						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 checked="" 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>WILLIAM A. ZATO, 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>WILLIAM A. ZATO, 12800 MISSISSIPPI PARKWAY, STE. B201, CROWN POINT, IN 46307</b>						44. License Number <b>02000629A</b>		45. Date Certified <b>10/27/2011</b>			
46. Additional Funeral Service Provider:						47. *Akas:					
48. Signature of Local Health Officer: <b>MARIA L STAMP, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>OCT 31 2011</b>					

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

**Survivorship Affidavit  
Exhibit  
B**