

5

1

Chicago Title Insurance Company

1302053

SURVIVORSHIP AFFIDAVIT

Parcel No.: 45-07-21-276-004.000-026

On this 4/24/13 before me personally appeared
(insert date)

Thomas M. Fistrovich

2014 OCT -7 AM 11:06

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

MICHAEL B. BROWN
RECORDER

2014 060940

MICHAEL B. BROWN
RECORDER

2013 JUN -6 AM 10:02

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

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

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

Affiant is son of the Owners
state interest of affiant in the above premises as "owner", "son of owner",

3. Said premises were formerly owned as joint tenants or as tenants by
entireties by Thomas M. Fistrovich and Dorothy J. Fistrovich
4/12/1924

4. Said Doroty J. Fistrovich
died on February 1, 2013

leaving a will;
insert "a" or "no"; if will left, attach a copy

5. The legal description of the premises in question is:
Highland Terrace 5th Add. Lot 109, to the Town of
Highland, Lake County, Indiana

6. Is there Federal or State inheritance tax liability by reason of the death of said
decendent? Yes No

If yes, then estimated taxes due are \$

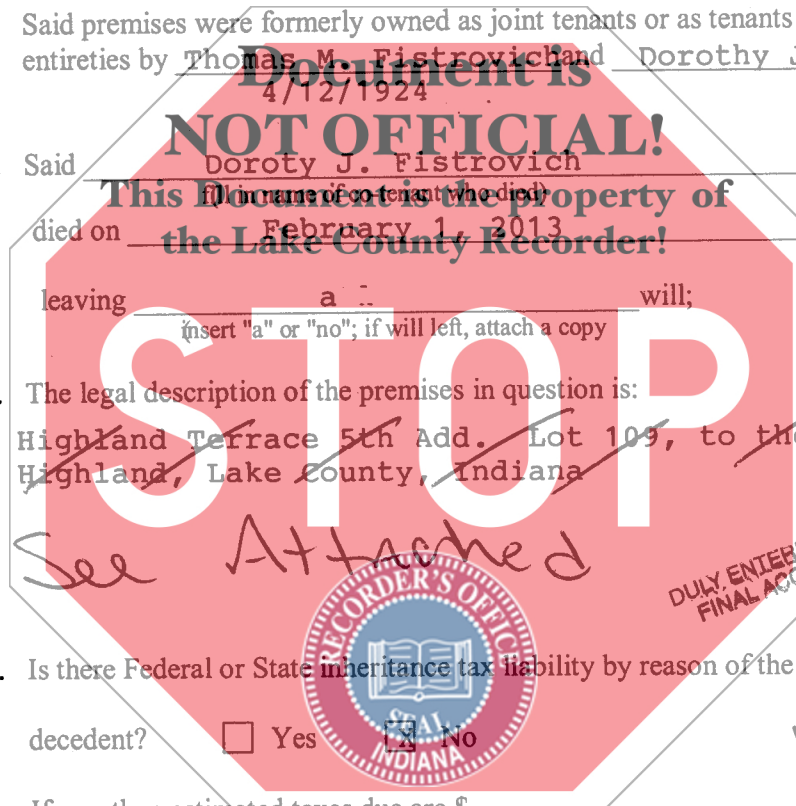
The taxes due are paid or unpaid..

21
REF
DO
CT

12804

FILED
JUN 05 2013
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

20
CT
PP



DULY ENTERED FOR TAXATION SUBJECT
FINAL ACCEPTANCE FOR TRANSFER
OCT 03 2014
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

26971

Note: This instrument being re-recorded to complete the chain of title.

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: [Handwritten Signature]

Printed Name Thomas M. Fistrovich

Address: 3127 98th Street

Highland, IN 46322

Subscribed and sworn to before me by the affiant

This 24th Day of April 2013
(insert date)

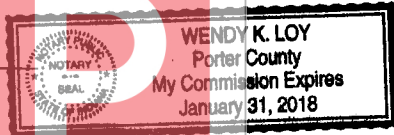
Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder!

Notary Public
Printed Name Wendy K. Loy

My County of Residence is: Porter

In the State of IN

My Commission Expires 1/31/18



This instrument prepared by Wendy K. Loy

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. Kevin Zarembo

EXHIBIT "A"

LOT 109 IN HIGHLAND TERRACE 5TH ADDITION TO THE TOWN OF HIGHLAND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 30, PAGE 19, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Property Address: 3018 Grand Blvd, Highland, IN 46322





1302053

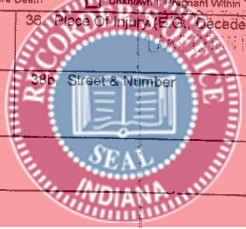
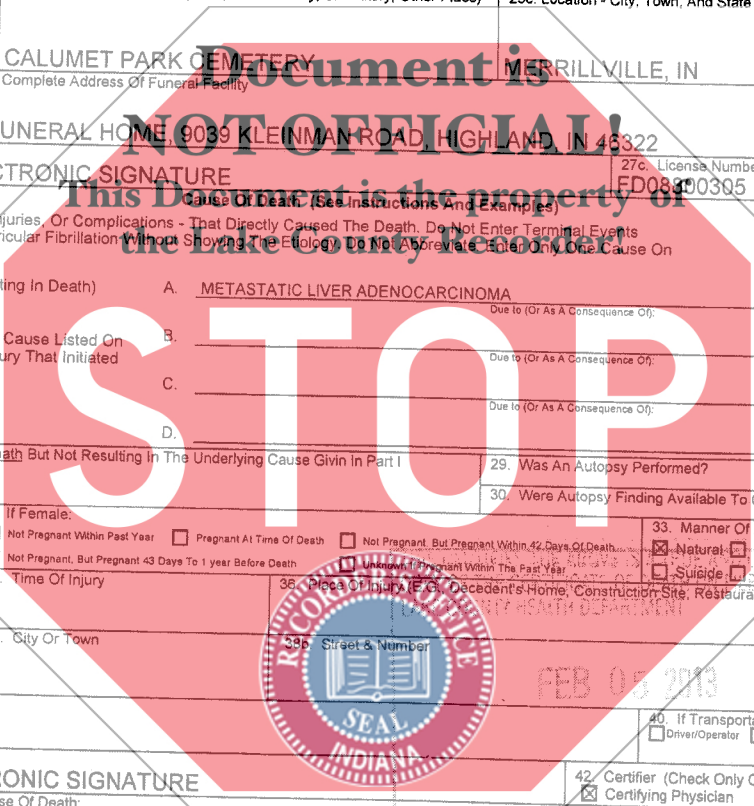
INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
Parcel No: 45-07-21-276-004.000-026
EDR No 000000304903

Local No 000415

State No 005626

Form fields including: 1. Decedent's Legal Name (DOROTHY FISTROVICH), 2. Sex (FEMALE), 3. Time Of Death (09:20 AM), 4. Date Of Death (02/01/2013), 5. Social Security Number, 6a. Age - Yrs (82), 7. Date of Birth (12/18/1930), 8. Birthplace (WHITING, IN), 11. Facility Name (WILLIAM J. RILEY MEMORIAL RESIDENCE, HOSPICE), 13. County Of Death (LAKE), 14. Marital Status (Widowed), 15. Surviving Spouse's Name, 16. Decedent's Usual Occupation (BILLING SUPERVISOR), 17. Kind Of Business/Industry (GOVERNMENT OFFICE), 18. Residence - State (INDIANA), 18a. County (LAKE), 18b. City Or Town (HIGHLAND), 18c. Street And Number (3018 GRAND BOULEVARD), 19. Decedent's Education (HIGH SCHOOL GRADUATE OR GED COMPLETED), 20. Decedent Of Hispanic Origin (NOT HISPANIC), 21. Decedent's Race (White), 22. Father's Name (GEORGE MAZUR), 23. Mother's Name (SOPHIA MAZUR), 24. Informant's Name (THOMAS FISTROVICH), 25a. Method Of Disposition (Burial), 25b. Place Of Disposition (CALUMET PARK CEMETERY), 25c. Location - City, Town, And State (MERRILLVILLE, IN), 26. Was Coroner Contacted?, 27. Name And Complete Address Of Funeral Facility (KUIPER FUNERAL HOME), 27a. Funeral Home License Number (FH10300021), 27b. Signature Of Indiana Funeral Service Licensee (LEONARD GREGORCZYK), 27c. License Number (FD08400305), 28. Part I. Enter The Chain Of Events (Cause Of Death: METASTATIC LIVER ADENOCARCINOMA), 29. Was An Autopsy Performed?, 30. Were Autopsy Finding Available To Complete The Cause Of Death?, 31. Did Tobacco Use Contribute To Death?, 32. If Female (Pregnancy status), 33. Manner Of Death (Natural), 34. Date Of Injury, 35. Time Of Injury, 36. Place Of Injury, 37. Injury At Work?, 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, 41. Signature, Of Person Certifying Cause Of Death (VAN HUGH GEISSLER), 42. Certifier (Check Only One) (Certifying Physician), 43. Name, Address And Zip Code Of Person Certifying Cause Of Death (VAN HUGH GEISSLER), 44. License Number (02000568A), 45. Date Certified (02/04/2013), 46. Signature of Local Health Officer (USAN W. BEST), 47. *Akas, 49. For Registrar Only - Date Filed (FEB 05 2013)

CHICAGO TITLE



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

* 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.

1302053
INDIANA STATE DEPARTMENT OF HEALTH
Parcel No: 45-07-21-276-004.000-026
CERTIFICATE OF DEATH

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

Local No. 572

Sept 1, 2005
Date Issued
Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

CHICAGO TITLE

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Thomas M. Fistrovich		2. SEX Male	3a. TIME OF DEATH 9:30 PM	3b. DATE OF DEATH (Month, Day, Year) August 25, 2005
4. SOCIAL SECURITY NUMBER 000-00-0000	5a. AGE—Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month, Day, Year) April 12, 1924
7. BIRTHPLACE (City and State or Foreign Country) Whiting, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a. FACILITY NAME (If not institution, give street and number) Select Specialty Hospital		9b. CITY, TOWN, OR LOCATION OF DEATH Hammond, IN	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Dorothy Mazur	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Research Assistant	12b. KIND OF BUSINESS/INDUSTRY Oil Refinery	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Highland	13d. STREET AND NUMBER 3018 Grand Boulevard	
13e. ZIP CODE 46322	13f. INDIAN CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) 12		18. DECEDENT'S PARENTS 18a. FATHER'S NAME (First, Middle, Last) Phillip Fistrovich 18b. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara Horvat		
20a. INFORMANT'S NAME (Type/Print) Dorothy Fistrovich		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3018 Grand Boulevard, Highland, IN 46322	20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) August 29, 2005 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, IN
22a. EMBALMER'S NAME Edgar C. Gleim		22b. EMBALMER'S LICENSE NO. FD01016173	22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Paul A. [Signature]</i>		24b. LICENSE NUMBER (of license) FD08601585	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kemper Funeral Home 9039 Kleinman Road Highland, IN 46322	
25. PART I: Enter the disease, injury, or complication that caused the death. Do not enter non-pathological conditions, such as organ or tissue injury, arrest, shock, or heart failure. List only one cause for each part. IMMEDIATE CAUSE (Final disease or condition resulting in death) PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): a. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): b. END STAGE RENAL DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. CHRONIC OBSTRUCTIVE LUNG DISEASE		26. SIGNATURE OF FUNERAL DIRECTOR <i>Paul A. [Signature]</i>		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I		27. WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) NO	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, both as to the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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) as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Abdab</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH OTHER THAN PHYSICIAN W. Abdab M.D., 7400 Columbia Avenue, Hammond, IN 46324		29c. MEDICAL LICENSE NO. 01046859A	29d. DATE SIGNED (Month, Day, Year) 9-1-05 (SEPTEMBER)	
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) September 1, 2005		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED		
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.		34i. DATE PRONOUNCED DEAD (Month, Day, Year)		

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