2014 081840

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2014 DEC 24 AM 8:51

MICHAEL B. BROWN
RECORDER

5

Mail Future Tax Statements to:

Mr. & Mrs. Kevin Horst
4229 August Dr.
Crown Point, IN 46307

Parcel #45-14-09-327-002.000-044
Parcel #45-17-09-327-003.000-044

STATE OF INDIANA)
) SS:
COUNTY OF ~~LAKE~~ Porter)

SURVIVORSHIP AFFIDAVIT

ANNA M. KUCIK, being first duly sworn upon oath, deposes and says:

That she is an adult and the surviving daughter of decedents, JOHN VAJDA, who died January 16, 1995, as evidenced by the redacted copy of his death certificate attached hereto and made a part hereof, marked as Exhibit "A", and ANNA VAJDA, who died on April 14, 2014, as evidenced by the redacted copy of her death certificate attached hereto and made a part hereof, marked as Exhibit "B".

That the parties were owners by the entireties of the following described real estate, to-wit:

LOTS 348 AND 349, LAKES OF THE FOUR SEASONS, UNIT NO. 10, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 39, PAGE 11, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Commonly known as: 4229 Augusta Dr., Crown Point, IN 46307

and that said parties were husband and wife when they took title and remained in title and lived

FILED

DEC 24 2014

29079 PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

19.-
CK. 205091
DI

continuously together as husband and wife until the death of JOHN VAJDA, on the date given above.

Affiant further states that she knows of her own knowledge that the value of the gross estate of the above decedent, JOHN VAJDA, at the time of his death, within the meaning of the Federal Estate Tax laws, was less than that required for the filing of a Federal Estate Tax Return, and that the estate of said decedent was not subject to any Federal Estate Tax.

Affiant further states that she knows of her own knowledge that no Indiana Inheritance Tax was due by reason of the death of JOHN VAJDA.

Affiant further states that all outstanding debts and obligations of the decedent, JOHN VAJDA, including funeral expenses and expense of last illness, were fully paid and discharged and that there is no estate proceeding pending and there are no outstanding claims or obligations against said decedent.

Affiant further sayeth not.

Anna M. Kucik

ANNA M. KUCIK, Affiant

STATE OF INDIANA*********COUNTY OF Porter SS:

Before me, the undersigned, a Notary Public for Porter County, State of Indiana, personally appeared ANNA M. KUCIK, who acknowledged the execution of this instrument this 19 day of Dec, 2014.

CYNTHIA L. REED
Porter County
My Commission Expires
June 8, 2016

NOTARY PUBLIC SIGNATURE

THIS INSTRUMENT PREPARED BY:
WILLIAM J. CUNNINGHAM, ATTORNEY #3471-45
HILBRICH CUNNINGHAM DOBOSZ VINOVICH & SANDOVAL, LLP
2637--45TH ST., HIGHLAND, IN 46322
PH: (219) 924-2427 FAX: (219) 924-2481

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.

William J. Cunningham, Attorney at Law

RETURN RECORDED INSTRUMENT TO: Attorney William J. Cunningham
2637 45th St., Highland, IN 46322

*ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities s voluntary and there will be no penalty for refusal."

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 011.6-95 CERTIFICATE OF DEATH State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
JOHN	VAJDA	Male	5:30 A.M	January 16, 1995

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)
	81			June 9, 1913	Czechoslovakia

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

DECEDENT

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
4229 Augusta Drive	Crown Point	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
Married	Anna Elko	Farmer	Farm

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Crown Point	4229 Augusta Drive

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 +)
46307	☒ No ☐ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White		2

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Michael Vajda	Mary Copak

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
Anna Vajda	4229 Augusta Dr., Crown Point, In. 46307	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	January 18, 1995 Calumet Park Cemetery	Merrillville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Robert A. Craigin, Jr.	FD08700735	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Robert A. Craigin Jr.	FD08700735	Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410

CAUSE OF DEATH

28. 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. ADENOCARCINOMA OF PANCREAS	2 Months
Conditions, if any, which gave rise to the immediate cause(s) 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):	

JAN 17 1995

PART II. Other significant 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)
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)
Zafar Khalid M.D.	0084369	1-16-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 28) (Type/Print)	32. DATE FILED (Month, Day, Year)
Zafar U. Khalid, M.D., 9001 Broadway, Merrillville, Indiana 46410	January 17, 1995

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE Alexander D. Williams, M.D

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.

SDH08-004 State Form 10110 (R4/3-93) Deathcer/PD 1

EXhibit "A"

I hereby affirm that I have redacted all social security numbers from this document. William J. Cunningham, Attorney

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 000385 EDR No 000000380196 State No 016967

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (If female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
ANNA VAJDA	ELKO	FEMALE	04:51 AM	04/14/2014

5. Social Security Number	6a. Age - Yrs	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)	8. Birthplace (City and State or Foreign Country)
	95					06/20/1918	BRADDOCK, PA

9. Ever In U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☒ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street and Number): VNA HOSPICE CENTER

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
VALPARAISO, IN, 46383	PORTER	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
		HOMEMAKER	HOME

18. Residence - State	18a. County	18b. City Or Town	18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
INDIANA	LAKE	CROWN POINT	4229 AUGUSTA DRIVE		46307	☐ Yes ☒ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
8TH GRADE OR LESS	NOT HISPANIC	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
MIKE ELKO	ZUZANNA ELKO	JENKO

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
ANNA M KUCIK	DAUGHTER	9011 NORRIS DRIVE, HOBART, IN 46342

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	CALUMET PARK CEMETERY	MERRILLVILLE, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	BURNS FUNERAL HOME (CROWN POINT), 10101 BROADWAY, CROWN POINT, IN 46307	FH83002445

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
JAMES E. BURNS , BY ELECTRONIC SIGNATURE	FD20700059

Cause Of Death (See Instructions And Examples)

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.

		Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. CONGESTIVE HEART FAILURE; DIASTOLIC LEFT VENTRICULAR FAILURE WITH PRESERVED EJECTION FRACTION	YEARS
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. HYPERTENSIVE HEART DISEASE WITH DIASTOLIC DYSFUNCTION	YEARS
	C. MITRAL VALVE INSUFFICIENCY WITH PULMONARY HYPERTENSION	YEARS
	D. CARDIAC CACHEXIA	YEARS

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I: SYSTEMIC ARTERIAL HYPERTENSION; HEALTH CARE ASSOCIATED PNEUMONIA

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Finding Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☒ No ☐ Unknown

32. If Female: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	35a. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ 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: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death: MICHAEL CARL WEISS , BY ELECTRONIC SIGNATURE

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Heath Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death: MICHAEL CARL WEISS , 2404 VALPARAISO STREET, VALPARAISO, IN 46383

44. License Number: 01030965A

45. Date Certified: 04/16/2014

46. Additional Funeral Service Provider:

47. *Akas:

48. Signature of Local Health Officer: MARIA L STAMP, VIA ELECTRONIC SIGNATURE

49. For Registrar Only - Date Filed (Month/Day/Year): APR 17 2014

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Exhibit "B"