

3

2014 083607

2014 DEC 30 AM 11:51

STATE OF INDIANA)
COUNTY OF LAKE)

)
) SS:
)

PARCEL NO. 45-11-21-101-010-000-036
Return to: Attorney Steve H. Tokarski
7803 W. 75th Ave., Suite 1, Schererville, IN 46375

AFFIDAVIT OF SURVIVORSHIP

Stephen R. Lukasik, after being duly sworn upon his oath states as follows:

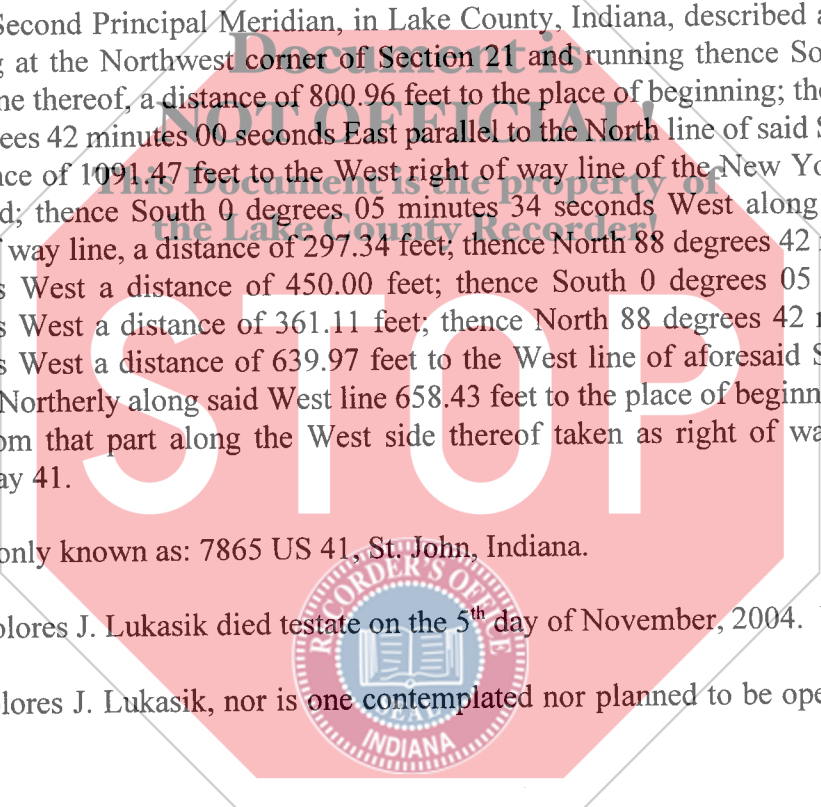
1) That Stanley Lukasik and Dolores J. Lukasik, held the following real estate in Lake County, Indiana, jointly as husband and wife and more particularly described as:

That Part of the West one half of Section 21, Township 35 North, Range 9 West of the Second Principal Meridian, in Lake County, Indiana, described as follows: Starting at the Northwest corner of Section 21 and running thence South on the West line thereof, a distance of 800.96 feet to the place of beginning; thence South 88 degrees 42 minutes 00 seconds East parallel to the North line of said Section 21, a distance of 1091.47 feet to the West right of way line of the New York Central Railroad; thence South 0 degrees 05 minutes 34 seconds West along said West right of way line, a distance of 297.34 feet; thence North 88 degrees 42 minutes 00 seconds West a distance of 450.00 feet; thence South 0 degrees 05 minute 34 seconds West a distance of 361.11 feet; thence North 88 degrees 42 minutes 00 seconds West a distance of 639.97 feet to the West line of aforesaid Section 21; thence Northerly along said West line 658.43 feet to the place of beginning, except therefrom that part along the West side thereof taken as right of way for U.S. Highway 41.

Commonly known as: 7865 US 41, St. John, Indiana.

2) Dolores J. Lukasik died testate on the 5th day of November, 2004. No estate has been opened for Dolores J. Lukasik, nor is one contemplated nor planned to be opened. No state nor

CHICAGO TITLE INSURANCE COMPANY



FILED

DEC 30 2014

29226

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

(5)
CT
D

83559C INV

federal inheritance or estate taxes are due and owing. A certified copy of Dolores Josephine Lukasik's death certificate is attached hereto and made a part hereof.

Dated this 23rd day of December, 2014.

Stephen R. Lukasik
Stephen R. Lukasik, Affiant

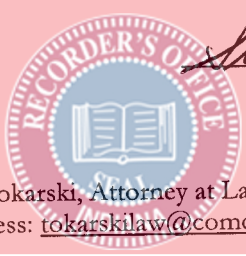
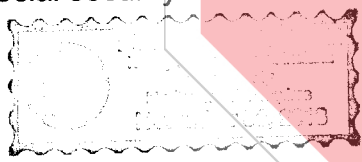
STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public, in and for said County and State this 23rd day of December, 2014, personally appeared: Stephen R. Lukasik and acknowledged the execution of the foregoing Affidavit of Survivorship. In witness whereof, I have hereunto subscribed my name and affixed my official seal.

My Commission Expires: Nov. 30, 2018
David Steven Tokarski Notary Public

County of Residence: Lake
Printed: David Steven Tokarski

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.



Steve H. Tokarski

This Instrument Prepared by: Steve H. Tokarski, Attorney at Law, 7803 West 75th Avenue, Suite 1, Schererville, IN 46375. (219)322-1271. E-mail address: tokarskilaw@comcast.net

NON ESTATE: The Social Security # is requested by this state agency in order to fulfill its statutory responsibility. Disclosure is required and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

File No. 2693-01

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

E/PRINT IN PERMANENT INK

IDENT

ENTS

RMANT

OSITION

ISE OF TH

TIFIER

LTH ICER

1. DECEASED—NAME (First Middle, Last) DOLORES JOSEPHINE LUKASIK				2. SEX FEMALE		3a. TIME OF DEATH 6:45 P.M.		3b. DATE OF DEATH (Month, Day, Yr.) November 5, 2004	
4. *SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) 71		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) OCTOBER 28, 1933	
7. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS		8a. WAS DECEDENT A U.S. VETERAN? NO		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) ST ANTHONY MEDICAL CENTER				9c. CITY, TOWN, OR LOCATION OF DEATH CROWN POINT			9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) STANLEY LUKASIK		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER			12b. KIND OF BUSINESS/INDUSTRY OWN HOME		
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION LOWELL			13d. STREET AND NUMBER 17207 STATE LINE ROAD		
13e. ZIP CODE 46356		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 12 College (1-4 or 5+) 		18. FATHER'S NAME (First Middle, Last) WILLIAM JARYSZAK				19. MOTHER'S NAME (First Middle, Maiden Surname) EMILY SULSKI			
20a. INFORMANT'S NAME (Type/Print) STANLEY LUKASIK				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17207 STATE LINE RD., LOWELL, IN 46356				20c. Relationship HUSBAND	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) NOVEMBER 9, 2004 FULLER CEMETERY				21c. LOCATION—City or Town, State LOWELL, INDIANA	
22a. EMBALMER'S NAME MARC MOSQUEDA				22b. EMBALMER'S LICENSE NO. FD08800240		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				24b. LICENSE NUMBER (of Licensee) FD20400030		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FAGEN MILLER FUNERAL HOME FH10200006 8580 WICKER AVENUE ST. JOHN, INDIANA 46373			
26. 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. SEVERE CORONARY ARTERY DISEASE Approximate Interval Between Onset and Death: one year DUE TO (OR AS A CONSEQUENCE OF): b. CARDIOGENIC SHOCK one week DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last									
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) 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, death occurred at 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) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. MEDICAL LICENSE NO. 01033686		29d. DATE SIGNED (Month, Day, Year) 11/9/04	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Thach Nguyen 200 E 80th St Merrillville, IN 46416									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) December 9, 2004			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) JUN 13 2008		34d. DESCRIBE HOW INJURY OCCURRED	
34a. 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.						