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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2015 061549

2015 SEP -8 PM 1:40

MICHAEL B. BROWN
RECORDER

AFFIDAVIT of SURVIVORSHIP

Tax: I.D. NO. 45-11-18-176-014.000-034

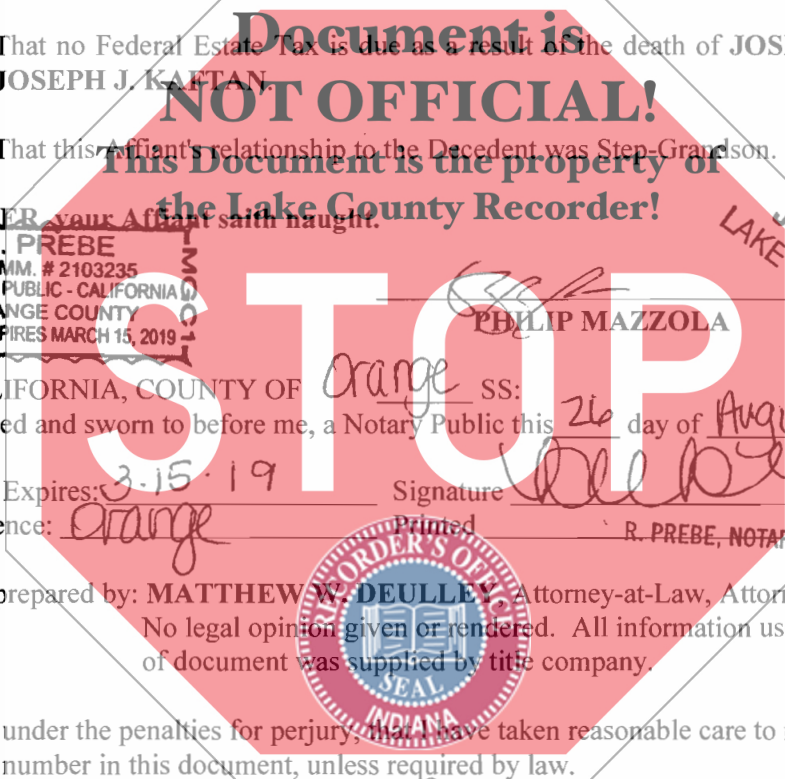
PHILIP MAZZOLA, being first duly sworn upon oath, deposes and says:

1. That **JOSEPH KAFTAN a/k/a JOSEPH J. KAFTAN**, died on the 12th day of December, 1999 at Dyer, Lake County, Indiana.
2. That at the time of his death, he was co-owner as Joint Tenant with Anthony Mazzola and Kathy Mazzola in the following described real estate:

LOT 74, UNIT 2, PINWOOD ESTATES ADDITION TO THE TOWN OF DYER, AS RECORDED IN PLAT BOOK 50, PAGE 74, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Commonly known as: **1011 ARROWHEAD DRIVE, DYER, IN 46311**

3. That no Federal Estate Tax is due as a result of the death of **JOSEPH KAFTAN a/k/a JOSEPH J. KAFTAN**.
4. That this Affiant's relationship to the Decedent was Step-Grandson.



FILED
SEP 04 2015
JOHNE PETALAS
LAKE COUNTY AUDITOR

STATE OF CALIFORNIA, COUNTY OF Orange SS:
 Subscribed and sworn to before me, a Notary Public this 26 day of August, 2015
 My Commission Expires: 3.15.19 Signature [Signature]
 County of Residence: Orange Printed R. PREBE, NOTARY PUBLIC Notary Public

This instrument prepared by: **MATTHEW W. DEULLEY** Attorney-at-Law, Attorney ID No. 27813-45
No legal opinion given or rendered. All information used in preparation of document was supplied by title company.

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.

[Signature]
Signature of Preparer

Daleas Birchel
Printed Name of Preparer

015132

COMMUNITY TITLE COMPANY
FILE NO 158343

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CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA }
 COUNTY OF Orange } S.S.

R. PREBE, NOTARY PUBLIC

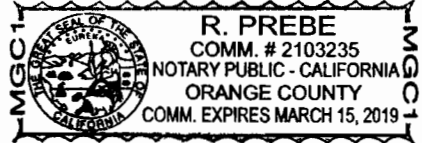
On 8-26-19, before me, Antip Mazzola,
 personally appeared _____,

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature [Handwritten Signature] (Seal)



OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

DESCRIPTION OF ATTACHED DOCUMENT

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) other than named above _____

CAPACITY(IES) CLAIMED BY SIGNER(S)

INDIVIDUAL

CORPORATE OFFICER(S)
 TITLE(S) _____

PARTNER(S)- LIMITED
 GENERAL

ATTORNEY-IN-FACT

TRUSTEE(S)

GUARDIAN OR CONSERVATOR

OTHER _____

INDIVIDUAL

CORPORATE OFFICER(S)
 TITLE(S) _____

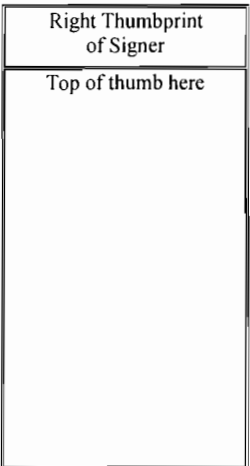
PARTNER(S)- LIMITED
 GENERAL

ATTORNEY-IN-FACT

TRUSTEE(S)

GUARDIAN OR CONSERVATOR

OTHER _____



SIGNER IS REPRESENTING:

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

Local No. 2841-99

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

36778
PE/PRINT
IN
PERMANENT
ACK INK

DECEDENT

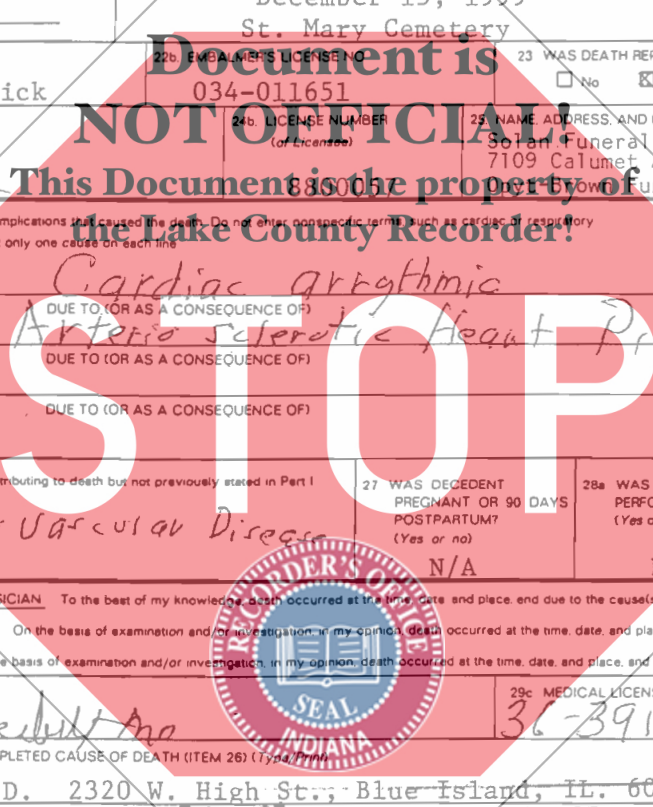
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

1 DECEASED—NAME (First, Middle, Last) JOSEPH J. KAFTAN		2 SEX Male	3a. TIME OF DEATH 9:19 AM	3b. DATE OF DEATH (Month, Day, Yr.) December 12, 1999
4. *SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE—Last Birthday (Years) 84	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) June 19, 1915
7 BIRTHPLACE (City and State or Foreign Country) Coal City, Illinois	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" 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. Margaret Mercy	9c. CITY, TOWN, OR LOCATION OF DEATH Dyer	9d. COUNTY OF DEATH Lake	10. MARITAL STATUS (Specify) Widower	
11. SURVIVING SPOUSE (If wife, give maiden name) None	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crane Rigger	12b. KIND OF BUSINESS/INDUSTRY Electro Motive	13a. RESIDENCE—STATE Indiana	
13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Dyer	13d. STREET AND NUMBER 1011 Arrowhead Drive	13e. ZIP CODE 46311	
13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) 12th
18. FATHER'S NAME (First, Middle, Last) Joseph Kaftan	19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary N/A			
20a. INFORMANT'S NAME (Type/Print) Kathy Mazolla		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Arrowhead Dr., Dyer, Indiana 46311		20c. Relationship Daughter
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) December 15, 1999 St. Mary Cemetery		21c. LOCATION—City or Town, State Evergreen Park, Illinois
22a. EMBALMER'S NAME Brian E. Fitzpatrick		22b. EMBALMER'S LICENSE NO. 034-011651	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Dea L. Wagon</i>		24b. LICENSE NUMBER (of licensee) 889005	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, Indiana 46324 Dyer Funeral Home Ltd. 14338 S. Indiana St. Riverdale, Illinois 60827	
26. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions, if any, which gave rise to the immediate cause stating the underlying cause last				
<p>a. Cardiac arrhythmic DUE TO (OR AS A CONSEQUENCE OF)</p> <p>b. Arterio sclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF)</p> <p>c. _____ DUE TO (OR AS A CONSEQUENCE OF)</p> <p>d. _____ DUE TO (OR AS A CONSEQUENCE OF)</p>				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Cerebrovascular Disease				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A	
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>Paul Vanderbilt, M.D.</i>		29c. MEDICAL LICENSE NO. 36-39153	29d. DATE SIGNED (Month, Day, Year) December 13, 1999	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Paul Vanderbilt, M.D. 2320 W. High St., Blue Island, IL. 60406				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, M.D.</i>			32. DATE FILED (Month, Day, Year) December 15, 1999	
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) AUG 11 2015	34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home farm street factory office building, etc. (Specify) Susan J Best, DO		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) LAKE COUNTY HEALTH OFFICER		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger, pedestrian, etc.		



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