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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

1502998 <sup>2015</sup> 062576

2015 SEP 11 AM 10:51

RE: Parcel No. 45-07-21-277-005.000-026  
Address: 8341 5<sup>th</sup> Street, Highland IN 46322

MICHAEL B. BROWN  
RECORDER

**AFFIDAVIT**

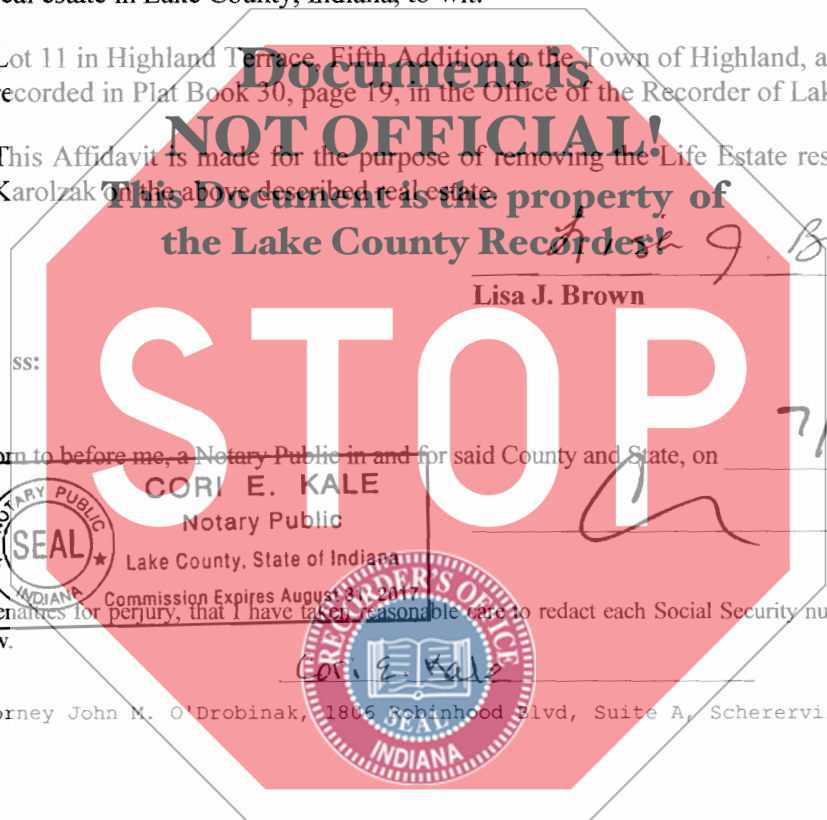
Lisa J. Brown, being sworn upon her oath, states that:

1. She is the adult Daughter of James R. Karolzak, who died on November 3, 2006.
2. She is currently serving as Successor Trustee of the Karolzak Living Trust, dated August 9, 2000, which Trust is still in existence.
3. James R. Karolzak and Catherine J. Karolzak were Trustees under the Trust Agreement known as the Karolzak Trust, dated August 9, 2000, which owned the following described real estate in Lake County, Indiana, to-wit:

Lot 11 in Highland Terrace, Fifth 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

4. This Affidavit is made for the purpose of removing the Life Estate reserved by James R. Karolzak on the above described real estate.

Chicago Title Insurance Company



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

*[Signature]*  
Lisa J. Brown

State of Indiana )  
) ss:  
County of Lake )

Subscribed and sworn to before me, a Notary Public in and for said County and State, on 7/14, 2015.



CORI E. KALE  
Notary Public

Lake County, State of Indiana

*[Signature]*  
Notary Public

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.



Prepared by Attorney John M. O'Drobinak, 1806 Robinhood Blvd, Suite A, Schererville IN 46375; (219) 865-2285

**FILED**

SEP 09 2015

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

*[Handwritten]* \$13.00  
M.E  
O-T

*[Handwritten]* 21518

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 2631-26

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>James Robert Karolzak</b>		2. SEX <b>Male</b>		3a. TIME OF DEATH <b>11:59 pm</b>		3b. DATE OF DEATH (Month, Day, Yr) <b>November 03, 2006</b>	
4. SOCIAL SECURITY NUMBER <b>[REDACTED]</b>		5a. AGE—Last Birthday (Years) <b>74</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) <b>September 11, 1932</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Milwaukee, WI</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>Sept 1954</b>		9. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input 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			
9a. FACILITY NAME (If not institution, give street and number) <b>8341 - 5th Street</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>Highland</b>			9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		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) <b>Metallurgist</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>	
13a. RESIDENCE—STATE <b>IN</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Highland</b>		13d. STREET AND NUMBER <b>8341 - 5th Street</b>	
13e. ZIP CODE <b>46322</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
16. FATHER'S NAME (First, Middle, Last) <b>Stanley Karolzak</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)					
18. MOTHER'S NAME (First, Middle, Last) <b>Elizabeth Hendrickson</b>		20a. INFORMANT'S NAME (Last, First) <b>Catherine Karolzak</b>		20b. MAILING ADDRESS (Street, Rte, P.O. Box, Apt. No., P.O. Box, P.O. Number, City, Town, State, Zip Code) <b>8341 - 5th Street, Highland, IN 46322</b>		20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE, U.S. PLACE OF DISPOSITION, and other place <b>November 7, 2006 Northwest Indiana Cremation Service</b>		21c. LOCATION—City or Town, State <b>Crown Point, IN 46307</b>			
22a. EMBALMER'S NAME <b>Richard Miller</b>		22b. EMBALMER'S LICENSE NO. <b>FD20400030</b>		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 License) <b>FD 20400030</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Fagen-Miller Funeral Home Lic. # FH83003035 2828 Highway Avenue, Highland, Indiana, 46322</b>			
26. PART I. Enter the disease, injury, 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. <b>MEGASTATIC PANCREATIC CELL CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF)		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		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. <b>01031582</b>		29d. DATE SIGNED (Month, Day, Year) <b>11-6-06</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Lyle Munn 4321 Fir Street East Chicago, IN 46312</b>							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE SIGNED (Month, Day, Year) <b>NOV 06 2006</b>		THIS CERTIFIES THE ABOVE COPY OF THE CERTIFICATE IS A TRUE AND CORRECT COPY OF THE ORIGINAL.			
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)	
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED <b>NOV 03 2006</b>					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) # yes, specify driver, passenger, pedestrian, etc.					