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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2015 072484

2015 OCT 27 AM 9: 17

STATE OF INDIANA)
COUNTY OF LAKE)

) SS:
)

MICHAEL B. BROWN
RECORDER

AFFIDAVIT

I, Suzanne E. Kaegebein, being duly sworn, state as follows:

- Affiant resides at the address given below affiant's signature.
- Affiant is the Successor Trustee of the Frank and Julia Sloboda Living Trust dated May 12, 2004, and the daughter of the decedent.
- Said Frank N. Sloboda died on December 22, 2006. See attached Death Certificate for Frank N. Sloboda.
- The legal description of the premises in question is:
Lot number Nineteen (19), Twin Creek Block 4 to the Town of Munster, Indiana, as recorded in Plat Book 50, Page 97.
Commonly known as: 1140 Tamarack Place, Munster, IN 46321
Key No.: 45-07-31-129-003.000
- There is no Federal or State Inheritance tax liability by reason of the death of said decedents.
- This affidavit relates to a Life Estate interest.
- Affiant's relationship to the deceased was his daughter.



Suzanne E Kaegebein

 Suzanne E. Kaegebein, Affiant
 1410 Oak Court, Apt. 1
 Schererville, IN 46375

FILED

OCT 27 2015

JOHN E. PETALAS
LAKE COUNTY AUDITOR

DIS-00
M.E.
#7769

22640

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Suzanne E. Kaegebein, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 20th day of October, 2015.

My commission expires: 2/13/2018



Signature: *Lesia A. Potacki*
Lesia A. Potacki
Resident of: Lake County, IN



"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." /s/Gary P. Bonk

This instrument prepared by: Gary P. Bonk, Attorney; 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 3106-06

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANTS

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) FRANK N. SLOBODA		2. SEX Male	3a. TIME OF DEATH 11:05 PM	3b. DATE OF DEATH (Month, Day, Yr.) December 22, 2006
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.) January 7, 1922
7. BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9a. 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 checked="" type="checkbox"/> Other (Specify) Hospice <input type="checkbox"/> Residence	
9b. FACILITY NAME (If not institution, give street and number) Riley Home		9c. CITY, TOWN, OR LOCATION OF DEATH Munster	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) married	11. SURVIVING SPOUSE (If wife, give maiden name) Julia Gerka	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pipefitter	12b. KIND OF BUSINESS/INDUSTRY Amoco Oil Co.	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Munster	13d. STREET AND NUMBER 1140 Tamarack Pl.	
13e. ZIP CODE 46321	13f. INSIDE 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? 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) 10th		18. FATHER'S NAME (First, Middle, Last) Stephen Sloboda Sr.		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Sampias		20. INFORMANT'S NAME (Type/Print) Julia M. Sloboda		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1140 Tamarack Pl., Munster, Indiana 46321		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. LOCATION—City or Town, State Solan-Pruzin Crematory, Schererville, Indiana		21c. LOCATION—City or Town, State Schererville, Indiana
22a. EMBALMER'S NAME None		22b. EMBALMER'S LICENSE NO. -----		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John A. Pruzin</i>		24b. LICENSE NUMBER (of Licensee) FD#1007231		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME SOLAN-PRUZIN FUNERAL HOME #10200037 14 Kennedy Ave. Schererville, Indiana
26. PART I. Enter the disease, 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) CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST a. _____ b. _____ c. _____ d. _____				46375 Approximate Interval Between Onset and Death
PART II. Other significant conditions - Conditions contributing to death but not previously stated.				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) -----
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>P. Keshvani</i>			29c. MEDICAL LICENSE NO. 01042431	29d. DATE SIGNED (Month, Day, Year) 12/27/06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) PYARALI KESHVANI, M.D. 8731 INDIANAPOLIS BLVD., HIGHLAND, IN. 46322				
31. HEALTH OFFICER'S SIGNATURE <i>Susan A. Burt</i>				32. DATE FILED (Month, Day, Year) December 28, 2006
33. MANNER OF DEATH <input 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. DESCRIBE HOW INJURY OCCURRED December 22, 2006		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.				

