

TRANSFER ON DEATH AFFIDAVIT

Ziggie Mielczarek, Upon personal knowledge and belief, makes these
(Name of Beneficiary)

2016 NOV 21 PM 8:40
MICHAEL B. BRUNN
RECORDER

FILED FOR RECORD

Helena Mielczarek, (Owner) died 10-3-2013 (a certified
Owner's name) (Date of Death)

copy of the Owner's death certificate is attached as Exhibit A) owning an interest in the following
described real estate:

(Description)

Lot 14 in Del-Mar Terrance, in the City of Gary, as per plat
thereof, recorded in Plat Book 34, page 29, in the Office of the
Recorder of Lake County, Indiana.
Parcel ID - 45-08-34-178-005.000-014

2. On May 29, 2012, Owner signed a Transfer on Death Deed transferring on
(Date of Transfer on Death Deed)

Owner's death, Owner's interest in the real estate described above which document was recorded
June 4, 2012 in the Office of the Recorder of Lake County, Indiana as
(Date of Recording) (Name of County)

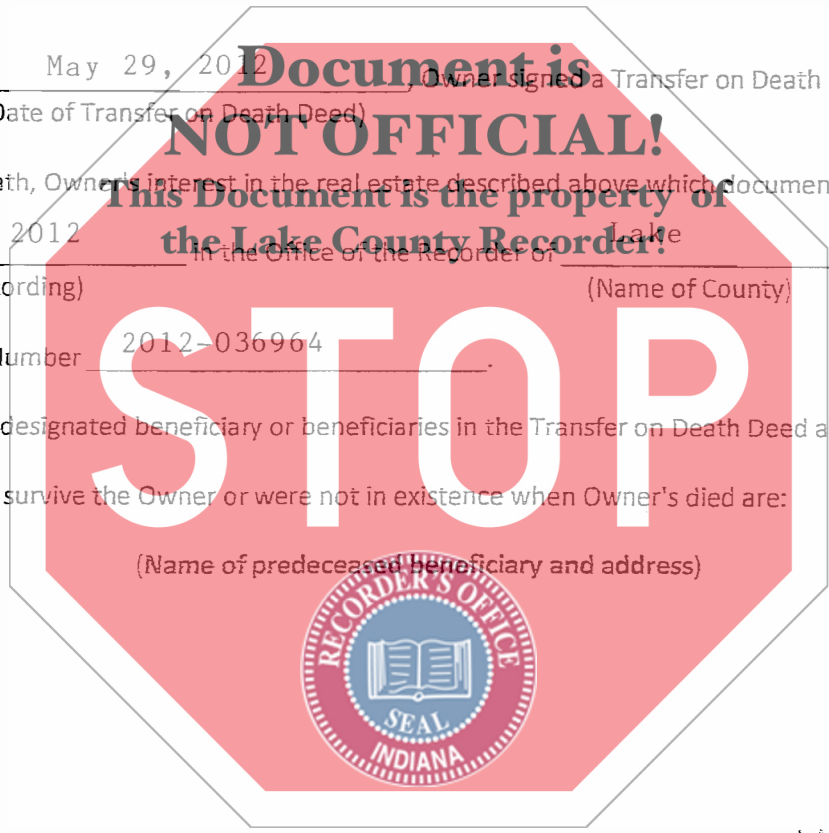
Document Number 2012-036964

3. The designated beneficiary or beneficiaries in the Transfer on Death Deed and their addresses
who did not survive the Owner or were not in existence when Owner's died are:

(Name of predeceased beneficiary and address)

None

4. The designated beneficiary or beneficiaries in the Transfer on Death Deed and their addresses
who survive the Owner or are in existence at Owner's death are:



027679

FILED

NOV 21 2016

JOHN E. PETALAS
LAKE COUNTY AUDITOR

M-E
8:16:00
NC
CRASH

(Name of Beneficiary (ies) and addresses)

- 1. Ziggye Mielczarek, 521 Apache Lane, Lowell IN 46356
- 2. Joe Mielczarek, 7910 Live Oak Ave, Santa Palo, CA 93060

5. The purpose of this Affidavit is to comply with the requirements of I.C. 32-17-14(S6(B)(20) to transfer on death Owner'(s)' interest in the real estate described above to the Transfer on Death Deed beneficiary(ies)

Dated this 21st day of November, 2016.

Ziggye Mielczarek Affiant Affiant
 Ziggye Mielczarek

STATE OF INDIANA, COUNTY OF LAKE, SS:

Before me, a notary public in and for said county and state residing in Lake County, Indiana, personally appeared Ziggye Mielczarek, and acknowledged the execution of the foregoing document, and who(m), having been duly sworn, stated that the representations hereon contained are true.

Witness my hand and notarial seal this 21st day of November

2016

My Commission Expires:
7-1-17

Ervin C. Carstensen
Notary Public

Ervin C. Carstensen
Printed Name of 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.



THIS INSTRUMENT WAS PREPARED BY: ERVIN C. CARSTENSEN, ATTORNEY AT LAW,
503 MAIN STREET, HOBART, IN 46342

ATTORNEY I.D. #3141-45



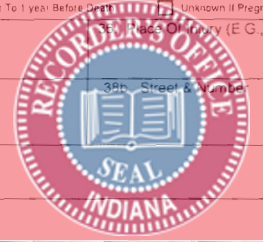
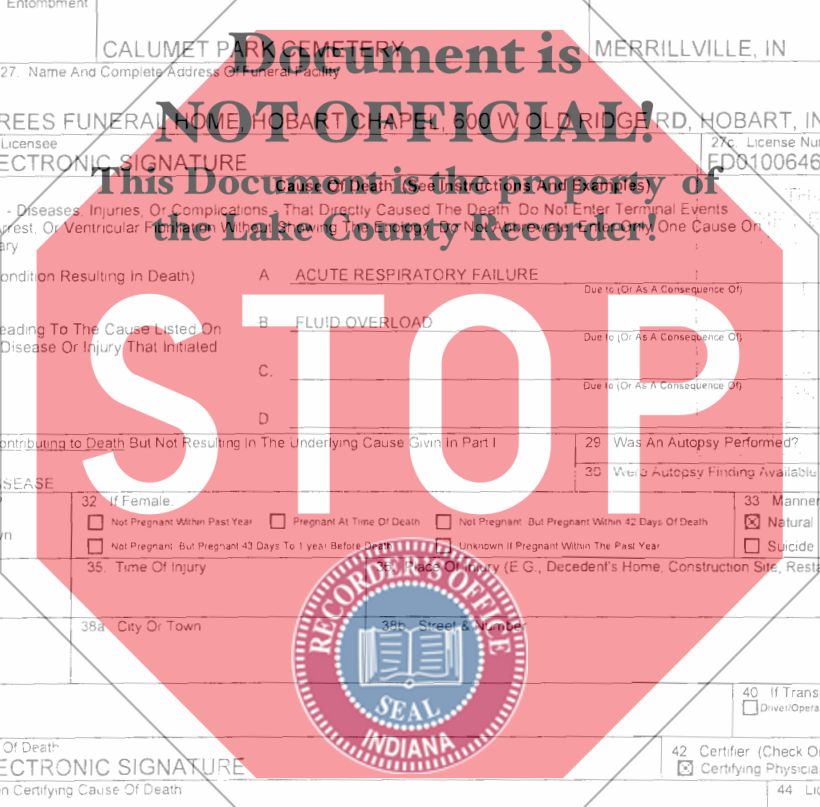
INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 003466

EDR No 000000346732

State No 048732

1 Decedent's Legal Name (First, Middle, Last) HELENA MIELCZAREK				1a Maiden Name (If female) KURALEVSKA		2 Sex FEMALE	3 Time Of Death 05:59 PM	4 Date Of Death (Month/Day/Year) 10/03/2013		
5 Social Security Number [REDACTED]	6a Age - Yrs 87	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) 12/28/1925		8 Birthplace (City and State or Foreign Country) UNAVAILABLE, PO		
9 Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10 If Death Occurred In A Hospital. <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department <input type="checkbox"/> Outpatient <input type="checkbox"/> Dead on Arrival			10a If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)					
11 Facility Name (If Not Institution, Give Street and Number) ST ANTHONY MEDICAL CENTER OF CROWN POINT										
12 City Or Town, State, And Zip Code CROWN POINT, IN, 46307					13 County Of Death LAKE			14 Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15 Surviving Spouse's Name				15a (If Wife) Give Maiden Last Name		16 Decedent's Usual Occupation HOMEMAKER		17 Kind Of Business/Industry HOME		
18 Residence - State INDIANA		18a County LAKE			18b City Or Town LOWELL					
18c Street And Number 521 APACHE LANE						18d Apt. No.	18e Zip Code 46409	18f Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
19 Decedent's Education 8TH GRADE OR LESS			20 Decedent Of Hispanic Origin NOT HISPANIC			21 Decedent's Race White				
22 Father's Name (First, Middle, Last) JUSEF KURALEVSKA				23 Mother's Name (First, Middle, Last) ANNA KURALEVSKA			23a Mother's Maiden Last Name UNAVAILABLE			
24 Informant's Name ZIGGIE MIELCZAREK			24a Relationship To Decedent SON		24b Mailing Address (Street And Number, City, State, Zip Code) 521 APACHE LANE, LOWELL, IN 46409					
25a Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)		25b Place Of Disposition (Name Of Cemetery, Crematory, Other Place) CALUMET PARK CEMETERY			25c Location - City, Town, And State MERRILLVILLE, IN					
26 Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27 Name And Complete Address Of Funeral Facility REES FUNERAL HOME HOBART CHAPEL, 600 W OLD BRIDGE RD, HOBART, IN 46342					27a Funeral Home License Number FH83003069			
27b Signature Of Indiana Funeral Service Licensee JAMES J. KRAUSE, BY ELECTRONIC SIGNATURE		27c License Number (Of Licensee) FD01006463			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. Withholding Breathing Or Nutrition For Not More Than 48 Hours. One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A ACUTE RESPIRATORY FAILURE Due to (Or As A Consequence Of) 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 FLUID OVERLOAD Due to (Or As A Consequence Of) C. D.					
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. Withholding Breathing Or Nutrition For Not More Than 48 Hours. One Cause On A Line. Add Additional Lines If Necessary.						Approximate Interval Onset To Death 2 DAYS		OCT 29 2013 HYPE		
Part II Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I HYPERTENSION CHRONIC KIDNEY DISEASE						29 Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30 Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
31 Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32 If Female <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33 Manner Of Death. <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined			37 Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
34 Date Of Injury (Month/Day/Year)		35 Time Of Injury		36 Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			38 Location Of Injury - State		38a City Or Town	
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. <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
41 Signature Of Person Certifying Cause Of Death SANJAY V RAIKAR, BY ELECTRONIC SIGNATURE						42 Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43 Name, Address And Zip Code Of Person Certifying Cause Of Death SANJAY V RAIKAR, 1201 S MAIN ST., CROWN POINT, IN 46307						44 License Number 01067950A		45 Date Certified 10/25/2013		
46 Additional Funeral Service Provider						47 *Akas				
48 Signature of Local Health Officer SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						49 For Registrar Only - Date Filed (Month/Day/Year) OCT 25 2013				



State Form 60396 - 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.