

AFFIDAVIT

STATE OF INDIANA

File No.: FNW1702567-DS

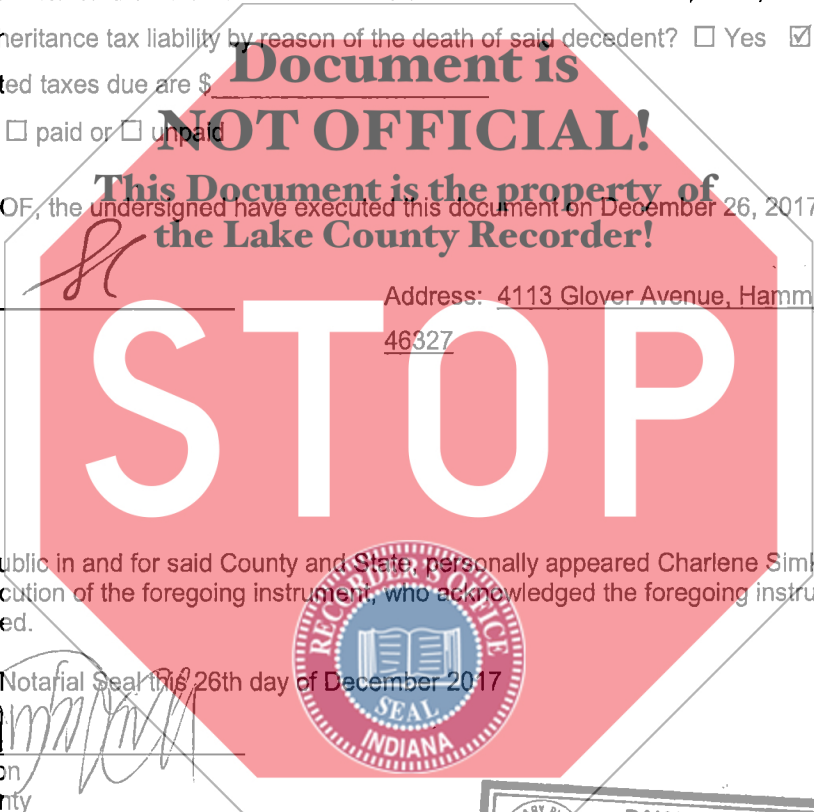
COUNTY OF LAKE

*Charlene Simko*

On this December 26, 2017 before me personally appeared ~~to me personally known~~, who being duly sworn on oath did say that:

- Affiant resides has knowledge of the life tenancy to the address given below affiant's signature;
- That Chester J. Pisowicz and Celia M. Pisowicz held a life estate interest in the following described land  
SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF  
A.K.A. CHESTER PISOWICZ
- Said Chester J. Pisowicz died on 10/15/2015 and Celia Pisowicz dies on June 21, 2010;
- Is there Federal inheritance tax liability by reason of the death of said decedent?  Yes  No  
If yes, then estimated taxes due are \$  
The taxes due are  paid or  unpaid

2017 7 088232



IN WITNESS WHEREOF, the undersigned have executed this document on December 26, 2017.

*Charlene*

*SC*

Address: 4113 Glover Avenue, Hammond, Indiana 46327

Charlene Simko

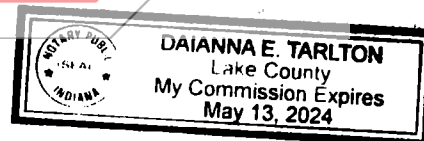
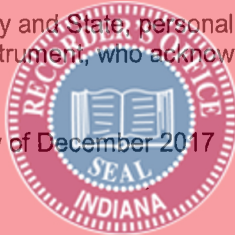
STATE OF INDIANA

COUNTY OF LAKE

Before me, a Notary Public in and for said County and State, personally appeared Charlene Simko who acknowledged the execution of the foregoing instrument, who acknowledged the foregoing instrument to be his/her free act and deed.

Witness my hand and Notarial Seal this 26th day of December 2017

Signature:  
Printed: Daianna Tarlton  
Resident of: Lake County  
State of: INDIANA  
My Commission expires:



This instrument prepared by: Timothy R. Kuiper  
Austgen Kuiper Jasaitis P.C.  
130 North Main Street, Crown Point, IN 46307

DULY ENTERED FOR TAXATION SUBJECT  
FINAL ACCEPTANCE FOR TRANSFER

DEC 27 2017

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

"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."

Daianna Tarlton

43870

Printed: 12.26.17 @ 02:28 PM by CAS  
IN-FT-FIDS-01040.246347-FNW1702567

FIDELITY NATIONAL  
TITLE COMPANY  
FNW1702567 LC

25-  
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am

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2017 DEC 28 AM 10:10  
MICHAEL B. BROWN  
RECORDER

**EXHIBIT "A"**  
Legal Description

**For APN/Parcel ID(s): 45-02-25-127-004.000-023**

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LOT SIX (6), AND THE NORTH HALF OF LOT SEVEN (7), BLOCK TWO (2), IN J. WM. ESCHENBURG'S STATE LINE ADDITION TO HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 2 PAGE 2, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

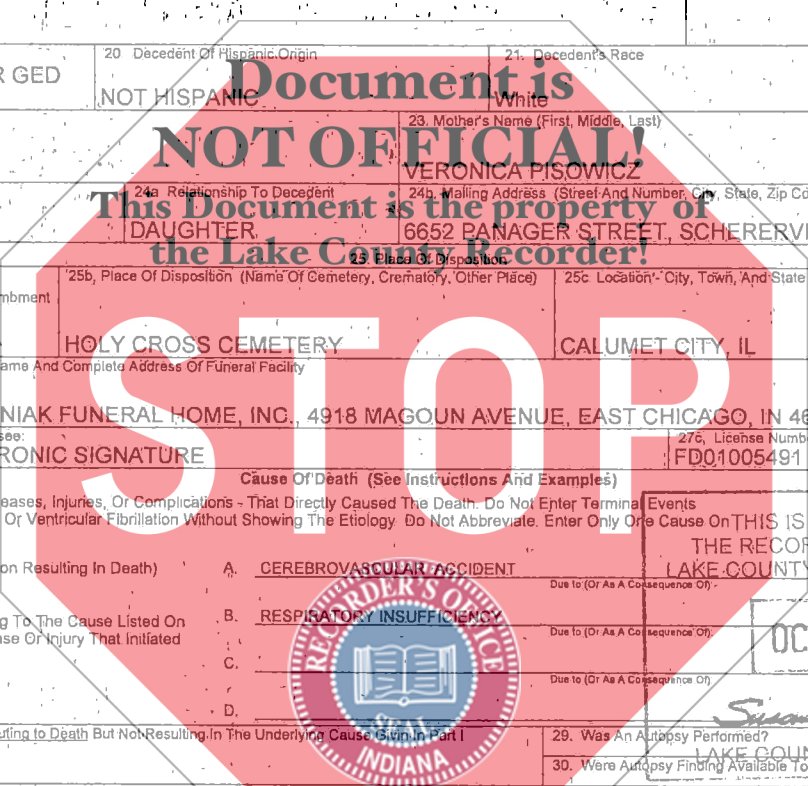
Tracking No. 67987

Local No 003427

EDR No 00000474277

State No 049255

1. Decedent's Legal Name (First, Middle, Last) <b>CHESTER PISOWICZ</b>				1a. Maiden Name (if female)		2. Sex <b>MALE</b>	3. Time Of Death <b>06:30 PM</b>	4. Date Of Death (Month/Day/Year) <b>10/15/2015</b>			
5. Social Security Number <b>36-21-9999</b>		8a. Age - Yrs <b>91</b>	8b. Under 1 Year Months	8c. Under 1 Month Days	8d. Under 1 Day Hours	8e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) <b>07/20/1924</b>		8. Birthplace (City and State or Foreign Country) <b>EAST CHICAGO, IN</b>		
9. Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department 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) <b>ST MARGARET MERCY HEALTHCARE CENTERS-HAMMOND</b>											
12. City Or Town, State, And Zip Code <b>HAMMOND, IN, 46320</b>				13. County Of Death <b>LAKE</b>			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 <b>POSTMAN</b>		17. Kind Of Business/Industry <b>U S POSTAL SERVICE</b>			
18. Residence - State <b>INDIANA</b>			18a. County <b>LAKE</b>		18b. City Or Town <b>HAMMOND</b>			18c. Street And Number <b>4113 GROVER STREET</b>	18d. Apt. No.	18e. Zip Code <b>46327</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>			20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>			21. Decedent's Race <b>White</b>					
22. Father's Name (First, Middle, Last) <b>STANLEY PISOWICZ</b>				23. Mother's Name (First, Middle, Last) <b>VERONICA PISOWICZ</b>				23a. Mother's Maiden Last Name <b>ROSSA</b>			
24. Informant's Name <b>PATTY EVACKO</b>				24a. Relationship To Decedent <b>DAUGHTER</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>6652 BANNER STREET, SCHERERVILLE, IN 46375</b>					
25a. Method Of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):			25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>HOLY CROSS CEMETERY</b>			25c. Location - City, Town, And State <b>CALUMET CITY, IL</b>					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>LESNIAK FUNERAL HOME, INC., 4918 MAGOUN AVENUE, EAST CHICAGO, IN 46312</b>					27a. Funeral Home License Number <b>FH83001601</b>				
27b. Signature Of Indiana Funeral Service Licensee: <b>JOHN B. LESNIAK, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD01005491</b>					
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 Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT, INDIANAPOLIS, INDIANA Immediate Cause (Final Disease Or Condition Resulting In Death) A. <b>CEREBROVASCULAR ACCIDENT</b> 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. <b>RESPIRATORY INSUFFICIENCY</b> Due to (Or As A Consequence Of) - C. Due to (Or As A Consequence Of) - D.									Approximate Interval: Onset To Death <b>12 HR</b>		
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I						29. Was An Autopsy Performed? <b>NO</b>			30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" 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						
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)			37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
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"/> Other					
41. Signature Of Person Certifying Cause Of Death <b>MANZOOR SHAH, BY ELECTRONIC SIGNATURE</b>						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: <b>MANZOOR SHAH, 1479 RING ROAD, CALUMET CITY, IL 60409</b>						44. License Number <b>01031445A</b>	45. Date Certified <b>10/20/2015</b>				
46. Additional Funeral Service Provider						47. *Ages					
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year). <b>OCT 21 2015</b>					
<b>AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)</b>											



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH



Local No. 000152

State No. ....

1. Decedent's Legal Name (First, Middle, Last) <b>Celia Pisowicz</b>				1a. Maiden Last Name (If Female) <b>SucHECKI</b>		2. Sex <b>Female</b>	3. Time Of Death <b>1:05pm</b>	4. Date Of Death (Month/Day/Year) <b>June 21 2010</b>		
5. Social Security Number <del>3022051</del>		6a. Age - Yrs <b>85</b>	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) <b>Oct 7 1924</b>		8. Birthplace (City And State Or Foreign Country) <b>East Chicago In</b>	
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 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) <b>St Catherine Hospital</b>										
12. City Or Town, State, And Zip Code <b>East Chicago In 46312</b>					13. County Of Death <b>Lake</b>			14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name <b>Chester Pisowicz</b>			15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation <b>Homemaker</b>		17. Kind Of Business/Industry <b>Own Home</b>			
18. Residence - State <b>Indiana</b>		18a. County <b>Lake</b>		18b. City Or Town <b>Hammond</b>			18d. Apt. No.	18e. Zip Code <b>46327</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
18c. Street And Number <b>4113 Grover</b>		20. Decedent Of Hispanic Origin <b>No</b>	21. Decedent's Race <b>White</b>	22. Father's Name (First, Middle, Last) <b>Frank Suchecki</b>	23. Mother's Name (First, Middle, Last) <b>Mary Suchecki</b>		23a. Mother's Maiden Last Name <b>Ostrowski</b>			
24. Informant's Name <b>Chester Pisowicz</b>		24a. Relationship To Decedent <b>Spouse</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>4113 Grover Hammond In 46327</b>						
25a. Method Of Disposition: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>Holy Cross Cemetery</b>		25c. Location - City, Town, And State <b>Calumet City IL</b>						
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	27. Name And Complete Address Of Funeral Facility <b>Lesniak FH 4918 Magoun East Chicago In 46312</b>					27a. Funeral Home License Number: <b>FH83001601</b>				
27b. Signature Of Indiana Funeral Service Licensee: <i>John B. Lesniak</i>					27c. License Number (Of Licensee): <b>FD01005491</b>					
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 Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <b>Acute ascending cholangitis</b> B. <b>Septic embolus</b> C. <b>Acute myocardial infarction</b> D. <b>Acute congestive heart failure</b> Approximate Interval: Onset To Death										
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I					29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input 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 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					
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)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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 <i>Jagdish Patel</i>					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: <b>J Patel MD 4321 First 220 East Chicago In 46312</b>						44. License Number <b>01029938A</b>		45. Date Certified <b>06/24/2010</b>		
46. Additional Funeral Service Provider:						47. *Akas:				
48. Signature Of Local Health Officer: <i>Gina Bonina</i>						49. For Registrar Only - Date Filed (Month/Day/Year): <b>6/24/10</b>				

