



32025434

SURVIVORSHIP AFFIDAVIT

STATE OF Indiana

S. S.

COUNTY OF Lake

On this 8th day of April 1992 before me personally appeared

Patricia A. Velasquez a/k/a Patricia Velasquez

to me personally known, who being duly sworn on oath did say that:

- 1. Affiant resides at the address given below affiant's signature;
2. Affiant is owner (state interest of affiant in the above premises as "owner," "son of owner," etc.);
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Daniel Velasquez and Patricia Velasquez a/k/a Patricia A. Velasquez

4. Said Daniel Velasquez died on 1-15-90 leaving NO This Document is the property of the Lake County Recorder!

5. The legal description of the premises in question is: Lot 36, Fairmeadow 13th Addition to the town of Munster, as shown in Plat Book 39, page 99, in Lake Co. Indiana.

Key # 28-295-36

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent.

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

(If answer is "Yes," identify the divorce proceedings:

8. Affiant's relationship to the deceased was wife

Signature: Patricia A. Velasquez
Address: 1506 HOLLY LN MUNSTER, IN. 46321

Subscribed and sworn to before me by the affiant

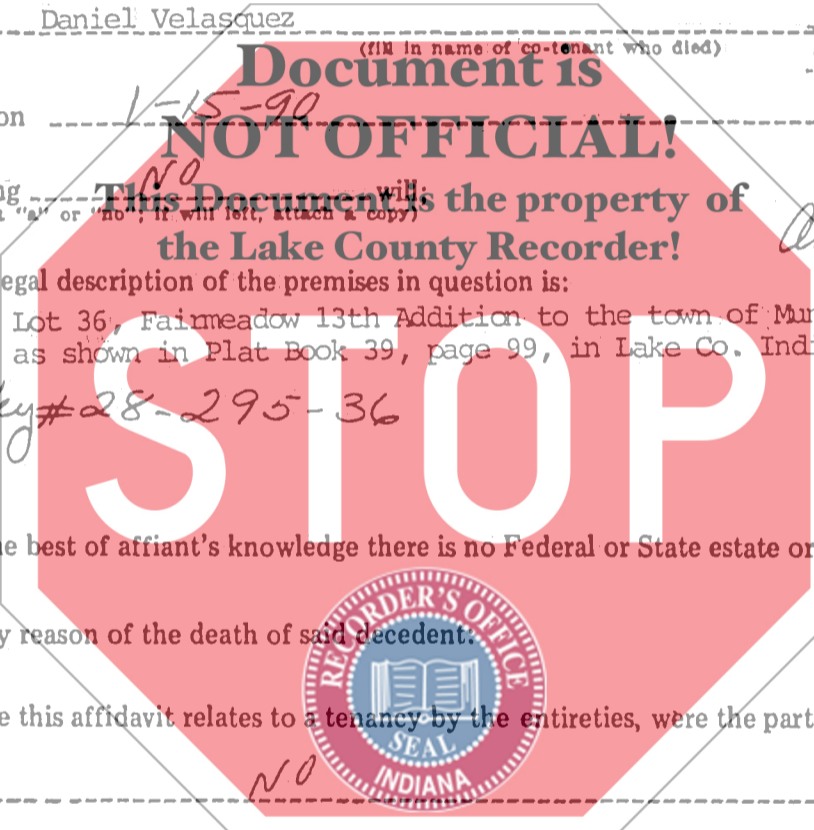
this 8th day of April, 1992

Roberta S. Tate Notary Public Res. of Porter

My Commission Expires 12-17-93

This instrument prepared by Patricia A. Velasquez

CHICAGO TITLE INSURANCE COMPANY INDIANA DIVISION



FILED

APR 22 1992

Anna N. Anton AUDITOR LAKE COUNTY



STATE OF INDIANA, S.H.1. LAKE COUNTY, INDIANA APR 24 1992 PM 1:02

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96-0060

INDIANA STATE BOARD OF HEALTH

Local No.

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First Middle Last) Daniel Velasquez		2. SEX Male	3a. TIME OF DEATH 11:00 P.M.	3b. DATE OF DEATH (Month Day Year) January 15, 1990	
4. SOCIAL SECURITY NUMBER 307-58-6846		5a. AGE—Last birthday (years) 35	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo Day Yr) May 10, 1954		7. BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO, IND			
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NONE	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> FR/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) Methodist Hospital, Northlake		9c. CITY, TOWN OR LOCATION OF DEATH Gary	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife give maiden name) Patricia Rogan	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Restaurant	12b. KIND OF BUSINESS/INDUSTRY Fast Foods		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Munster	13d. STREET AND NUMBER 1506 Holly Lane		
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 type="checkbox"/> No <input checked="" 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) Elementary/Secondary (10-12) 12 yrs College (1-4 or 5+) 2 yrs		18. FATHER'S NAME (First Middle Last) ALBERT VELASQUEZ			
19. MOTHER'S NAME (First Middle Maiden Surname) JUSTINA ROBLEDO		20a. INFORMANT'S NAME (Type/Print) PATRICIA VELASQUEZ			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 HOLLY LANE, MUNSTER, IN 46321		20c. Relationship WIFE			
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) CONCORDIA CEMETERY		21c. LOCATION—City or Town, State HAMMOND, IND.	
22a. EMBALMER'S NAME THOMAS J. BURNS		22b. EMBALMER'S LICENSE NO. 1045184	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b. LICENSE NUMBER (of Licensee) 1045184	25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish F.H. FH 3002819 5840 Hohman, Hammond, IN 46320		
26. PART I. Enter the diseases, 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) a. Gunshot wound of chest & heart; Status post surgical repair with survival of 8 days. b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		Approximate Interval Between Onset and Death Unknown			
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) Yes	
28b. WERE TOXICOLOGY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes		APR 2 1990 AUDITOR LAKE COUNTY			
29a. CERTIFIER (Check only one) <input 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 checked="" 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>Daniel D. Thomas</i> 29c. MEDICAL LICENSE NO. 16120 29d. DATE SIGNED (Month Day, Year) Jan. 23, 1990			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DANIEL D. THOMAS, M.B., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307					
31. HEALTH OFFICER'S SIGNATURE <i>Daniel D. Thomas</i>				32. DATE FILED (Month Day, Year) JAN. 24 1990	
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 checked="" type="checkbox"/> Homicide		34a. DATE OF INJURY (Month Day, Year) Jan. 8, 1990	34b. TIME OF INJURY Unknown	34c. INJURY AT WORK? (Yes or no) Yes	34d. DESCRIBE HOW INJURY OCCURRED Gunshot wound
34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) Restaurant			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3600 Broadway, Gary, IN		
34g. DATE PRONOUNCED DEAD (Month Day, Year) Jan. 15, 1990		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. N/A			

DECEDENT

RENTS

FORMANT

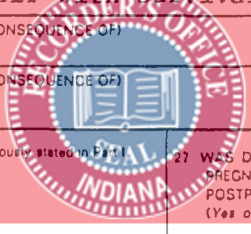
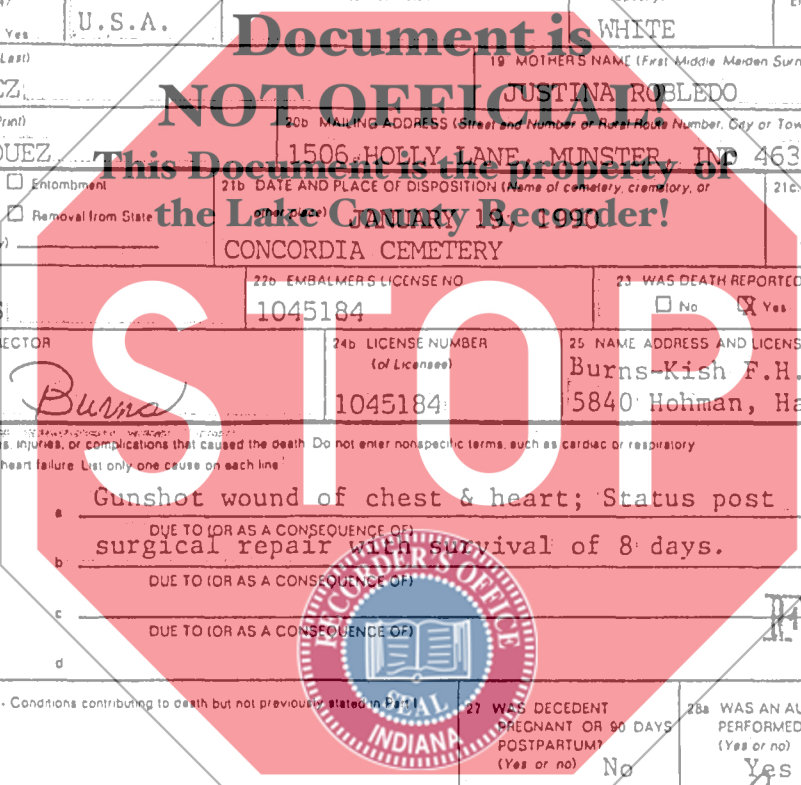
POSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER ONLY



FILED

CHICAGO TITLE INSURANCE COMPANY INDIANA DIVISION

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