190627 - Ticor N.C.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

95 JAN -4 AM 9:42
AMASA G. COLBY
CHIEF DEP. RECORDER

95000517

# TICOR TITLE INSURANCE

## AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE )

CARMEN RODRIGUEZ, being first duly sworn upon oath, deposes and says:

1. That ARMANDO RODRIGUEZ died on July 3, 1994 at Hammond, Indiana.

2. That ARMANDO RODRIGUEZ and CARMEN RODRIGUEZ were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 1 in Block 17 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

45-33-22-1



3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Carmen Rodriguez
Carmen Rodriguez

Subscribed and sworn to before me, a Notary Public, this 29th day of December, 1994.

Thomas G. Schiller Notary Public

My Commission expires: 06-07-96

Lake
County of Residence:

FILED
JAN -3 1995
Auditor

This Instrument prepared by Carmen Rodriguez

000025

*ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 551

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

July 12, 1994 (Date Issued) — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED—NAME (First, Middle, Last): Armando Rodriquez
2 SEX: Male
3a TIME OF DEATH: 1:06a M
3b DATE OF DEATH (Month, Day, Yr): July 3,1994
4 SOCIAL SECURITY NUMBER: 573-94-5973
5a AGE—Last Birthday (Years): 44
5b UNDER 1 YEAR Months / Days:
5c UNDER 1 DAY Hours / Minutes:
6 DATE OF BIRTH (Mo. Day, Yr): May6,1950
7 BIRTHPLACE (City and State or Foreign Country): Mexico
8a WAS DECEDENT A U.S. VETERAN? NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE
8e PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Margaret Mercy North
9c CITY, TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Carmen Luna
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Crane Operator
12b KIND OF BUSINESS/INDUSTRY: scrap metal
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Hammond
13d STREET AND NUMBER: 226 Gostlin
13e ZIP CODE: 46327
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY: Mexico
15 WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): Mexican
16 RACE—American Indian, Black, White, etc. (Specify): White
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): - -

**PARENTS**

18 FATHER'S NAME (First, Middle, Last): Tobias Rodriquez
19 MOTHER'S NAME (First, Middle, Maiden Surname): Rosa DeLaCruz

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): Carmon Rodriquez
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 226 Gostlin, Hammond, IN 46327
20c Relationship: Wife

**DISPOSITION**

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 7,1994 Holy Cross Cemetery
21c LOCATION—City or Town, State: Calumet City, IN
22a EMBALMER'S NAME: James Porras
22b EMBALMER'S LICENSE NO.: 1045964
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b LICENSE NUMBER (of Licensee): 1045184
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home #3002819, 5840 Hohman Ave., Hammond, IN 46320, For: Panozzo Brothers F.H./ Chicago, IL

**CAUSE OF DEATH**

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.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) a. | Laceration of stomach, abdominal aorta and right | Unknown |
| DUE TO (OR AS A CONSEQUENCE OF) b. | kidney due to gunshot wounds | |
| DUE TO (OR AS A CONSEQUENCE OF) c. | | |
| DUE TO (OR AS A CONSEQUENCE OF) d. | | |

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: N/A

27. WAS DECEDENT PREGNANT OR 60 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): YES
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): YES

**CERTIFIER**

29a CERTIFIER (Check only one): Deputy
☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.
☐ 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.
☒ 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: Kathy Philpot Deputy Coroner
29c MEDICAL LICENSE NO: N/A
29d DATE SIGNED (Month, Day, Year): July 11, 1994
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Kathy Philpot, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Orenuda M.D.
32. DATE FILED (Month, Day, Year): July 12, 1994

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☒ Homicide
34a. DATE OF INJURY (Month, Day, Year): July 3,1994
34b TIME OF INJURY: Unknown
34c. INJURY AT WORK? (Yes or no): No
34d DESCRIBE HOW INJURY OCCURRED: Gunshot wounds
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): Business
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1147 150th Avenue Hammond, Indiana
34g DATE PRONOUNCED DEAD (Month, Day, Year): July 3, 1994
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: No