



481638

Chicago Title Insurance Company

PLEASE RECORD & RETURN TO SECURITY FEDERAL BANK, a F.S.B.

4518 INDIANAPOLIS BLVD.
EAST CHICAGO, IN 46312
2600 Highway ave. Hgt

481638 20
4049

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA
COUNTY OF LAKE

} S. S.

On this 19th July 1995 before me personally appeared FELICIANO RODRIGUEZ
(insert date)

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

- Affiant resides at the address given below affiant's signature;
- Affiant is OWNER
(state interest of affiant in the above premises as "owner," "son of owner," etc.)
- Said premises were formerly owned as joint tenants or as tenants by the entireties by FELICIANO RODRIGUEZ and RUTH RODRIGUEZ

4. Said RUTH RODRIGUEZ
(fill in name of co-tenant who died)

died on SEPTEMBER 1, 1994

leaving NO will;
(insert "a" or "no" if will left, attach a copy)

5. The legal description of the premises in question is:

LOT 11, BLOCK 5, RESUBDIVISION OF PART OF THE NORTHEAST QUARTER OF SECTION 29, TOWNSHIP 37 NORTH, RANGE 9 WEST OF THE 2nd P.M., IN THE CITY OF EAST CHICAGO, AS SHOWN IN PLAT BOOK 5, PAGE 2, IN LAKE COUNTY, INDIANA.

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?

NO SEP 19 1995

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

FILED
SAM ORLICH
AUDITOR LAKE COUNTY

8. Affiant's relationship to the deceased was HER HUSBAND

Signature: Feliciano Rodriguez
FELICIANO RODRIGUEZ

Address: 4213 OLCOTT AVE.
EAST CHICAGO, IN. 46312

Subscribed and sworn to before me by the affiant

this JULY 19, 1995

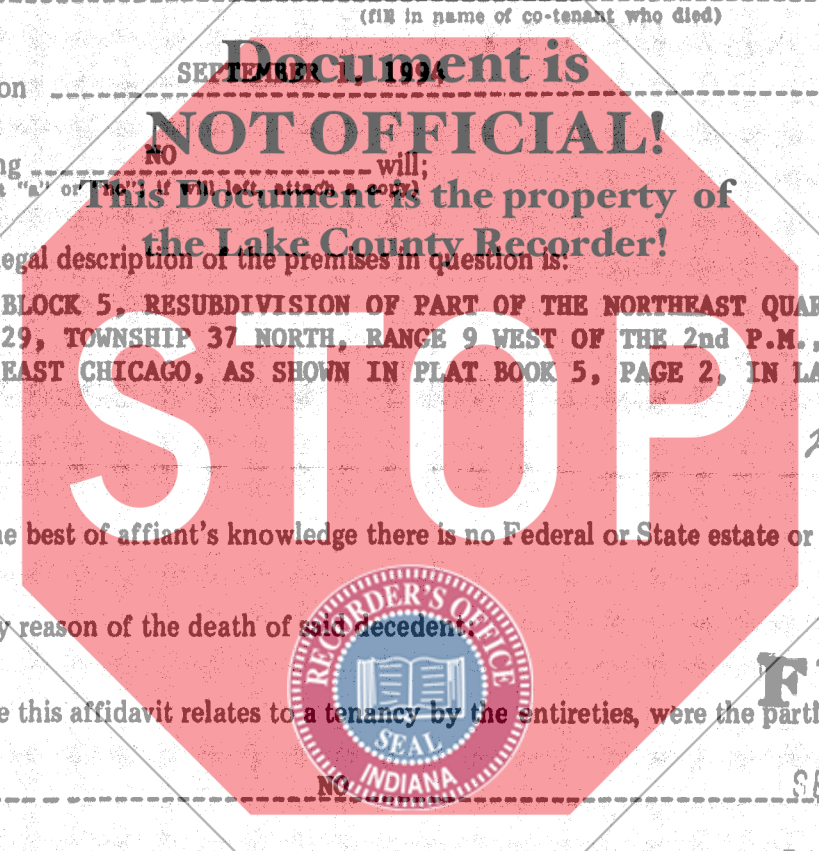
Patricia A. Naumoff
Notary Public PATRICIA A. NAUMOFF

My Commission Expires APRIL 19, 1995 RESIDENT OF LAKE COUNTY

This instrument prepared by FRANK X. BECERRA

001223

Chicago Title Insurance Company
95056558



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
95 SEP 20 PM 1:24
RECORDER

24-30-20-11

11-15

*ATTENTION ESTATE: Disclosure of the SS# is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 94-290

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

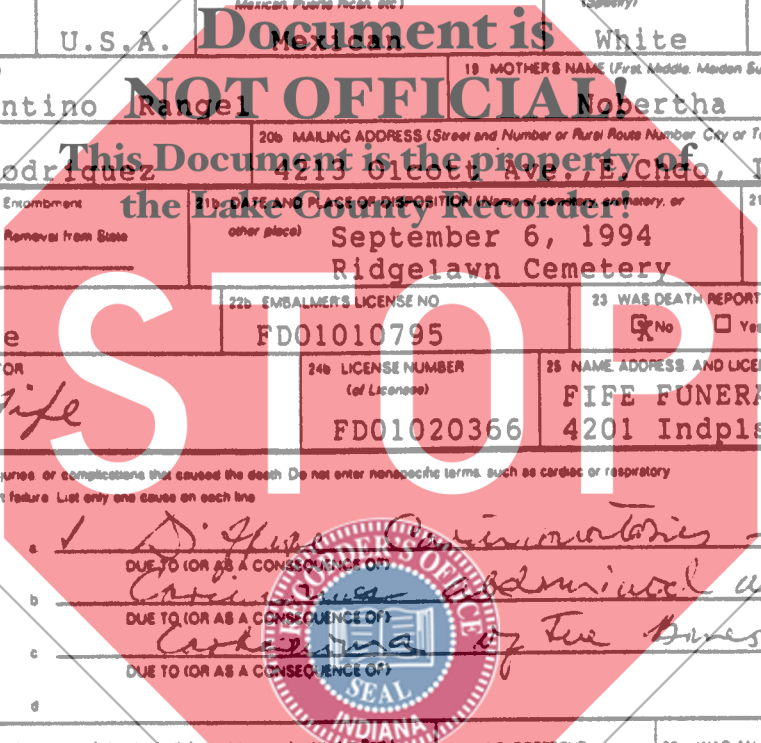
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Ruth Rodriguez		2 SEX Female	3a TIME OF DEATH 6:30a	3b DATE OF DEATH (Month Day Yr) September 1, 1994	
4 SOCIAL SECURITY NUMBER 450-40-7664	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Feb. 1, 1926	
7 BIRTHPLACE (City and State or Foreign Country) Bridgeport, Texas	8a WAS DECEDENT A US VETERAN? No				
8b YEAR LAST SERVED IN US ARMED FORCES? -		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence			
9b FACILITY NAME (If not institution, give street and number) 4213 Olcott Avenue		9c CITY, TOWN OR LOCATION OF DEATH East Chicago	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Feliciano Rodriguez	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION East Chicago	13d STREET AND NUMBER 4213 Olcott Avenue		
15a ZIP CODE 46312	15b INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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.) Mexican	16 RACE—American Indian, Black, White, etc. (Specify) White	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) 8		College (1-4 or 5+) -			
18 FATHER'S NAME (First Middle Last) Florentino Rangel		19 MOTHER'S NAME (First Middle Maiden Surname) Noberta Fabre			
20a INFORMANT'S NAME (Type/Print) Feliciano Rodriguez		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Olcott Ave., E.Chgo, IND 46312		20c Relationship Husband	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) September 6, 1994 Ridgelawn Cemetery		21c LOCATION—City or Town, State Gary, Indiana	
22a EMBALMER'S NAME James H. Fife		22b EMBALMER'S LICENSE NO. FD01010795		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>John B. Fife</i>		24b LICENSE NUMBER (of Licensee) FD01020366		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FIFE FUNERAL HOME - FH83001512 4201 Indpls. Blvd., E.Chgo, IND	
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. a. D. Hep. C. Cirrhosis b. Cirrhosis c. Cardiac of the Liver				Approximate Interval Between Onset and Death FILED	
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Duodenal ulcers				27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	
28a WAS AN AUTOPSY PERFORMED? (Yes or no) No				28b COUNTY OF DEATH? (Yes or no) Lake County	
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>[Signature]</i>			29c MEDICAL LICENSE NO. 101021815	29d DATE SIGNED (Month, Day, Year) Sept. 2, 1994	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) F.G. Delacotera, M.D. - 9030 Columbia Ave., Munster, Indiana 46321					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) 9-6-94	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)			34b 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.			



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