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SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA }  
COUNTY OF LAKE } S. S.

2

On this 3/13/96 before me personally appeared

Joanne Pagan

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 1815 W 93rd Place Crown Point, Ind 46007  
(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

Joanne & Ismael Pagan and Joseph & Olivia Pagan

4. Said Ismael Pagan  
(fill in name of co-tenant who died)

died on February 15, 1996

leaving no will;  
(insert "s" or "d" or "and" or "with" or "without" or "to")

5. The legal description of the premises in question is:  
the Lake County Recorder!

LOT 47 Fountain Ridge Add Unit 3, LOT  
PT Book 39, Page 39 ADD

THIS DOCUMENT IS BEING RE-RECORDED TO CORRECT THE LEGAL DESCRIPTION

6. To the best of affiant's knowledge there is no Federal or State estate of the affiant's property 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

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

8. Affiant's relationship to the decedent as wife

Signature: Joanne Pagan

Address: 1815 W 93rd Place  
Crown Point, Ind 46007

Subscribed and sworn to before me by the affiant

this 3/13/96  
(insert date)

Star Gya  
Notary Public

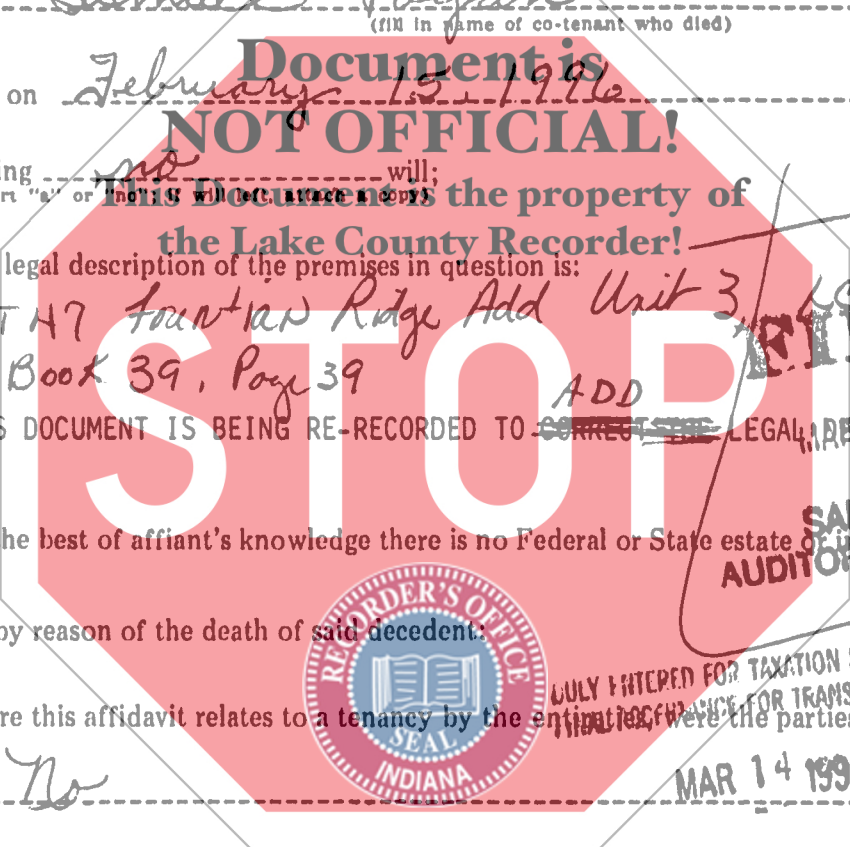
My Commission Expires

This instrument prepared by

JOANNE PAGAN

000711

Lot 33, Burnside's Chapel Hill Farms Phase 1, an Addition to the Town of Merrillville, Lake County, Indiana, as shown in Plat Book 72, page 23, of Lake County, Indiana.



Chicago Title Insurance  
196018500

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
96 MAR 14 PM 1:14  
MARGARETTE CRAWFORD  
RECORDER

SAM ORLICH  
AUDITOR LAKE COUNTY  
MAR 14 1996  
DULY ENTERED FOR TAXATION SUBJECT TO  
INDIAN SUCCESSION ACT  
96065669

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
96 MAR 12 PM 1:18  
RECORDER  
000043

\* ATTENTION: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and it will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 0344-96

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) <b>ISMAEL PAGAN</b>		2 SEX <b>MALE</b>	3a TIME OF DEATH <b>4:15 p.m.</b>	3b DATE OF DEATH (Month Day Year) <b>February 15, 1996</b>
4 SOCIAL SECURITY NUMBER <b>341-28-9006</b>	5a AGE—Last Birthday (Years) <b>63</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) <b>March 27, 1932</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Puerto Rico</b>	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) <b>1815 W.93rd Place</b>		9b CITY TOWN OR LOCATION OF DEATH <b>Crown Point</b>	9c COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Joanne Cassano</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Laborer</b>	12b KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Crown Point</b>	13d STREET AND NUMBER <b>1815 W.93rd Place</b>	
13e ZIP CODE <b>46307</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) <b>Puerto Rican</b>	16 RACE—American Indian, Black White etc (Specify) <b>White</b>
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <b>8</b> College (11-4 or 5 +) <b></b>		18 FATHER'S NAME (First Middle Last) <b>Jose Pagan</b>		
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Simona Roman</b>		20a INFORMANT'S NAME (Type/Print) <b>Joanne Pagan</b>		
20b ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1815 W.93rd Place Crown Point Indiana</b>		20c Relationship <b>Wife</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>February 19, 1996 Memory Lane Memorial Garden</b>		21c LOCATION—City or Town, State <b>Schererville</b>
22a EMBALMER'S NAME <b>David F. McCoy</b>		22b EMBALMER'S LICENSE NO. <b>FD08700581</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24 SIGNATURE OF FUNERAL DIRECTOR <i>David F. McCoy</i>		24b LICENSE NUMBER (of Licensee) <b>FD08700581</b>	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323</b>	
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory. List only one cause on each line. <b>CONGESTIVE HEART FAILURE</b> IMMEDIATE CAUSE OF DEATH (Disease or condition resulting in death) <b>DM with Severe Cardiovascular Disease</b> Conditions if any which pertain to the immediate cause stating the underlying cause last <b>FILED</b>				
PART II Other significant conditions, conditions contributing to death but not previously stated in Part I <b>LAKE COUNTY HEALTH COMMISSIONER</b>				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>	
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 <b>Cal Streeter DO</b>		
29c MEDICAL LICENSE NO. <b>543</b>		29d DATE SIGNED (Month, Day, Year) <b>2/16/96</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Calvin Streeter 9635 Saric Drive Highland, Indiana</b>				
31 HEALTH OFFICER'S SIGNATURE <b>FILED Depoyster &amp; Williams, M.D.</b>				32 DATE FILED (Month, Day, Year) <b>February 20, 1996</b>
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 type="checkbox"/> Homicide	34a DATE OF INJURY (Month, Day, Year) <b>OCT 1 1996</b>	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) <b>SAM ORLICH AUDITOR LAKE COUNTY</b>			34f LOCATION (Street and Number or Rural Route Number, City or Town, State)	
34g DATE PRONOUNCED DEAD		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <b>000712000044</b>		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER