Chicago Title Insurance Company

#491753 LD

SURVIVORSHIP AFFIDAVIT

STATE OF Indiana
COUNTY OF LAKE } S. S. 265-72-7133

On this 3-18-97 (insert date) before me personally appeared Edelmiro Rivera

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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 Edelmiro Rivera and Antonia Rivera;

4. Said Antonia Rivera (fill in name of co-tenant who died)
died on July 31, 95
leaving NO will; (insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:
Lot 8 Block 4, Roxana 1ST Addition to Hammond, as shown in Plat Book 20, Page 24, 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: NO

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: NO);

8. Affiant's relationship to the deceased was Husband

Signature: Edelmiro Rivera

Address: 7407 marshall av

Subscribed and sworn to before me by the affiant this 3-18-97 (insert date)

Albert J. Horvat
Notary Public

My Commission Expires 4-19-99

FILED
APR 18 1997
SAM ORLICH
AUDITOR LAKE COUNTY

This instrument prepared by Tony Arroyo

1200

001032

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 APR 21 AM 9:21
MORRIS W. CARTER
RECORDER

97046335

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

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 95-211

CERTIFICATE OF DEATH

State No. .....

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): Antonia G. Rivera
2. SEX: Female
3a. TIME OF DEATH: 6:38 P. M
3b. DATE OF DEATH (Month, Day, Yr): July 31, 1995
4. SOCIAL SECURITY NUMBER: 261-74-9739
5a. AGE—Last Birthday (Years): 48
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr): June 13, 1947
7. BIRTHPLACE (City and State or Foreign Country): Camuy, Puerto Rico
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. 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. Catherine Hospital
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): Edelmiro Rivera
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: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7407 Marshall Avenue
13e. ZIP CODE: 46323
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☐ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): Puerto Rican
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Gervacio Gomez
19. MOTHER'S NAME (First, Middle, Maiden Surname): Valentina Rodriguez Gomez

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Edelmiro Rivera
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7407 Marshall Ave., Hammond, IN 46323
20c. Relationship: Husband

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): August 4, 1995 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Vernon R. Engel
22b. EMBALMER'S LICENSE NO.: FDO 9200094
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Vernon R Engel
24b. LICENSE NUMBER (of Licensee): FDO 9200094
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ENGEL Funeral Home - FDH 3007893, 2700 Willowcreek, Portage, IN 46368

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.	Cardiopulmonary Arrest	3 days
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF): b.	Acute Hypocalcemia	3 hr.
DUE TO (OR AS A CONSEQUENCE OF): c.	Hypothyroid Status	3 wks.
DUE TO (OR AS A CONSEQUENCE OF): d.	Hypothyroidism	2 weeks

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): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

CERTIFIER

29a. CERTIFIER (Check only one):
☒ 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:
29c. MEDICAL LICENSE NO.: 01019251
29d. DATE SIGNED (Month, Day, Year): 8-1-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Fred Adler, M.D., 800 MacArthur, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): 8-2-95

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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:
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):
34f. 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.: