STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

98 JUN 17 AM 9:35

MORRIS W. CARTER
RECORDER

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98015201

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JOHN RAMOS, JR., being first duly sworn upon oath, deposes and says:

1. That HELEN B. RAMOS died on MAY 3, 1997, 19___ at ST. MARGARET-MERCY.

2. That JOHN RAMOS, JR. and HELEN B. RAMOS were ~~husband and wife and legally married at the time they acquired title as husband and wife~~ and ~~owned the following~~ described real estate:

K # 28-231-22

~~TENANTS IN COMMON~~/

Lot 22, University Estates First Addition, to the Town of Munster, as per plat thereof, recorded in Plat Book 35 page 71, in the Office of the Recorder of Lake County, Indiana.

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 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.

FILED

JUN 16 1998

SAM ORLICH
AUDITOR LAKE COUNTY

Further affiant sayeth not.

JOHN RAMOS, JR.

Subscribed and sworn to before me, a Notary Public, this 12TH day of JUNE, 19 98.

KAREN KANE Notary Public

My Commission expires: 09-12-99

PORTER

County of Residence:

This Instrument prepared by JOHN RAMOS, JR

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

Local No. 358

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19 3

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

Franklin D. Bremuda MD

Hammond Health Commissione

St MAY 9 1997 Date Issued

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Helen B. Ramos ~~Ramos~~

2 SEX: female

3a TIME OF DEATH: 4:00P M

3b DATE OF DEATH (Month, Day, Yr.): May 3, 1997

4. SOCIAL SECURITY NUMBER: 316-24-5527

5a AGE—Last Birthday (Years): 69

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Mo. Day, Yr.): July 22, 1927

7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana

8a WAS DECEDENT A US VETERAN?: no

8b YEAR LAST SERVED IN US ARMED FORCES?: n/a

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number): St. Margaret-Mercy Healthcare Center-North

9c CITY, TOWN, OR LOCATION OF DEATH: Hammond

9d COUNTY OF DEATH: Lake

10. MARITAL STATUS (Specify): widowed

11 SURVIVING SPOUSE (If wife, give maiden name): n/a

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker

12b KIND OF BUSINESS/INDUSTRY: Own Home

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Griffith

13d STREET AND NUMBER: 243 North Raymond Street

13e ZIP CODE: 46319

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY?: USA

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] 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 (0-12): 12; College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First, Middle, Last): Alex Jankauskus

19 MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Rusterr

INFORMANT

20a INFORMANT'S NAME (Type/Print): John Ramos, Jr.

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 243 North Raymond Street Griffith, Indiana 46319

20c Relationship: son

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify) _____

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 7, 1997 Ridgelawn Cemetery

21c LOCATION—City or Town, State: Gary Indiana

22a EMBALMER'S NAME: Edgar C. Gleim

22b EMBALMER'S LICENSE NO: FD01016173

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: David R Retman

24b LICENSE NUMBER (of Licensee): FD08601585

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Ro Highland, Indiana 46322 FH83007500

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. respiratory failure

DUE TO (OR AS A CONSEQUENCE OF): b. ~~Emphysema~~ chronic restrictive lung disease, thoracoplasty

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death

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)

[X] 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: Don Dumond MD

29c. MEDICAL LICENSE NO: 01033451

29d DATE SIGNED (Month, Day, Year): 5-8-97 (MAY)

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Don Dumond, MD, 761-45th St., Suite 103, Munster IN 463

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Bremuda M.D.

32. DATE FILED (Month, Day, Year): MAY 09 1997

33 MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide

34a DATE OF INJURY (Month, Day, Year)

34b TIME OF INJURY

34c INJURY AT WORK? (Yes or no)

34d DESCRIBE HOW INJURY Ooccurred

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)

34f [illegible] (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.

FILED

JUN 16 [illegible]

SAM ORLICH
UDITOR LAKE COUNT

001164

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1