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TICOR TITLE INSURANCE

2000 002760

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 JAN 13 AM 9:50

MORRIS W. CARTER
RECORDER

Chicago Title Insurance Company

991158 BT

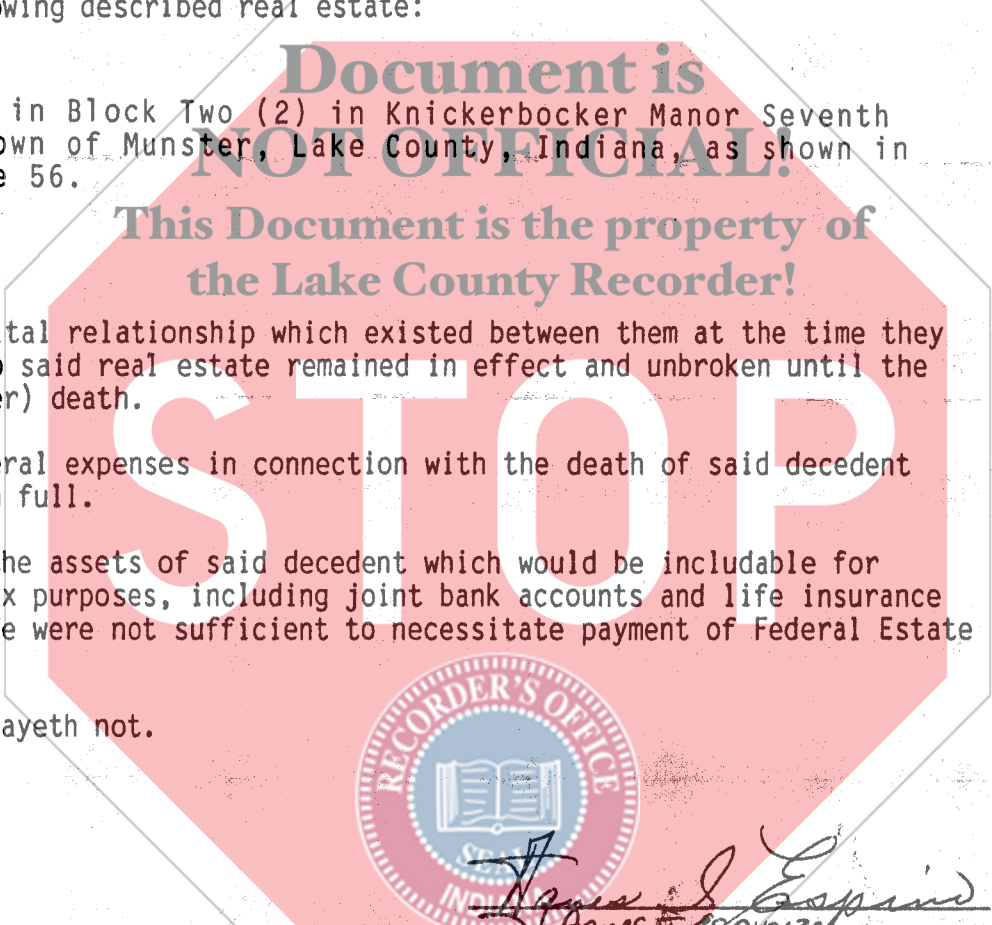
AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Agnes I. Espino, being first duly sworn upon oath, deposes and says:

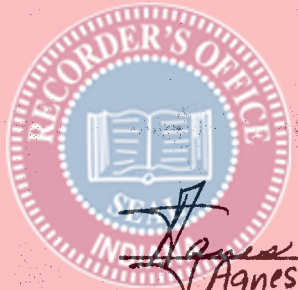
1. That Jose C. Espino died on December 21, 1997 at 8523 Forest Ave.
2. That Jose C. Espino and Agnes I. Espino were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot Fourteen (14) in Block Two (2) in Knickerbocker Manor Seventh Addition to the Town of Munster, Lake County, Indiana, as shown in Plat Book 32, page 56.



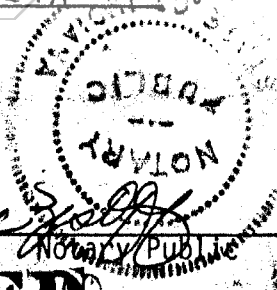
3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets 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.



Subscribed and sworn to before me, a Notary Public, this 16th day of NOVEMBER, 1999.

Agnes I. Espino
Agnes I. Espino
 Notary Public



My Commission expires:

FEBRUARY 4, 2000

County of Residence:

LAKE

FILED
 JAN 12 2000
 PETER BENJAMIN
 LAKE COUNTY AUDITOR

This Instrument prepared by Agnes I. Espino

00666

ct
1/13/00
M

25x10

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 26-75-97
41073

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) Dr. Jose C. Espino		2 SEX Male	3a TIME OF DEATH 10:10A	3b DATE OF DEATH (Month Day, Yr) December 21, 1997
4 SOCIAL SECURITY NUMBER 307-38-7272	5a AGE—Last Birthday (Years) 83	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) July 13, 1914
7 BIRTHPLACE (City and State or Foreign Country) Manila, Phillipines	8a PLACE OF DEATH (Check only one See instructions)			
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		
9b FACILITY NAME (If not institution, give street and number) 8523 Forest Ave.		9c CITY, TOWN OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Agnes Bonner	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Physician	12b KIND OF BUSINESS/INDUSTRY Medical	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Munster	13d STREET AND NUMBER 8523 Forest Ave.	
13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) Asian
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		18 FATHER'S NAME (First Middle Last) Rojelio Espino		
19 MOTHER'S NAME (First Middle Maiden Surname) Rose Cancio		20a INFORMANT'S NAME (Type/Print) Agnes Espino		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8523 Forest Ave. Munster, IN 46321		20c Relationship Wife		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 24, 1997 NW IN Crematory		21c LOCATION—City or Town, State Crown Point, IN
22a EMBALMERS NAME Brian T. Burns		22b EMBALMERS LICENSE NO. 8601763	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licenses) 1021590	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321	
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. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) x Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF) b hypertension 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				
Coronary Artery Disease				
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) ---				
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 x Amedeo Bluts		29c MEDICAL LICENSE NO. 01027402	29d DATE SIGNED (Month Day, Year) Dec. 22, 1997	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) C. Castor M.D. 911 Fran-lin Pkwy Munster, IN 46321				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32 DATE FILED (Month Day, Year) December 22, 1997		
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)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) DEC 22 1997		
34g DATE PRONOUNCED DEAD (Month Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. Alexander S. Williams, M.D. LAKE COUNTY HEALTH COMMISSIONER		