FA# F29400
LEGAL DESCRIPTION:
Lot 12 in Paul Csontos' Addition to Hammond, as per plat thereof, recorded in Plat Book 16, page 1, in the Office of the Recorder of Lake County, Indiana.

First American Title Insurance Company

PROPERTY ADDRESS:
835 Cherry Street, Hammond, IN 46324

ESTATE AFFIDAVIT

JUAN MONTALVO CUEVAS , Affiant, states that:

1. **MARIA QUILES CUEVAS** , deceased, died on the day ~~MAY~~ 5TH of MAY 1996

2. Affiant is: ☑ the surviving spouse of the deceased,
☐ the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: ☐ leaving a will which has been probated;
☐ leaving a will which has not been probated;
☑ leaving no will;

4. The deceased and Affiant were married on the day of ; and were never divorced.
(This item applies only to the surviving spouse.)

5. ☑ All expenses of the last illness and funeral of the deceased have been paid.

6. ☑ All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. ☑ There have been no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

2-11-00
Date

Juan Montalvo Cuevas
By Michael A Cuevas as POA.
Signature of Affiant
JUAN MONTALVO CUEVAS
BY: MICHAEL A. CUEVAS AS POA
Juan Montalvo Cuevas
By Michael A Cuevas as POA.
Printed Name of Affiant

State of Indiana, County of **LAKE**

Subscribed and sworn to before me, this **11** day of **FEBRUARY**, **2000**

Druanne M. Bocek
Printed Name of Notary

Druanne M Bocek
Signature of Notary

My Commission expires: **08/28/2006**

My County of Residence is: **LAKE**

THIS INSTRUMENT WAS PREPARED BY: _____

HOLD FOR FIRST AMERICAN TITLE

ATTENTION ESTATE: 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. 0937-96 — CERTIFICATE OF DEATH — State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Maria	Quiles	Cuevas	Female	4:15 PM	May 5, 1996

4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months	Days	5c UNDER 1 DAY Hours	Minutes	6 DATE OF BIRTH (Mo. Day. Yr)	7 BIRTHPLACE (City and State or Foreign Country)
582-37-0852	82					Dec. 22, 1913	Puerto Rico

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
No	n/a	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Hospital (Southlake)	Merrillville	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Juan Cuevas Montalvo	Homemaker	Own Home

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	835 Cherry Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46324	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☐ No ☒ Yes Puerto Rican	White	n/a	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Nicanor Quiles	Anna Ramos

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Juan D. Cuevas	3809 E. 109th St., Crown Point, IN	Son

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 8, 1996 Calumet Park Cemetery	Merrillville, IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
Charles W. Wells	FD0104372	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
David L. Pastrick	FD08800012	Oleska-Pastrick Funeral Home #155 3934 Elm St., East Chicago, IN

CAUSE OF DEATH

26 PART I — Enter only one cause per line for (a), (b), and (c). Do not enter nonspecific terms, such as cardiac or respiratory.

Approximate Interval Between Onset and Death

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

DUE TO (OR AS A CONSEQUENCE OF): b. Coronary heart disease & Congestive heart failure

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

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

PART II Other significant 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): No

FILED
MAY 7 1996
Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

FEB 22 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF THE ORIGINAL CERTIFICATE OF DEATH AS FILED WITH THE LAKE COUNTY HEALTH DEPT

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	29d DATE SIGNED (Month, Day, Year)
Zabaneh M D	010336 20	5-7-96

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Ibrahim G. Zabaneh, M.D., 6111 Harrison Street, Merrillville, Indiana 46410

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD

32 DATE FILED (Month, Day, Year): May 7, 1996

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				12 5

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.