

**SURVIVORSHIP AFFIDAVIT**

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

STATE OF INDIANA )  
                          )SS:  
COUNTY OF LAKE )

**2000 030007**

2000 MAY -3 AM 10:34

MORRIS W. CARTER  
RECORDER

On this 23RD day of OCTOBER, 1998, before me personally appeared AURORA M. RUBIO, who being duly sworn on his/her oath states the following:

1. That the Affiant is the owner of the real estate located in Lake County, State of Indiana, more particularly described as follows:  
THE NORTH 60 FEET OF LOTS 1 AND 2, BLOCK 9, SUBDIVISION OF BLOCKS 3, 4, 9 AND THE NORTH HALF OF BLOCK 10, IN THE NORTHEAST QUARTER OF SECTION 29, TOWNSHIP 37 NORTH, RANGE 9 WEST OF THE 2ND PRINCIPAL MERIDIAN, IN THE CITY OF EAST CHICAGO, AS SHOWN IN PLAT BOOK 5 PAGE 13 IN LAKE COUNTY, INDIANA.

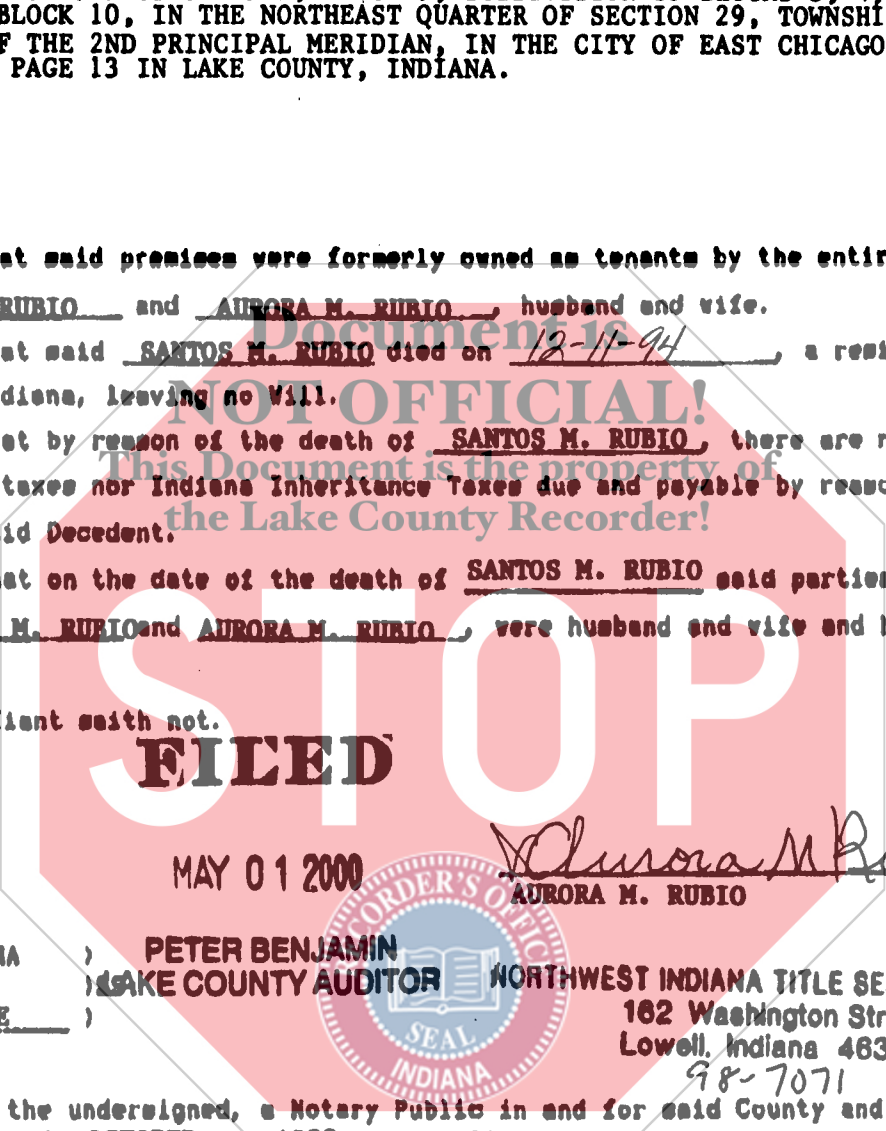
2. That said premises were formerly owned as tenants by the entirety by SANTOS M. RUBIO and AURORA M. RUBIO, husband and wife.

3. That said SANTOS M. RUBIO died on 12-11-94, a resident of Lake County, Indiana, leaving no Will.

4. That by reason of the death of SANTOS M. RUBIO, there are no Federal Estate taxes nor Indiana Inheritance Taxes due and payable by reason of the death of said Decedent.

5. That on the date of the death of SANTOS M. RUBIO said parties, namely, SANTOS M. RUBIO and AURORA M. RUBIO, were husband and wife and have not been divorced.

Further Affiant saith not.



Aurora M Rubio  
AURORA M. RUBIO

STATE OF INDIANA )  
                          )  
COUNTY OF LAKE )

PETER BENJAMIN  
LAKE COUNTY AUDITOR

NORTHWEST INDIANA TITLE SERVICES, INC.  
162 Washington Street  
Lowell, Indiana 46356  
98-7071

Before me, the undersigned, a Notary Public in and for said County and State, this 23RD day of OCTOBER, 1998, personally appeared AURORA M. RUBIO and acknowledged the execution of the foregoing affidavit.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal.

My Commission expires: 10/17/06

Linda S. Wood  
LINDA S. WOOD Notary Public

County of Residence: LAKE

This instrument was prepared by RICHARD A. ZUNICA, Attorney at Law  
162 Washington Street, Lowell, IN 46356

9871

7011  
11.00  
Jed

ATTENTION ESTATE: Disclosure of the information we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 94-400

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

PARENTS

INFORMANT

DISPOSITION

USE OF  
ATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Santos M. Rubio</b>				2. SEX <b>Male</b>	3a. TIME OF DEATH <b>3:40 a.m.</b>	3b. DATE OF DEATH (Month, Day, Year) <b>December 11, 1994</b>	
4. SOCIAL SECURITY NUMBER <b>453-38-2649</b>		5a. AGE—Last Birthday (Years) <b>68</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Mar. 19, 1926</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Italy, Texas</b>	
8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1952</b>	9. PLACE OF DEATH (Check only one. See instructions.) <b>HOSPITAL</b> <input checked="" type="checkbox"/> <b>ER/Outpatient</b> <input type="checkbox"/> <b>DOA</b> <input type="checkbox"/> <input type="checkbox"/> <b>Nursing Home</b> <input type="checkbox"/> <b>Other (Specify)</b> <input type="checkbox"/> <input type="checkbox"/> <b>Residence</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>St. Catherine Hospital</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>East Chicago</b>	9c. COUNTY OF DEATH <b>Lake</b>			
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Aurora M. Munoz</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Crane Operator</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Inland Steel Co.</b>			
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>East Chicago</b>		13d. STREET AND NUMBER <b>3938 Pulaski Street</b>			
13e. ZIP CODE <b>46312</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>Mexican</b>	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>-</b>		
18. FATHER'S NAME (First, Middle, Last) <b>Simon Rubio</b>			19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Baselia Mota</b>				
20a. INFORMANT'S NAME (Type/Print) <b>Aurora M. Rubio</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>501 W. 143rd St., E. Chgo, IND 46312</b>			20c. Relationship <b>Wife</b>		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> <b>Burial</b> <input type="checkbox"/> <b>Cremation</b> <input type="checkbox"/> <b>Removal from State</b> <input type="checkbox"/> <b>Donation</b> <input type="checkbox"/> <b>Other (Specify)</b>		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>December 14, 1994 Ridgelawn Cemetery</b>		21c. LOCATION—City or Town, State <b>Gary, Indiana</b>			
22a. EMBALMER'S NAME <b>James H. Fife</b>		22b. EMBALMER'S LICENSE NO. <b>FD01010795</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b>			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John P. Fife</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01020366</b>		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>FIFE FUNERAL HOME - FH83001512 4201 Indpls. Blvd., E. Chgo, IND</b>			
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. <b>Advanced Carcinoma Colon</b> DUE TO (OR AS A CONSEQUENCE OF)							
b. _____ DUE TO (OR AS A CONSEQUENCE OF)							
c. _____ DUE TO (OR AS A CONSEQUENCE OF)							
d. _____ DUE TO (OR AS A CONSEQUENCE OF)							
PART II: Other significant conditions - Conditions contributing to death but not necessarily stated in Part I							
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>-</b>		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> <b>CERTIFYING PHYSICIAN</b> 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"/> <b>HEALTH OFFICER</b> 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"/> <b>CORONER</b> 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 <i>Michael</i>				29c. MEDICAL LICENSE NO. <b>29782</b>		29d. DATE SIGNED (Month, Day, Year) <b>December 12, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>M.Y. Ali, M.D. - 9116 Columbia Avenue, Munster, Indiana 46321</b>							
31. HEALTH OFFICER'S SIGNATURE <i>TR</i>					32. DATE FILED (Month, Day, Year) <b>12-13-94</b>		
33. MANNER OF DEATH <input type="checkbox"/> <b>Natural</b> <input type="checkbox"/> <b>Pending Investigation</b> <input type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Could not be Determined</b> <input type="checkbox"/> <b>Homicide</b>		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED		
34a. 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.					