2

MAIL TAX BILLS TO:
3609 Hemlock
East Chicago, IN 46312

KEY # 30-289-5

2000 044900

2000 JUN 26 AM 10: 22

MORRIS W. CARTER
RECORDER

QUITCLAIM DEED

THIS INDENTURE WITNESSETH, that grantor ANA MARIA RODRIGUEZ, formerly Anna M. Roman, of Lake County in the State of Indiana, QUITCLAIMS TO:

HECTOR L. RODRIGUEZ and ERNESTO RODRIGUEZ, as joint tenants with right of survivorship, GRANTOR ANA MARIA RODRIGUEZ RETAINING A LIFE ESTATE UNTO HERSELF

of Lake County, State of Indiana, in consideration of Ten ($10.00) Dollars and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the following described real estate in Lake County, State of Indiana:

Lot 5, Block 57, in Indiana Harbor, in the City of East Chicago, as per plat thereof, recorded in Plat Book 5, page 9, in the office of the recorder of Lake Co., IN
Commonly known as 3609 Hemlock
East Chicago, Indiana 46312

Dated this 20th day of February, 2000.

Ana Maria Rodriguez
ANA MARIA RODRIGUEZ formerly
Anna M. Roman

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

JUN 20 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

STATE OF INDIANA)
COUNTY OF ~~LAKE~~ PORTER) SS:

Before me, the undersigned a Notary Public in and for said County this 20th day of February, 2000, personally appeared ANA MARIA RODRIGUEZ and acknowledged the execution of the foregoing deed. In witness whereof, I have hereunto subscribed my name and affixed my official seal.

NOTARY PUBLIC, ~~Lake~~ County, IN PORTER CO.
My Commission expires: 1-12-08

This instrument prepared by:

CARMEN A. FERNANDEZ, Indiana No. 6815-45
7207 Indianapolis Blvd., Hammond, IN 46324
219.845.9540/219.845.9908 (fax)
e-mail: carmfern@netnitco.net

21195 16.00

4305

* **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

Local No. 272 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)
Andres Rodriguez	Male	6:53a M	October 11, 1999

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)
311-36-2926	79			Nov. 5, 1919	Puerto Rico

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
No	–	HOSPITAL [X] 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
St. Catherine Hospital	East Chicago	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	Ana Avilez	Janitorial	Inland Steel Co.

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	East Chicago	3609 Hemlock 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 (Specify Black, White, etc.)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46312	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[ ] No [X] Yes Puerto Rican	White	3	–

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Emiliano Rodriguez	Juana Roman

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
Migdalia Garcia	7600 Foxwood Drive, Schererville, IN 46375	Daughter

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	October 14, 1999 Ridgelawn Cemetery	Gary, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
James H. Fife	FD01010795	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John S. Fife	FD01020366	FIFE FUNERAL HOME, INC. - FH83001512 4201 Indpls.Blvd., East Chicago, IND

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. Ventricular Fibrilation	
	DUE TO (OR AS A CONSEQUENCE OF) b. End Stage Cardiomyopathy	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) c. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF) d.	

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No	–

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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
J [signature]	J 25594	October 12, 1999

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Dr. R. Llobet, M.D. - 4320 Fir Street, East Chicago, Indiana 46312

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Mrs. Timothy Carpenter	10-14-99

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				

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.

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