



TICOR TITLE INSURANCE

2000247BT/Kudlo

AFFIDAVIT

2000 052916

STATE OF INDIANA)
COUNTY OF LAKE) SS:

HECTOR ROQUE, JR., being first duly sworn upon oath, deposes and says:

1. That RAMONA ROQUE died on March 11, 1997 at Munster.

2. That RAMONA ROQUE and HECTOR ROQUE, JR. were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 20 in Parrish Park Sixth Subdivision, in the City of Hammond, per plat thereof, recorded in Plat Book 47 page 58, in the Office of the Recorder of Lake County, Indiana.

Key # 32-247-20

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.

Further affiant sayeth not.

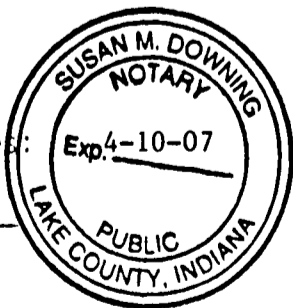


JUL 25 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

Hector Roque, Jr.
HECTOR ROQUE, JR.

Subscribed and sworn to before me, a Notary Public, this 21st day of July, 19 00.



Susan M. Downing
SUSAN M. DOWNING Notary Public

My Commission expires: Exp. 4-10-07

County of Residence:

LAKE

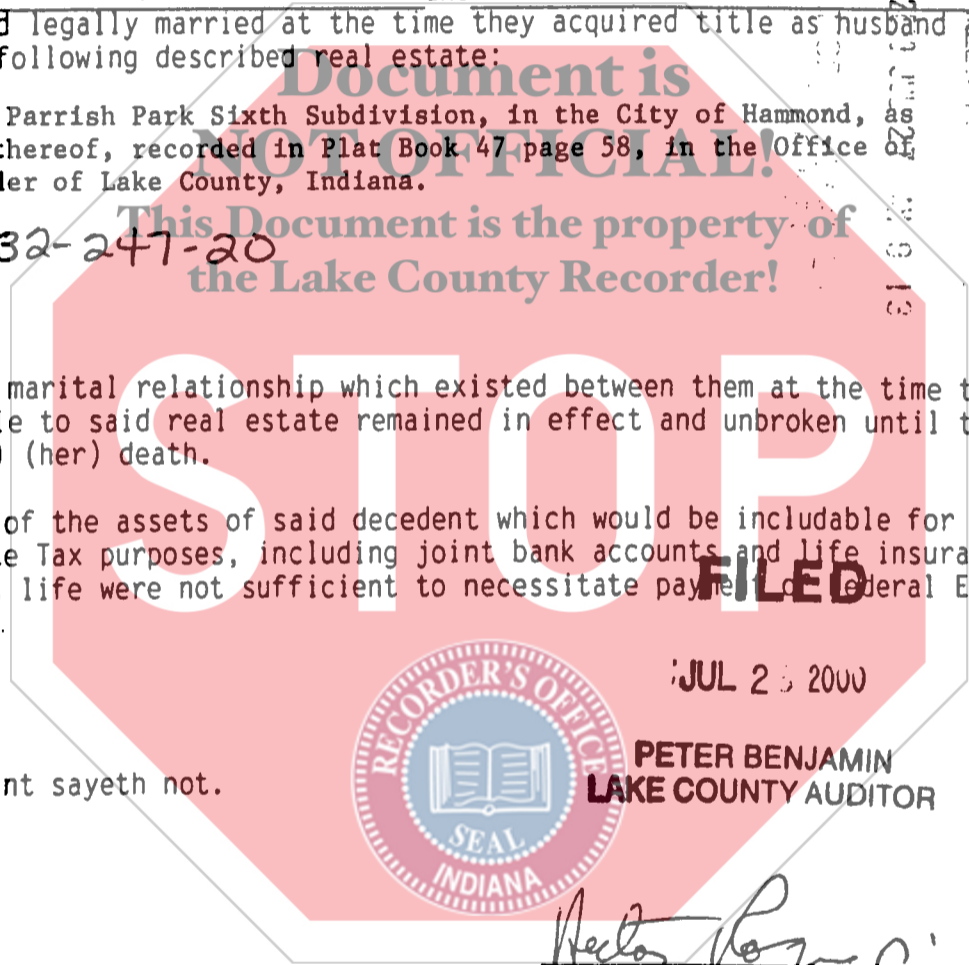
This Instrument prepared by HECTOR ROQUE, JR.

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Kudlo H/o 2000247 BT
BURNET TITLE



ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 0562-97

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

RE/PRINT IN PERMANENT INK

DECEDENT

RELIGION

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Ramona Monin Roque		2 SEX Female	3a TIME OF DEATH 1:05 P.M.	3b DATE OF DEATH (Month, Day, Year) March 11, 1997	
4 SOCIAL SECURITY NUMBER 075-28-5489	5a AGE—Last Birthday (Years) 63	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month, Day, Year) May 11, 1933	
7 BIRTHPLACE (City and State or Foreign Country) Villalba, Puerto Rico	8a WAS DECEDENT A U.S. VETERAN? No				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? -----	8c PLACE OF DEATH (Check only and See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9a FACILITY NAME (If not institution, give street and number) The Community Hospital		9b CITY TOWN OR LOCATION OF DEATH Munster		9c COUNTY OF DEATH Lake Co.	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Hector Roque Jr.	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Administrative Assistant		12b KIND OF BUSINESS/INDUSTRY Social Services	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 7447 Idaho Street		
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) Puerto Rican	16 RACE—American Indian, Black, White, etc. (Specify) White	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary 10-12 College (1-4 or 5-)		+2		
18 FATHER'S NAME (First, Middle, Last) Jose Menendez		19 MOTHER'S NAME (First, Middle, Last) Eufemia Villafane			
20a INFORMANT'S NAME (Type/Print) Hector Roque Jr.		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7447 Idaho Street Hammond, Indiana 46323		20c Relationship Husband	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) -----		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) March 14, 1997 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Scherville, Indiana	
22a EMBALMER'S NAME Ronald J. Mesarch		22b EMBALMER'S LICENSE NO. FD01005912	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert A. Craig</i>		24b LICENSE NUMBER (of Licensee) FD08700735	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83007762 7905 Broadway Merrillville, IN 46410		
26 PART I (Enter the diseases, injuries, or conditions 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. <u>Hepatomegaly with ascites, bilateral plural effusion</u>				Approximate Interval Between Onset and Death Unknown	
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 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) Yes	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes		
29a CERTIFIER (Check only one) <input 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 checked="" 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 <i>[Signature]</i> Deputy		29c MEDICAL LICENSE NO. N/A	29d DATE SIGNED (Month, Day, Year) March 17, 1997		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Donna Me Lyon, Deputy Coroner, 2290 North Main Street, Crown Point, Indiana, 46307					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander D. Johnson, M.D.</i>			32 DATE FILED (Month, Day, Year) March 17, 1997		
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		33a DATE OF INJURY (Month, Day, Year)	33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)	33d DESCRIBE HOW INJURY OCCURRED THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH AS FILED WITH THE LAKE COUNTY HEALTH OFFICE.
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34b LOCATION (Street, City, or Rural Route Number, City or Town, State)			
34c DATE PRONOUNCED DEAD (Month, Day, Year) March 11, 1997		34d MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. No			