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STATE OF INDIANA)
)
COUNTY OF LAKE)

In Re: Vera E. Castillo, Deceased, January 7, 2001
SS :

2002 068110

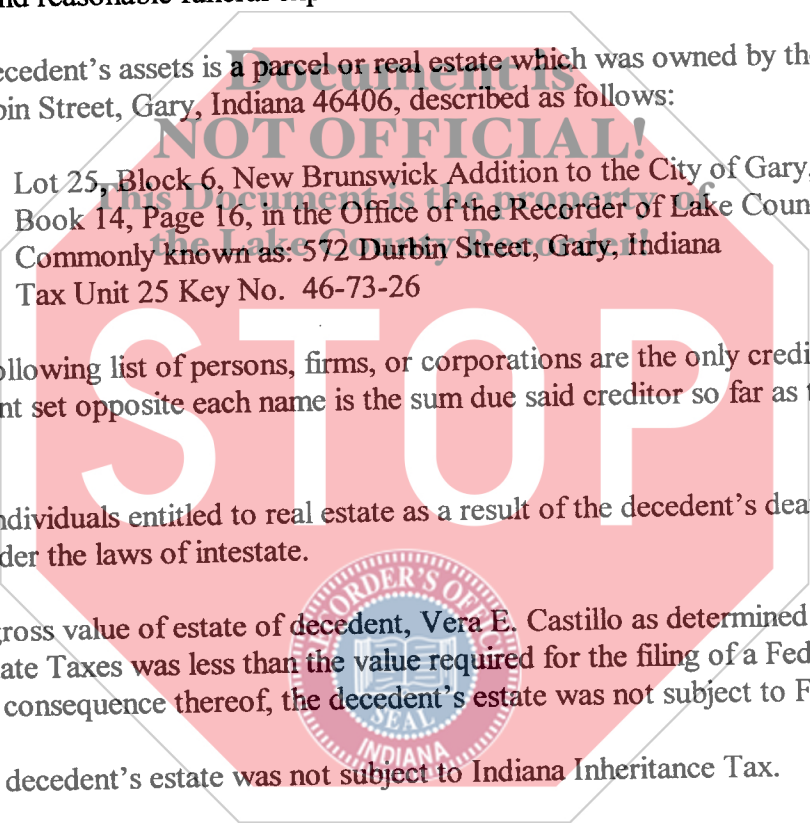
Affidavit For Transfer of Real Property

1. That the above named decedent died intestate on date.
2. That forty-five (45) days have elapsed since the death of decedent.
3. That no application or petition for the appointment of personal representation is pending or has been granted in any jurisdiction, nor is any administration contemplated.
4. That the following named person is the legal heir of decedent: Benito Castillo, Husband, 2239 Wheeler Street, Gary, Indiana 46406
5. That the value of the decedent's estate does not exceed the sum of the allowance provided by IC 29-8:1 and reasonable funeral expenses.

6. That the decedent's assets is a parcel or real estate which was owned by the decedent, located at 572 Durbin Street, Gary, Indiana 46406, described as follows:

Lot 25, Block 6, New Brunswick Addition to the City of Gary, as shown in Plat Book 14, Page 16, in the Office of the Recorder of Lake County, Indiana.
Commonly known as: 572 Durbin Street, Gary, Indiana
Tax Unit 25 Key No. 46-73-26

7. That the following list of persons, firms, or corporations are the only creditors of the estate and the amount set opposite each name is the sum due said creditor so far as the same is:
NONE
8. That the individuals entitled to real estate as a result of the decedent's death is the heir at law provided under the laws of intestate.
9. That the gross value of estate of decedent, Vera E. Castillo as determined for purposes of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return. As consequence thereof, the decedent's estate was not subject to Federal Estate Tax.
10. That the decedent's estate was not subject to Indiana Inheritance Tax.



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EXHIBIT A
SURVIVORSHIP AFFIDAVIT

RE: Vera E. Castillo, deceased, January 7, 2001
Legal: Lot 25, Block 6, New Brunswick Addition
To Gary, as shown in Plat Book 14, Page 16,
In Lake County, Indiana (25-46-73-26)

STATE OF INDIANA)

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SS:

COUNTY OF LAKE)

On this 8th day of July, 2002 before me personally appeared Benito Castillo, me personally known, who being duly sworn on oath did say that:

- Affiant resides at the address given below Affiant's signature:
- Affiant is Heir, Husband of decedent(s), owner
(Interest of Affiant in the above premises as "owner" "heir of owner" etc.)
- Said premises were formerly owned by Benito Castillo and Vera E. Castillo, husband and wife.
- Said Vera E. Castillo, deceased January 7, 2001, intestate, domiciled in Lake County, Indiana.
- The total value of the taxable estate of said deceased including, tenancies by entireties individual ownerships of both real and personal property, and insurance does not exceed the sum of \$25,000.00, and to the best of Affiant's knowledge there is no Inheritance tax liability by reason of the death of said decedent;
- Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?
No (if yes identify the divorce proceedings: N/A _____);
- Affiant's relationship to the deceased was Husband.

State of Indiana

:SS

County of Lake

Signature Benito Castillo

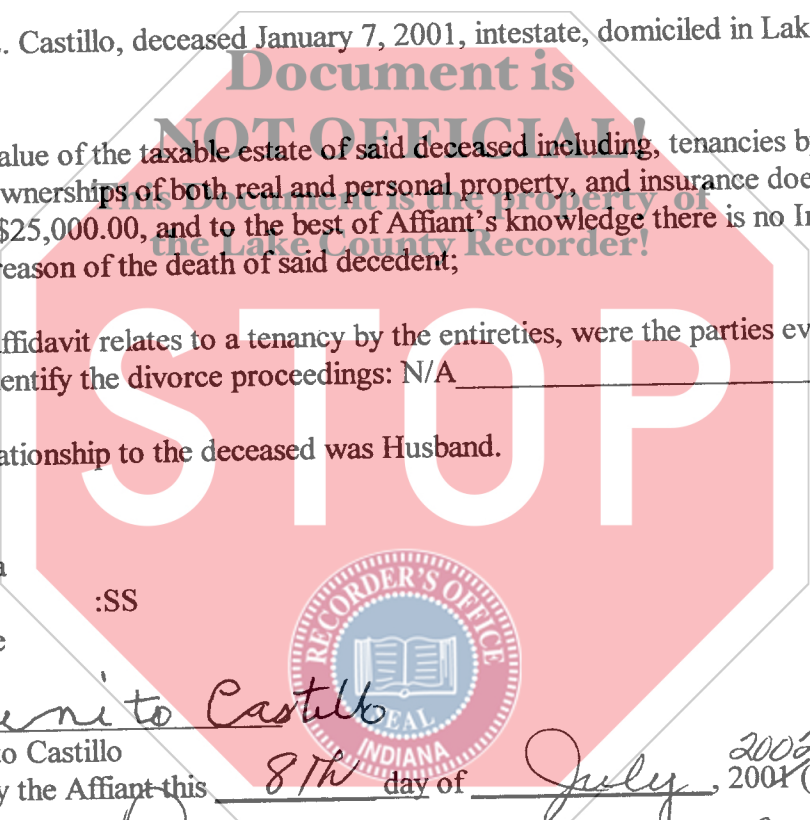
Benito Castillo

to before me by the Affiant this 8th day of July, 2002 (year)

Notary

My Commission expires: 12-13-2009

County of Lake



* 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

THIS CERTIFICATE THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

CERTIFICATE OF DEATH

SJDA 11/2001 Date Issued Hammond Health Commissioner

Local No. 18

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

#526293 TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) VERA E. CASTILLO			2 SEX Female		3a TIME OF DEATH 11:45^a M		3b DATE OF DEATH (Month Day Year) January 7, 2001	
4 *SOCIAL SECURITY NUMBER 523-22-8561		5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) Mar. 12, 1921		7 BIRTHPLACE (City and State or Foreign Country) Denver, Colorado	
8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b FACILITY NAME (If not institution, give street and number) Walnut Creek Nursing Home				9c CITY TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Benito Castillo		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife		12b KIND OF BUSINESS/INDUSTRY N/A		
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY TOWN OR LOCATION Gary		13d STREET AND NUMBER 2239 Wheeler St.		
13e ZIP CODE 46406		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.) Mexican		16 RACE—American Indian Black White etc (Specify) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)
18 FATHER'S NAME (First, Middle, Last) Luis DeLaCruz				19 MOTHER'S NAME (First, Middle, Maiden Surname) Margaret				
20a INFORMANT'S NAME (Type/Print) Benito Castillo				20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 2239 Wheeler St. Gary, In 46406			20c Relationship Husband	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input 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) January 11, 2001 Chapel Lawn Cemetery			21c LOCATION—City or Town State Schererville, Indiana		
22a EMBALMERS NAME Anthony S. Rendina Jr.			22b EMBALMER'S LICENSE NO FD01010402		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr.</i>			24b LICENSE NUMBER (of Licensee) FD01010402		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home FH83007810 5100 Cleveland St. Gary, In 46406			
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not use 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) Conditions of any, which gave rise to the immediate cause, stating the underlying cause last a Diabetes Mellitus b Sepsis c 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) 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	
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 <i>Sirajuddin Khays</i>					29c MEDICAL LICENSE NO 01032657		29d DATE SIGNED (Month Day Year) 1/8/01	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr Sirajuddin S. Khays MD 920 Fran Ln Parkway Munster IN 46321								
31 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Premuda M.D.</i>						32 DATE FILED (Month Day Year) January 11, 2001		
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 DESCRIBE HOW INJURY OCCURRED			
		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				