STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2004 100482

2004 NOV 30 AM 11:50

MORRIS W. CARTER
RECORDER

3

Deceased Joint Tenancy Affidavit
Cover Sheet

OTS# 4324-0115

STOP

O'Connor Title Services, Inc
162 West Hubbard Street
Chicago, IL 60610

RECORDER'S OFFICE
INDIANA

FILED
NOV 24 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

13.00
ZP

1930 27441

DECEASED JOINT TENANCY AFFIDAVIT
O'CONNOR TITLE COMPANY

State of Indiana)
) S.S.
County of Lake)

DECEASED JOINT TENANCY AFFIDAVIT

Celia F. Razo being duly sworn states that
She resides at 7431 Jarnecke Avenue, Hammond, Lake County, IN 46324
That She was acquainted with Manuel Razo
Deceased who, at the time of His death, was one of the owners of the land in Lake County, Indiana, described as:

The South 7 feet of Lot 9 and the North 34 feet of Lot 10 in Block 5 in Ford-Roxana Addition to Hammond, as per Plat thereof, recorded in Plat Book 20 page 23, in the Office of the Recorder of Lake County Indiana.

P.I.N #26-33-0095-0010
That the deceased died November 10, 2000, as evidenced by a Certified Copy of Death Certificate of the deceased attached hereto.
That the deceased died:
X Leaving no Last Will & Testament
____ Leaving a Last Will & Testament, a copy of which is attached hereto. The Original of the Unproven Will should be filed with the Clerk of the Probate Division of the Circuit Court of _____ County, Indiana.
____ Leaving a Last Will & Testament, which was filed, in the Unproven Will Box of the Probate Division of the Circuit Court of _____.

That the total value of the Estate of the deceased, including both Real and Personal Property owned by the deceased either individually or in Joint Tenancy at the time of the death of the deceased, does not exceed the sum of $_____ Dollars.

Affiant makes this affidavit for the purpose of inducing the Real Estate Index to issue its Title Insurance Policy describing the above-mentioned property.

Subscribed and sworn to before me by the said:

this 1 day of Nov. A.D. 2004

Notary Public
Commission expires 7/9/2006

Celia F. Razo

FILED
NOV 24 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

001930

* 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.

Local No. 906

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

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

Nov 13, 2000 Date Issued — Franklin D Grenada MD Hammond Health Commissione

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.)
MANUEL	RAZO	Male	10:00 PM	November 10, 2000

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)
317-16-7191	74			August 12, 1926	San Antonio, Texas

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)
Yes	1946	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
7431 Jarnecke Avenue	Hammond	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	Celia Flores	Steel Worker	Inland Steel Co.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	7431 Jarnecke Avenue

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.	Mexican	White	12th	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Louis Razo	Martina Villanueva

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
Celia Razo	7431 Jarnecke Ave., Hammond, Indiana 46324	Wife

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)	November 14, 2000 St. John Cemetery	Hammond, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Dean G. Wagner	8800057	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Dean L Wagner	8800057	Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN. 46324

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 Metastatic Cancer	1 year
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	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)	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	N/A

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) as stated and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
	01047256	11-13-00 (November)

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)		31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
G. Jano, M.D. 7905 Calumet Ave., Munster, IN. 46321	219-836-5800	Franklin D Grenada M.D.	November 13, 2000

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.

SDH06-004 State Form 10110 (R5/1-99)