

STATE OF INDIANA)
COUNTY OF LAKE)

) SS: 2005 044396

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2005 JUN -1 AM 9:02

MICHAEL A. E. JONK
RECORDER

3

AFFIDAVIT OF JOHN GALLO

Comes now John Gallo who now states under the penalties for perjury the following:

1. That the affiant herein, John Gallo, is the Personal Representative of the unsupervised estate of Yassimo Gallo, which estate is pending under Cause Number 45C01-0211-EU-133.
2. That the Decedent, Yassimo Gallo, passed away on the 31st day of August, 2002, a resident of Lake County, Indiana. Affiant attaches a copy of Decedent's death certificate marked as Exhibit A.
3. That Decedent, Yassimo Gallo, is also known as Jiassimo Gallo, as evidenced in a Deed of Conveyance in which the Decedent took title, along with her husband, Nunzio Gallo, to real estate commonly known as 4445 Madison Street in Gary, Lake County, Indiana. *45-206-12*
4. That Yassimo Gallo is the same person as Jiassimo Gallo in a deed of conveyance dated July 26, 1973 which deed was recorded in the Lake County Recorder's Office on August 2, 1973 and was Document No. 214158. The Affiant herein, John Gallo, makes this affidavit for the purpose of evidencing the fact that Yassimo Gallo is one and the same person as Jiassimo Gallo.

Affiant further sayeth naught.

FILED

MAY 31 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

John Gallo

JOHN GALLO, AFFIANT

BURNET TITLE
20050491

TICOR TITLE INSURANCE
2050-45TH AVE.
HIGHLAND, IN 46322

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LP
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STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Subscribed and sworn to before me, a Notary Public, this 23rd day of May, 2005.



Notary Public Corina Castel Ramos
Printed Name: _____
County of Residence: Lake

My Commission Expires:

5/16/09



INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

* 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. **02 0546**
503313

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) YASSIMO GALLO				2. SEX Female		3a. TIME OF DEATH 7:49a.M		3b. DATE OF DEATH (Month, Day, Yr.) August 31, 2002							
4. *SOCIAL SECURITY NUMBER 314-60-1001		5a. AGE—Last Birthday (Years) 83		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) Jan. 30, 1919		7. BIRTHPLACE (City and State or Foreign Country) Greece					
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 checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence											
9b. FACILITY NAME (If not institution, give street and number) Methodist Northlake Campus						9c. CITY, TOWN, OR LOCATION OF DEATH Gary			9d. COUNTY OF DEATH Lake						
10. MARITAL STATUS (Specify) Widowed		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) Housewife				12b. KIND OF BUSINESS/INDUSTRY							
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION GARY			13d. STREET AND NUMBER 4445 Madison St.								
13e. ZIP CODE 46408		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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 					
18. FATHER'S NAME (First, Middle, Last) Themostokis Diakoyannis						19. MOTHER'S NAME (First, Middle, Maiden Surname) Katerina									
20a. INFORMANT'S NAME (Type/Print) John Gallo				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 Taft Pl. Merrillville, In				20c. Relationship Son							
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) Sept. 4, 2002 St. John Cemetery				21c. LOCATION—City or Town, State Hammond, Indiana							
22a. EMBALMER'S 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 FH83007819 5100 Cleveland St. Gary, In 4640									
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. myocardial infarction coronary artery disease										Approximate Interval Between Onset and Death					
PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I. hypertension osteoarthritis										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)	
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 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>Michael J...</i>						29c. MEDICAL LICENSE NO. 1026067A			29d. DATE SIGNED (Month, Day, Year) 9/6/02						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 5490 Broadway Merrillville, IN 46410															
31. HEALTH OFFICER'S SIGNATURE <i>Michael J...</i>										32. DATE FILED (Month, Day, Year) SEP 06 2002					
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)													
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no)											

EXHIBIT
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