TICOR TITLE INSURANCE

2005 051699

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

GEORGIA CHAVEZ, being first duly sworn upon oath, deposes and says:

1. That CESAR A CHAVEZ JR died on JANUARY 29, 2001, 20 at COMMUNITY HOSPITAL, MUNSTER, IN

2. That CESAR A CHAVEZ JR and GEORGIA CHAVEZ were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 89 IN CORRECTED PLAT OF LAWNDALE GARDENS 4TH ADDITION TO GRIFFITH, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 35 PAGE 69, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

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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.

GEORGIA CHAVEZ

Subscribed and sworn to before me, a Notary Public, this 8th day of JUNE, 20 05.

RACHEL C LENTZ Notary Public

My Commission expires: 11/02/2011

County of Residence: LAKE

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
JUN 17 2005
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2005 JUN 23 MICHAEL A. BROWN RECORDER

TICOR TITLE INSURANCE Crown Point, Indiana

This Instrument prepared by CATHERINE L GONZALEZ, VICE PRESIDENT, RETAIL LENDING

Ticor Title recorded this document as an accommodation. Ticor did not examine the document or the title of the real estate affected.

61455

Return: Peoples Bank

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. 2949 939-01

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last): CESAR ARMANDO CHAVEZ JR.
2. SEX: MALE
3a. TIME OF DEATH: 10:38 AM
3b. DATE OF DEATH (Month, Day, Yr): JANUARY 29, 2001
4. SOCIAL SECURITY NUMBER: 465-84-9490
5a. AGE—Last Birthday (Years): 49
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): SEPTEMBER 5, 1951
7. BIRTHPLACE (City and State or Foreign Country): ELPASO, TEXAS
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 ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): GEORGIA HEDGER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CRANE OPERATER
12b. KIND OF BUSINESS/INDUSTRY: STEEL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: GRIFFITH
13d. STREET AND NUMBER: 1029 N. ARBOGAST
13e. ZIP CODE: 46319
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☐ No ☒ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): MEXICAN
16. RACE—American Indian, Black, White, etc. (Specify): MEXICAN
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): CESAR CHAVEZ
19. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE QULLAR

INFORMANT

20a. INFORMANT'S NAME (Type/Print): GEORGIA CHAVEZ
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1029 N. ARBOGAST GRIFFITH, IN. 46319
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 2, 2001 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME: MARC J. MOSQUEDA
22b. EMBALMER'S LICENSE NO: FD08800240
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01006015
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH83002754 ... 242 N. GRIFFITH BLVD. GRIFFITH, IN.

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STOP

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. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Valvular heart disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE ... LAKE COUNTY HEALTH DEPT.
FEB 0 1 2001

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

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) and manner as stated
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO: 01033200
29d. DATE SIGNED (Month, Day, Year): 1/31/01
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. E. FARA 761 45th St. Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature], M.D.
32. DATE FILED (Month, Day, Year): February 1, 2001

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

(2)

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