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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 071758

2006 AUG 17 AM 9:55

W. S. ... DOWN
RECORDER

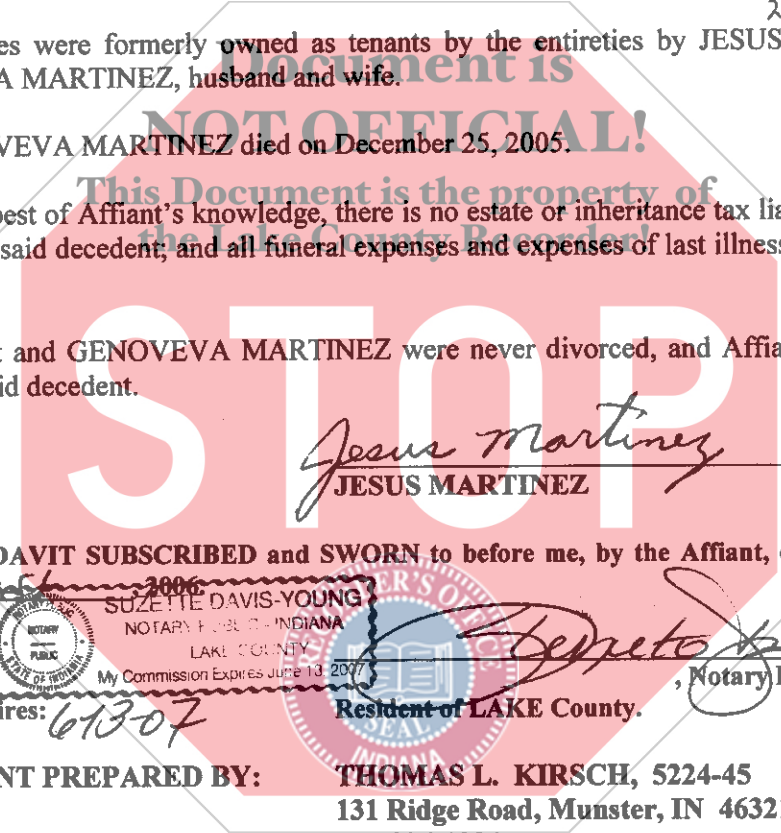
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SURVIVORSHIP AFFIDAVIT

On the 9 day of August, 2006, before me personally appeared JESUS MARTINEZ to me personally known, who being duly sworn upon oath, did say that:

1. Affiant resides at 818 Drackert Street, Hammond, IN 46320.
2. Affiant is the owner of the following described property:

Lots 12, 13 and the West half of Lot 14, Block 7, Oakland Addition, in the City of Hammond, as shown in Plat Book 6, page 35, in Lake County, Indiana. 26-35-0174-0012 & 26-35-0174-0013
3. Said premises were formerly owned as tenants by the entireties by JESUS MARTINEZ and GENOVEVA MARTINEZ, husband and wife.
4. Said GENOVEVA MARTINEZ died on December 25, 2005.
5. That to the best of Affiant's knowledge, there is no estate or inheritance tax liability by reason of the death of said decedent, and all funeral expenses and expenses of last illness have been paid in full.
6. That Affiant and GENOVEVA MARTINEZ were never divorced, and Affiant is the surviving spouse of said decedent.



Jesus Martinez
JESUS MARTINEZ

THIS AFFIDAVIT SUBSCRIBED and SWORN to before me, by the Affiant, on this 9 day of

August, 2006

SUZETTE DAVIS-YOUNG
NOTARY PUBLIC - INDIANA
LAKE COUNTY
My Commission Expires June 13, 2007

Suzette Davis-Young
Notary Public

My Commission Expires: 6/13/07

Resident of LAKE County.

THIS INSTRUMENT PREPARED BY:

THOMAS L. KIRSCH, 5224-45
131 Ridge Road, Munster, IN 46321 **15380**
219-836-1384

I affirm under the penalties for perjury that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

Thomas L. Kirsch

FILED

AUG 16 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

*1300 DU
23435 R*

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

CERTIFICATE OF DEATH

Dec 28, 2005 Date Issued *[Signature]* Hammond Health Commissioner

Local No. 840

Key# 35-174-12 + 13

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Genoveva Martinez		2. SEX Female	3a. TIME OF DEATH 12:32p	3b. DATE OF DEATH (Month, Day, Yr.) December 25, 2005
4. *SOCIAL SECURITY NUMBER 465-36-4327	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) Dec. 6, 1926
7. BIRTHPLACE (City and State or Foreign Country) San Benito, Texas	8a. WAS DECEDENT A U.S. VETERAN? No			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c. PLACE OF DEATH (Check only one. 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) Select Specialty Hospital		9b. CITY, TOWN, OR LOCATION OF DEATH Hammond	9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Jesus Martinez	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond		13d. STREET AND NUMBER 818 Drackert Street
13e. ZIP CODE 46320	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) 8 College (1-4 or 5+) -		18. FATHER'S NAME (First, Middle, Last) Guadalupe Longoria		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Petra Redon		20a. INFORMANT'S NAME (Type/Print) Jesus Martinez		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 Drackert Street, Hammond, IND 46320		20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) December 30, 2005 Elmwood Cemetery		21c. LOCATION—City or Town, State Hammond, Indiana
22a. EMBALMER'S NAME James H. Fife		22b. EMBALMER'S LICENSE NO. FD01010795	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John P. Fife</i>		24b. LICENSE NUMBER (of Licensee) FD01020366	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FIFE FUNERAL HOME, INC. - FH83001512 4201 Indpls. Blvd., East Chicago, IND	
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. FUNGEMIA DUE TO (OR AS A CONSEQUENCE OF) b. MULTIPLE ABDOMINAL SURGERIES DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) 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) N/A	
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>[Signature]</i> M.D. INDIANA			29c. MEDICAL LICENSE NO. 01055426A	29d. DATE SIGNED (Month, Day, Year) 12/27/05 (December)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26b) (Print) Rajarajeswari Majety 505 HOFFMAN AVE HAMMOND IN 46321				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) December 28, 2005
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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.				