3

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

BT 600357

On this ___ 9-15-06___ before me personally appeared _____
(insert date)
_____Rose Martinez_____

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:

2. Affiant is ____Owner_____
(state interest of affiant in the above premises as "owner"," son of owner", etc.

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by __Gines Martinez_____ and __Rose Martinez_____;

4. Said __Gines Martinez_____
(fill in name of co-tenant who died)
died on _____

leaving _____ will;
(insert "a" or "no"; if will left, attach a copy

5. The legal description of the premises in question is:

Lot 11, Block 9, Meadowdale Subdivision as recorded in Plat Book 31, Page 52 in the Office of the Recorder of Lake County, Indiana.

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? ☐ Yes ☐ No

If yes, then estimated taxes due are $_____

The taxes due are ☐ paid or ☐ unpaid..

2006 0833369

2006 SEP 22 AM 9:31

MICHAEL A. BROWN
RECORDER

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

FILED

SEP 21 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

(1)

018798

$16
CT
CPF

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? _____

(If answer is "Yes" , identify the divorce proceedings:

_____):

8. Affiant's relationship to the deceased was ____spouse Rose Martinez

Signature: P.O.A Joseph Martinez her P.O.A

Printed Name_Rose Martinez____

Address: __5440 Lincoln Street

_____ Merrillville, IN 46410

Subscribed and sworn to before me by the affiant

This _____9/15/06_____
(insert date)

_____
Notary Public

Printed Name____ Star Lugar _____

My County of Residence is:___ Lake _____

In the State of __Indiana_____

My Commission Expires ____ 6/25/07 _____

This instrument prepared by ___Rose Martinez_____

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

Local No. 2018-93

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

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.)
GINES	MARTINEZ	MALE	8:15 PM	AUGUST 18, 1993

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)
306-09-5320	75			Oct. 27, 1917	Spain

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	1945	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
THE COMMUNITY HOSPITAL	MUNSTER	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
		Stocker	Sheet & Tin Corp

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
IN.	Lake	Merrillville	5440 Lincoln Ave.

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)	
46410	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☐ No ☒ Yes	White	Elementary/Secondary (0-12): 8	College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Antonio Martinez	Adelaida Ramirez

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
Rose Martinez	5440 Lincoln Merrillville, IN. 46410	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)	August 21, 1993 Calumet Park	Merrillville, IN.

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
David Semplinski	FD08600686	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Robert J. Wiatrolik	FD01001293	FH300445 Stilinovich & Wiatrolik 7535 Taft Merrillville, IN.

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.	cerebral vascular accident	3 days.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF) b.	triple carotid comp artery stenosis	25 years.
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)	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	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Fred Adler M.D.	018799	AUGUST 19, 1993

FILED
SEP 21 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)			
DR. FRED ADLER, M. D.	800 MACARTHUR BLVD.	MUNSTER, INDIANA	46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander Indiana, MD	Aug 23, 1993

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.