

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 53 in \_\_\_\_\_  
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 \$ \_\_\_\_\_

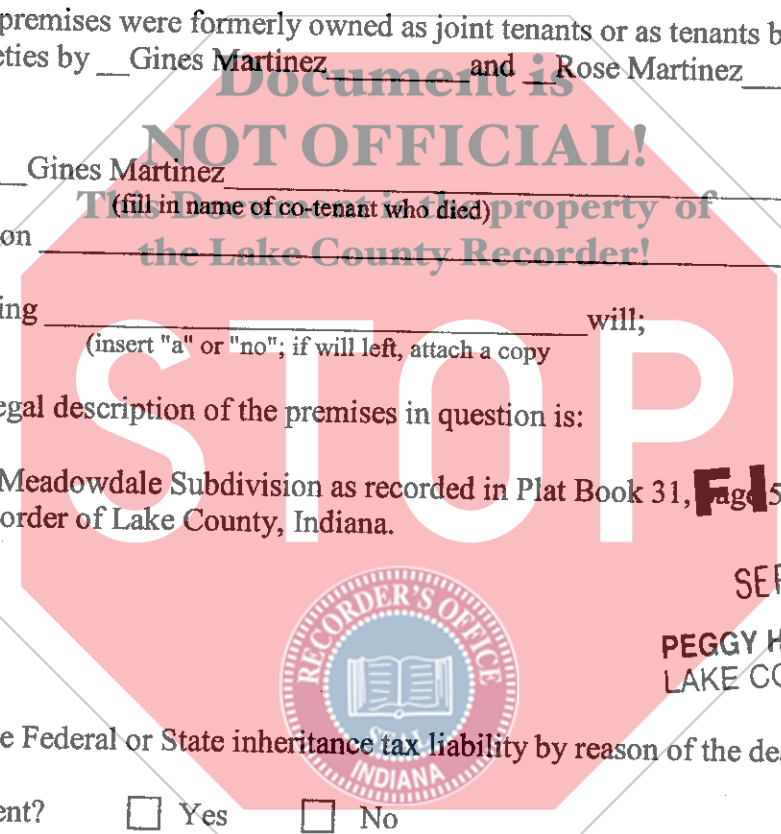
The taxes due are  paid or  unpaid..

2006 083369

2006 SEP 22 AM 9:31

MICHAEL A. JOWAN  
RECORDER

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD



**FILED**

SEP 21 2006

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR



018798

\$16  
CT  
CAP

CHICAGO TITLE INSURANCE COMPANY

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: Joseph Martinez *hus 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)

[Signature]  
Notary Public  
Printed Name Star Lugar

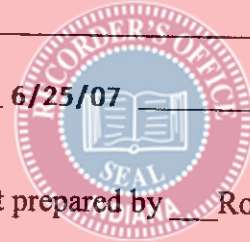
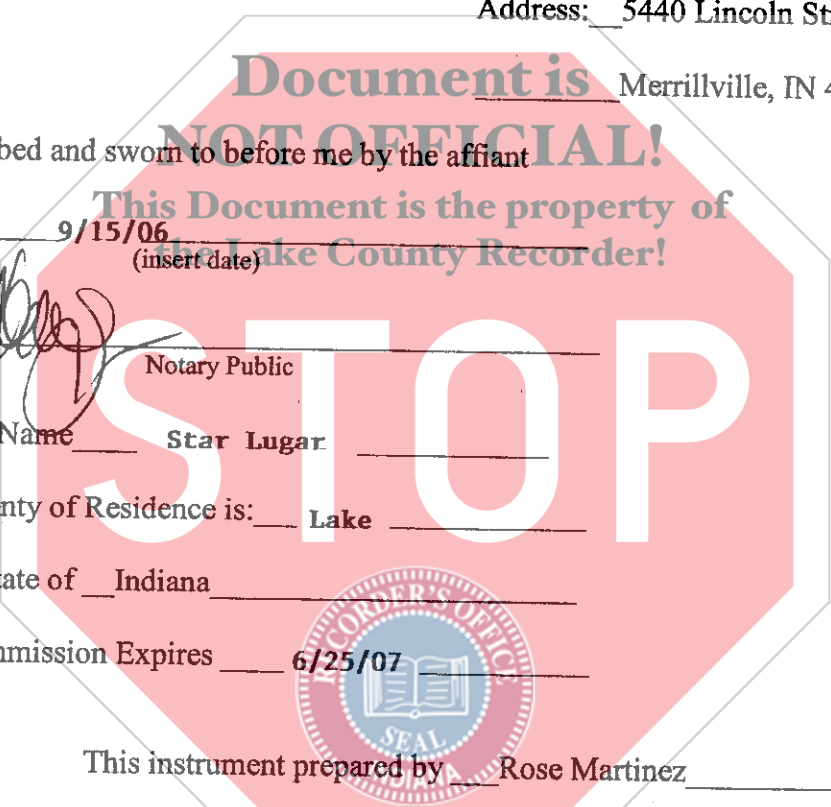
My County of Residence is: Lake

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**



INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2018-93

State No. \_\_\_\_\_

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) <b>GINES MARTINEZ</b>		2. SEX <b>MALE</b>	3a. TIME OF DEATH <b>8:15 P.M.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>AUGUST 18, 1993</b>
4. SOCIAL SECURITY NUMBER <b>306-09-5320</b>	5a. AGE—Last Birthday (Years) <b>75</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>Oct. 27, 1917</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Spain</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>	9a. 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	
9b. FACILITY NAME (If not institution, give street and number) <b>THE COMMUNITY HOSPITAL</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>		9d. COUNTY OF DEATH <b>LAKE</b>
10. MARITAL STATUS (Specify) <b>Wife</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Rose Martinez</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Stocker</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Sheet &amp; Tin Corp</b>
13a. RESIDENCE—STATE <b>IN.</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Merrillville</b>		13d. STREET AND NUMBER <b>5440 Lincoln Ave.</b>
13e. ZIP CODE <b>46410</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) <b>Antonio Martinez</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Adelaida Ramirez</b>		20a. INFORMANT'S NAME (Type/Print) <b>Rose Martinez</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5440 Lincoln Merrillville, IN. 46410</b>		20c. Relationship <b>Wife</b>		
21a. METHOD OF DISPOSITION <input checked="" 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) <b>August 21, 1993 Galumet Park</b>		21c. LOCATION—City or Town, State <b>Merrillville, IN.</b>
22a. EMBALMER'S NAME <b>David Semplinski</b>		22b. EMBALMER'S LICENSE NO. <b>FD08600686</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Robert Stilianovich</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01001293</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Stilianovich &amp; Wiatrolik 7535 Taft Merrillville, IN. FH300445</b>
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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. <i>Arterial aneurysm rupture</i> DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death <b>3 days</b>
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. <i>Trip to Paris, France</i> DUE TO (OR AS A CONSEQUENCE OF)		<b>25 years</b>
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) <b>NO</b>
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>Peggy Hoisinga Katona</i>		29c. MEDICAL LICENSE NO. <b>PEGGY HOISINGA KATONA</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUGUST 19, 1993</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>DR. FRED ADLER, M. D. 800 MACARTHUR BLVD. LAKE COUNTY AUDITOR MUNSTER, INDIANA 46321</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Fred Adler, M.D.</i>		32. DATE FILED (Month, Day, Year) <b>Aug 23, 1993</b>		
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, work, or other building, etc. (Specify) <b>018799</b>		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.		

