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STATE OF INDIANA)

COUNTY OF LAKE)

2011 SS: 070705

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2011 DEC -8 AM 10:13

MICHAEL J. HAN
RECORDER

SURVIVOR'S AFFIDAVIT

Comes now Connie Tina Marie Casas fka Connie Tina Marie Glorioso and states under oath that she is the biological daughter of Giuseppe Glorioso aka Joe Glorioso, who died on the 8th day of February, 2005 at 1:34 a.m., as shown by the attached Certificate of Death. This Affidavit is filed for the sole purpose of filing a personal representative's Deed regarding the following described real estate in Lake County, State of Indiana, to wit:

Lot 10, Block 11, Meadowdale Subdivision, as shown in Plat Book 31, page 52, in Lake County, Indiana

Tax mail

Commonly known as 5500 Pierce Street in Merrillville, Indiana 46410-1973

Key #45-12-04-128-018.000-031

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Connie Tina Marie Casas

Connie Tina Marie Casas

State of Indiana)

County of Lake)

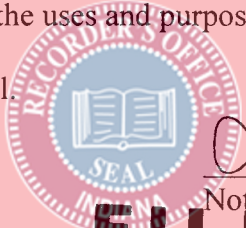
SS:

"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."

PREPARED BY: *[Signature]*

On this 1st day of December, 2011, before me, the undersigned, a Notary Public in and for said County and State, personally appeared Connie Tina Marie Casas and acknowledged the execution of said Survivor's Affidavit to be her voluntary act and deed for the uses and purposes expressed therein.

WITNESS my hand and official seal.



[Signature]

Notary Public

FILED

DEC 08 2011

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

AMOUNT \$ 13⁰⁰
CASH _____ CHARGE _____
CHECK # 5580
OVERAGE _____
COPY _____
NON-COM _____
CLERK 127

004725

NOTICE: The Social Security # is requested by this state agency in order to fulfill its statutory responsibility. Disclosure is required and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

File No. 426-05

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

1. DECEASED—NAME (First, Middle, Last) GIUSEPPE GLORIOSO		2. SEX MALE	3a. TIME OF DEATH 1:34a.m.	3b. DATE OF DEATH (Month, Day, Yr.) February 8, 2005	
4. *SOCIAL SECURITY NUMBER 312-05-5267	5a. AGE—Last Birthday (Years) 89	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr.) Mar. 15, 1915	
7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana		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 type="checkbox"/> Inpatient <input checked="" 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) St. Mary Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Hobart		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Nancy Fesi	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker		12b. KIND OF BUSINESS/INDUSTRY U.S. Steel Co.	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Merrillville		13d. STREET AND NUMBER 5500 Pierce St.	
13e. ZIP CODE 46410	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? 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) 12 College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) Giuseppe Glorioso			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Concetta DiPaola		20a. INFORMANT'S NAME (Type/Print) Nancy Glorioso			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5500 Pierce St. Merrillville, In		20c. Relationship Wife			
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) Feb. 12, 2005 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, 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 46408		
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) Cardiopulmonary Arrest				Approximate Interval Between Onset and Death	
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. CAD, Pernicious Anemia, HTN, Alzheimer's Disease, Parkinsonism					
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 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>		29c. MEDICAL LICENSE NO. 01053737A	29d. DATE SIGNED (Month, Day, Year) 2-10-05		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 2640 Hamstrom Rd. Portage IN 46368 Samir Saxena M.D.					
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>			32. DATE FILED (Month, Day, Year) APR 20 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.			

