STATE OF INDIANA )
)SS:
COUNTY OF LAKE )

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 055884

2013 JUL 30 PM 3:03

MICHAEL B. BROWN
RECORDER

**AFFIDAVIT OF SURVIVORSHIP**

Comes now Lucille Yanez, and upon being duly sworn does attest and say:

1. That the affiant is the daughter of Armando Yanez, deceased and Remedios Yanez, deceased.

2. That Lucille Yanez, Armando Yanez and Remedios Yanez, acquired the following property as Joint Tenants with Rights of Survivorship.

   Lots 1 and 2, Block 2, Yonan Air-Park Homesites, City of Lake Station, as shown in Plat Book 27, page 22, Lake County, Indiana.

   Commonly known as: 1919 Riverlane Dr., Lake Station, IN 46405
   Parcel No.: 45-09-20-102-001.000-021

3. That Armando Yanez died on the 18th day of April, 2003.

4. That Remedios Yanez died on the 1st day of October, 2005.

5. That Lucille Yanez became the fee simple owner of the property at the death of both Armando Yanez and Remedios Yanez.



I affirm under the penalties for perjury that the foregoing statements are true.

Lucille Yanez

STATE OF INDIANA )
COUNTY OF LAKE )SS:

Subscribed and sworn to before me this 29th day of July, 2013.

My Commission
Expires: 08/09/2020

Christopher L. Ray, Notary Public
Resident of Lake County

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.

Christopher L. Ray

*This Instrument Prepared by the Law Offices of Patricia A. Rees*
*5341 Central Avenue, Portage, IN 46368 &*
*600 West Old Ridge Road, Hobart, IN 46342*
*Phone: (219) 947-1692, Fax: (219) 763-9749*

14077

FILED
JUL 30 2013
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

LOCC

*** ATTENTION ESTATE:** Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 3527-05

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No.

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

**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) |
|---|---|---|---|
| REMEDIOS A. YANEZ | Female | 5:25AM | October 1, 2005 |

| 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) |
|---|---|---|---|---|---|
| 305-52-4807 | 90 | | | September 1, 1915 | Tarimoro, GTO |

| 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) |
|---|---|---|
| No | N/A | 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 |
|---|---|---|
| St. Mary Medical Center | Hobart | 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 |
|---|---|---|---|
| Widowed | NONE | Homemaker | Home |

| 13a. RESIDENCE - STATE | 13b. COUNTY | 13c. CITY TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Lake Station | 1919 Riverlane Drive |

| 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) | |
|---|---|---|---|---|---|---|---|
| | | | | | | Elementary/Secondary (0-12) | College (1-4 or 5+) |
| 46405 | ☐ No ☒ Yes | ☒ No ☐ Yes | USA | Mexican | White | 08 | |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Esteban Anaya | Luz Anaya |

**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 |
|---|---|---|
| Lucy Yanez | 1919 Riverlane Drive, Lake Station, IN 46405 | Daughter |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 21c. LOCATION - City or Town State |
|---|---|---|
| ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | October 4, 2005 Calvary Cemetery | Portage, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| James J. Krause | FD01006463 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| Joshua R. Krause | FD29700036 | 83005613 Rees Funeral Home, Olson Chapel 5341 Central Avenue, Portage, IN 46368 |



**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. | Abdominal Aortic Aneurysm | |
| Conditions if any which gave rise to the immediate cause stating the underlying cause last — b. DUE TO (OR AS A CONSEQUENCE OF) | Atherosclerosis | |
| 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 AUTOPSY PERFORMED? | 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) |
|---|---|---|
| Kenneth Blumenthal | 02000639 | 10/4/05 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Kenneth Blumenthal, DO, 3125 Willowcreek, Portage, IN 46368

**HEALTH OFFICER**

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month Day Year) |
|---|---|
| Susan W Burt D.O. | October 4, 2005 |

| 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. |
|---|---|
| | |

This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

# PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave Suite 104
Valparaiso IN 46383

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

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) |
|---|---|---|---|
| Armando A. Yanez, Sr. | Male | 8:03PM | April 18, 2003 |

| 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) |
|---|---|---|---|---|---|
| 329-26-4593 | 84 | | | March 19, 1919 | Tarimoro, Mexico |

| 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) |
|---|---|---|
| No | N/A | HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☒ Other (Specify) Hospice ☐ Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY TOWN OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| VNA Hospice Ctr.of Porter Co. | Valparaiso | Porter |

| 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 |
|---|---|---|---|
| Married | Remedios Anaya | Master Carpenter | Steel Manufacture |

| 13a. RESIDENCE - STATE | 13b. COUNTY | 13c. CITY TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| IN | Lake | Lake Station | 1919 Riverlane Dr. |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? | 16. RACE - American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| | | | | | | Elementary/Secondary (0-12) | College (1-4 or 5+) |
| 46405 | ☐ No ☒ Yes | ☒ No ☐ Yes | USA | ☐ No ☒ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) Mexican | Hispanic | 12 | |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Rafael Yanez | Petra Martinez |

**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 |
|---|---|---|
| Remedios Yanez | 1919 Riverlane Dr., Lake Station, IN 46405 | 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 |
|---|---|---|
| ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | April 22, 2003 Calvary Cemetery | Portage, IN |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| James J. Krause | FD01006463 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| James L Krause | FD29700036 | 83005613 Rees Funeral Home, Olson Chapel 5341 Central Avenue , Portage, IN 46368 |

**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. Cardiac Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF) b. | |
| Conditions if any which gave rise to the immediate cause stating the underlying cause last | 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) |
|---|---|---|---|
| CVA Absolute Center | 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) |
|---|---|---|
| Kenneth Blumenthal | 0700063 | 4/21/03 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Kenneth Blumenthal, DO, 3125 Willowcreek, Portage, IN 46368

**HEALTH OFFICER**

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month Day Year) |
|---|---|
| Gary A. Babcock MD | April 21, 2003 |

| 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. |
|---|---|
| | |