

3

# Chicago Title Insurance Company

## SURVIVORSHIP AFFIDAVIT

1306732

45-07-27-355-026.000-026

On this 12/10/13 before me personally appeared Valerie N. Gonzalez  
(insert date)

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 Spouse  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

Said premises were formerly owned as joint tenants or as tenants by the  
entireties by Anthony R. Gonzalez and Valerie N Gonzalez;

Anthony R. Gonzalez

(fill in name of co-tenant who died)  
died on 11/17/12

leaving \_\_\_\_\_ will;  
(insert "a" or "no"; if will left, attach a copy)

The legal description of the premises in question is:

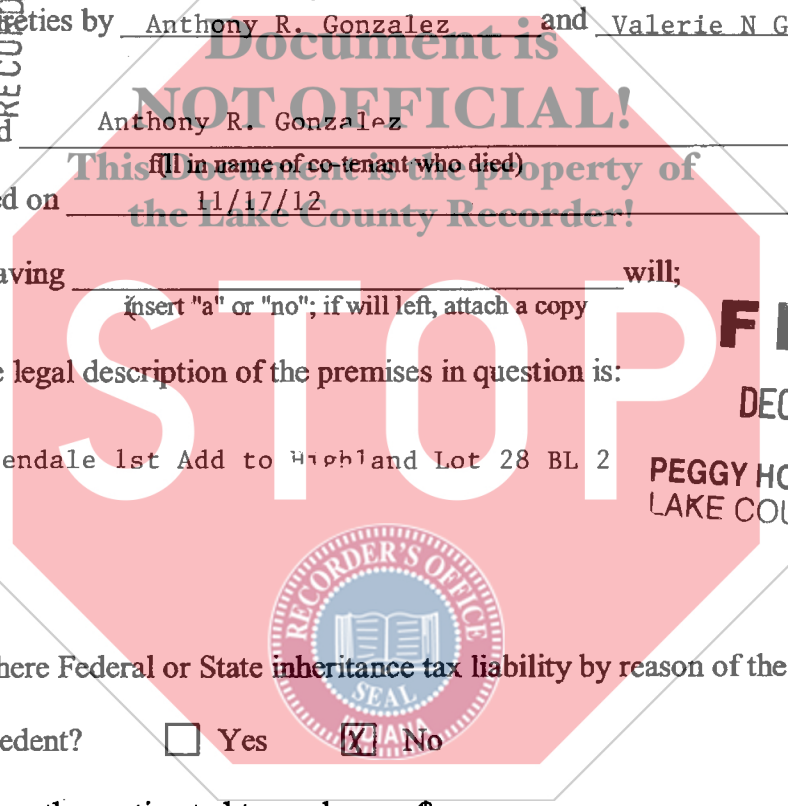
Ellendale 1st Add to Highland Lot 28 BL 2

STATE OF ILLINOIS  
LAKE COUNTY  
FILED FOR RECORD

2013 DEC 16 AM 10:56

MICHAEL BROWN  
RECORDER

2013 09158.7



**FILED**  
DEC 13 2013

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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..

1600  
sum  
CT  
AN

007012

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

Signature: *Valerie N Gonzalez*

Printed Name Valerie N Gonzalez

Address: 400 N. Lafayette St.  
Griffith, IN 46319

Subscribed and sworn to before me by the affiant

This 12/10/13  
(insert date)

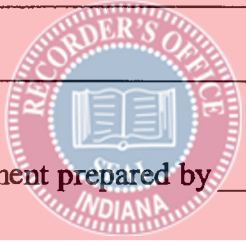
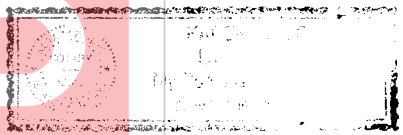
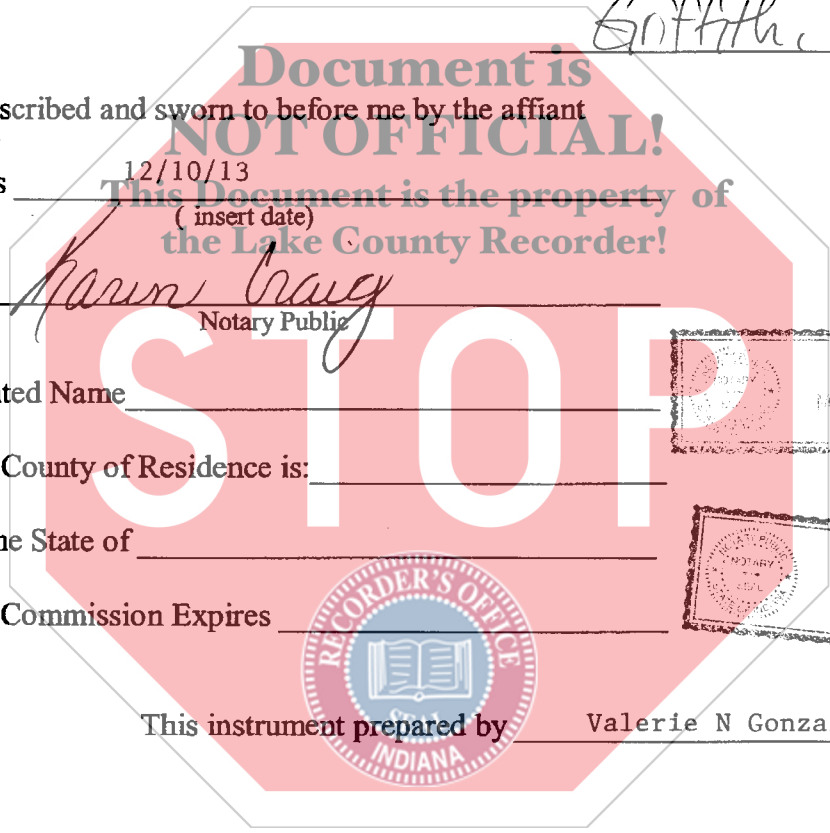
*Karen Craig*  
Notary Public

Printed Name \_\_\_\_\_

My County of Residence is: \_\_\_\_\_

In the State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_



This instrument prepared by Valerie N Gonzalez

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. *[Signature]*



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

#45-07-27-355-026 000-026

Local No 003602

EDR No 00000290384

State No

1. Decedent's Legal Name (First, Middle, Last) <b>ANTHONY R GONZALEZ</b>				1a. Maiden Name (if female)		2. Sex <b>MALE</b>	3. Time Of Death <b>06:51 AM</b>	4. Date Of Death (Month/Day/Year) <b>11/17/2012</b>		
5. Social Security Number <b>██████████</b>	6a. Age - Yrs <b>39</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) <b>02/06/1973</b>		8. Birthplace (City and State or Foreign Country) <b>HAMMOND, IN</b>		
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival			10a. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)					
11. Facility Name (If Not Institution, Give Street and Number) <b>COMMUNITY HOSPITAL</b>										
12. City Or Town, State, And Zip Code <b>MUNSTER, IN, 46321</b>				13. County Of Death <b>LAKE</b>			14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			
15. Surviving Spouse's Name <b>VALERIE N. GONZALEZ</b>			15a. (If Wife) Give Maiden Last Name <b>MILLER</b>			16. Decedent's Usual Occupation <b>SALES MANAGER</b>		17. Kind Of Business/Industry <b>DEX</b>		
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>GRIFFITH</b>						
18c. Street And Number <b>400 NORTH LAFAYETTE STREET</b>						18d. Apt. No.	18e. Zip Code <b>46319</b>	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
19. Decedent's Education <b>MASTER'S DEGREE (MA, MS, MENG, MED, MSW, MBA)</b>			20. Decedent Of Hispanic Origin <b>HISPANIC</b>			21. Decedent's Race <b>White</b>				
22. Father's Name (First, Middle, Last) <b>RICARDO GONZALEZ</b>				23. Mother's Name (First, Middle, Last) <b>KATHY GONZALEZ</b>			23a. Mother's Maiden Last Name <b>MARTIN</b>			
24. Informant's Name <b>VALERIE GONZALEZ</b>			24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>400 NORTH LAFAYETTE STREET, GRIFFITH, IN 46319</b>					
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)			25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>KELLY CARROLL CREMATORY</b>			25c. Location - City, Town, And State <b>GARY, IN</b>				
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>WHITE FUNERAL HOME &amp; CREMATION SERVICE, 921 WEST 45TH AVENUE, GRIFFITH, IN 46319</b>					27a. Funeral Home License Number <b>FH10600026</b>			
27b. Signature Of Indiana Funeral Service Licensee: <b>RAYMOND E. WHITE JR, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD08700086</b>				
28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.										
Immediate Cause (Final Disease Or Condition Resulting In Death) A. <b>MASSIVE INTRAPERITONEAL HEMORRHAGES DUE TO PROBABLE DIC</b> <span style="float: right;">Approximate Interval: Onset To Death <b>UNKNOWN</b></span>										
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last B. <b>WITH EMERGENCY EXPLORATORY LAPAROTOMY</b>										
C. <b>FOR INCARCERATED HERNIA</b>										
D. _____										
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I						29. Was An Autopsy Performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		29. Were Autopsy Finding Available To Complete The Cause Of Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant 60 Days Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, BU Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined					
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number			38c. Apt. No.	38d. Zip Code		
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
41. Signature, Of Person Certifying Cause Of Death: <b>DONNA MELYON, BY ELECTRONIC SIGNATURE</b>						42. Certifier (Check Only One) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>DONNA MELYON, 2900 WEST 93RD AVENUE, CROWN POINT, IN 46307</b>						44. License Number		45. Date Certified <b>11/19/2012</b>		
46. Additional Funeral Service Provider:						47. *Alias:				
48. Signature of Local Health Officer: <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year) <b>NOV 19 2012</b>				

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

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.