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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2014 008811

2014 FEB 14 AM 9:29

MICHAEL B. BROWN  
RECORDER

**AFFIDAVIT OF SURVIVORSHIP**

Alfredo Hernandez, of adult age, being first duly sworn, upon deposes and says:

That, Alfredo Hernandez is the Husband of Martha Hernandez a/k/a Martha Sue Hernandez, deceased, who died on October 18, 2006 a resident of Lake County, Indiana.

That affiant and said decedent, as acquired title to the following described real estate located in Lake County, IN to wit:

SEE ATTACHED LEGAL DESCRIPTION

and hereinafter sometimes called "the Real Estate" for convenience by a Deed from recorded as Document No. in the Office of the Office of the Recorder of Lake County, Indiana.

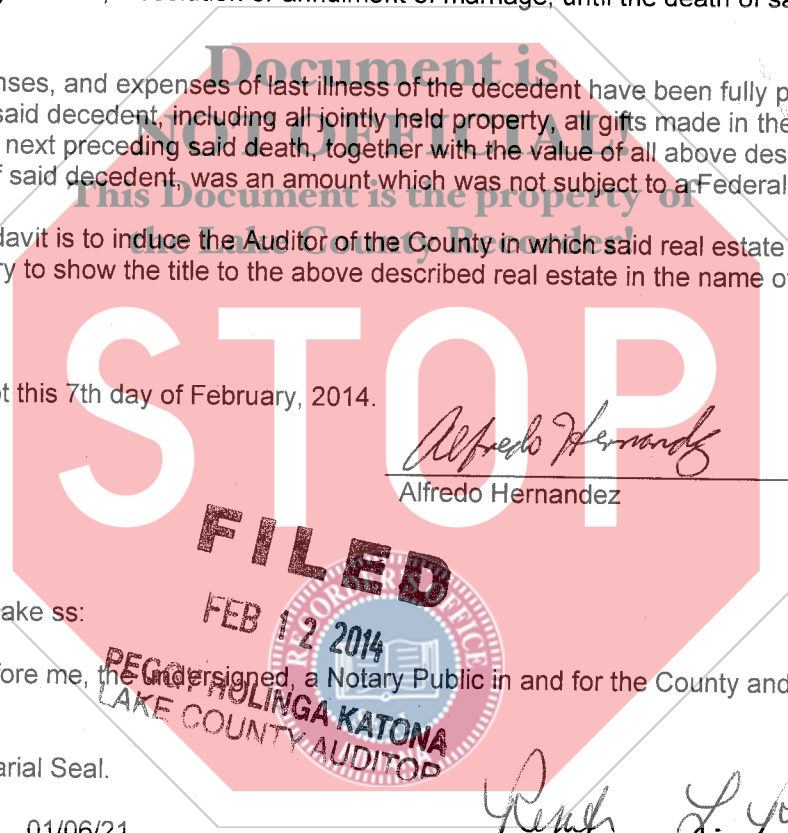
That affiant and said decedent were legally married to one another at this time and that said marital relationship between them continued unbroken by divorce, dissolution or annulment of marriage, until the death of said decedent on the date hereinabove indicated.

That all debts, funeral expenses, and expenses of last illness of the decedent have been fully paid and satisfied. That the gross value of he estate of said decedent, including all jointly held property, all gifts made in the contemplation of death, or made within the three years next preceding said death, together with the value of all above described, plus the proceeds of all insurance on the life of said decedent, was an amount which was not subject to a Federal Estate Tax.

That the purpose of this affidavit is to induce the Auditor of the County in which said real estate is located to change the tax records, and, if necessary to show the title to the above described real estate in the name of, surviving spouse of the decedent.

And further affiant sayeth not this 7th day of February, 2014.

*Alfredo Hernandez*  
Alfredo Hernandez



State of Indiana, County of Lake ss:

Subscribed and sworn to before me, the undersigned, a Notary Public in and for the County and State aforesaid, this 7th day of February, 2014.

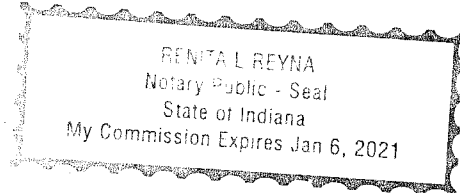
WITNESS my hand and Notarial Seal.

My Commission Expires: 01/06/21

*Renita L. Reyna*  
Signature of Notary Public

Renita L. Reyna  
Printed Name of Notary Public

Lake County, Indiana  
Notary Public County and State of Residence



This instrument was prepared by:  
Debra A. Guy, Attorney-at-Law, IN #24473-71 MI #P69602  
202 S. Michigan Street, Ste. 300, South Bend, IN 46601

Property Address:  
7232 South Willowbrook Drive, Lowell, IN 46356

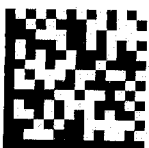
File No.: 14-2438

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. Renita Reyna (Type or Print Name)

HOLD FOR MERIDIAN TITLE

14-2438

15-  
MT  
RT



1949435-1005

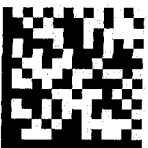
010690

**LEGAL DESCRIPTION**

Lot Numbered 16 in Northbrook Estates 2nd Addition to the Town of Lowell, as per plat thereof recorded in Plat Book 45, page 65 in the Office of the Recorder of Lake County, Indiana.

Tax ID Number(s):  
17-04-0086-0016

45-19-23-180-012.000-008



NOTE: The Social Security # is by this state agency in order to verify responsibility. Disclosure is required. There will be no penalty for refusal.

2015-06

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

State No. ....

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

IDENTIFICATION	1 DECEASED—NAME (First, Middle, Last) <b>MARTHA SUE HERNANDEZ</b>		2 SEX <b>Female</b>		3a TIME OF DEATH <b>8:20 P.</b>		3b DATE OF DEATH (Month, Day, Yr.) <b>October 18, 2006</b>	
	4 *SOCIAL SECURITY NUMBER [REDACTED]		5a AGE—Last Birthday (Years) <b>73</b>		5b UNDER 1 YEAR Months: Days:		5c UNDER 1 DAY Hours: Minutes:	
DECEASED	6 DATE OF BIRTH (Mo, Day, Yr.) <b>June 10, 1933</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Sheffield, Alabama</b>					
	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>-</b>		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Residence			
DECEASED	9b FACILITY NAME (If not institution, give street and number) <b>Lowell Health care</b>		9c CITY, TOWN OR LOCATION OF DEATH <b>Lowell</b>			9d COUNTY OF DEATH <b>Lake</b>		
	10 MARITAL STATUS (Specify) <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>Alfredo Hernandez</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>		12b KIND OF BUSINESS/INDUSTRY <b>At Home</b>	
DECEASED	13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN OR LOCATION <b>Lowell</b>		13d STREET AND NUMBER <b>7232 Willowbrook</b>	
	13e ZIP CODE <b>46356</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
DECEASED	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>6</b> College (1-4 or 5+) <b>-</b>		18 FATHER'S NAME (First, Middle, Last) <b>Martin Luther Hayes</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Thomason</b>	
	20a INFORMANT'S NAME (Type/Print) <b>Alfredo Hernandez</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7232 Willowbrook Lowell, IN 46356</b>			20c Relationship <b>Husband</b>		
DISPOSITION	21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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>October 23, 2006 Lowell Memorial Cemetery</b>			21c LOCATION—City or Town, State <b>Lowell, Indiana</b>		
	22a EMBALMER'S NAME <b>Ronald J. Mesarch</b>		22b EMBALMER'S LICENSE NO. <b>FDO1005912</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
CAUSE OF DEATH	24a SIGNATURE OF FUNERAL DIRECTOR <i>Ronald J. Mesarch</i>		24b LICENSE NUMBER (of Licensee) <b>FDO1005912</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Geisen Funeral Home Inc. FH83007762 7905 Broadway Merrillville, IN 46410</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. <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Cause and Death <b>Days</b>							
CERTIFIER	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) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>			
HEALTH OFFICER	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>Richard Kreisa - Physician</i>		29c MEDICAL LICENSE NO. <b>10201002</b>		29d DATE SIGNED (Month, Day, Year) <b>11-1-06</b>	
	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Richard J. Kreisa 317 W. Commercial Lowell, Indiana 46356</b>							
HEALTH OFFICER	31 HEALTH OFFICER'S SIGNATURE <i>Susan J. Best D.O.</i>		32 DATE FILED (Month, Day, Year) <b>NOV 03 2006</b>		THIS CERTIFIES THE ABOVE IS CORRECT <b>NOV 03 2006</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 PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e 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.						