SURVIVORSHIP AFFIDAVIT

STATE OF 104499

COUNTY OF LAKE } S. S.

N

On this October 18, 1989 (Insert date) before me personally appeared

CLARENCE E. JENNINGS

to me personally known, who being duly sworn on oath did say that:

STATE OF INDIANA, S.S. NO.
LAKE COUNTY
FILED FOR RECORD
JUN 7 9 56 AM '90
ROBERT [illegible]
RECORDER [illegible] LAKE

1. Affiant resides at the address given below affiant's signature;

2. Affiant is the owner of said premises;
(state interest of Affiant in the above premises as "owner," "son of owner," etc.)

3. Said premises were formerly owned ~~XXXXXXXXXXXXXX~~ as tenants by the entireties by Clarence E. Jennings and Juanita Jennings;

4. Said Juanita Jennings
(fill in name of co-tenant who died)
died on August 4, 1989;
leaving a will;
(insert "a" or "no"; if will is given, attach a copy)

5. The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, and insurance does not exceed the sum of $ 8,500.00 and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of said decedent;

6. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? NO

(If answer is "Yes," identify the divorce proceedings:

N/A);

7. Affiant's relationship to the deceased was Husband.

Signature: Clarence E. Jennings
CLARENCE E. JENNINGS

Address: 2026 Willard
Gary, IN 46404

Tarrytown 1st
Lt 8 Blk 8
#47-444-8

FILED

JUN 07 1990

AUDITOR LAKE COUNTY

Subscribed and sworn to before me by the affiant this October 18, 1989 (Insert date)

Jacqueline Perry
Notary Public

My Commission Expires April 1, 1990

5.50

000473

This instrument prepared by ATTORNEY CORNELL COLLINS
607 S. Lake St., Gary, IN 46403

Local No. 89-0511

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME — FIRST: Juanita — MIDDLE: — LAST: Jennings
2. SEX: Female
3. DATE OF DEATH (Mo. Day Yr.): August 4, 1989
4. SOCIAL SECURITY NUMBER: 349-16-1555
5a. AGE—Last Birthday (Years): 64
5b. UNDER 1 YEAR — Months — Days
5c. UNDER 1 DAY — Hours — Minutes
6. DATE OF BIRTH (Month Day Year): 8/11/1924
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Ill.
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: None
9a. PLACE OF DEATH (Check only one. See instructions) — HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Clarence Jennings
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Residence
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2026 Willard St.
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46404
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No ☐ Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): Black
16. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): Herman Tarleton
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel I. Bishop

INFORMANT

19a. INFORMANT'S NAME (Type/Print): David Jennings
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2300 W. 5th Ave. Apt. 14G New York 10037
19c. Relationship: Son

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 9, 1989 Evergreen Memorial Park
20c. LOCATION—City or Town, State: Hobart, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: Roosevelt Allen [signature]
21b. LICENSE NUMBER (of Licensee): 0151701
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 2959 W. 11th Ave GAry, IN #83007704

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 4:34 AM
25. DATE PRONOUNCED DEAD (Month, Day, Year): August 4, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Carcinoma of Lung with MET.

DUE TO (OR AS A CONSEQUENCE OF):

b. Staph. Septicemia

DUE TO (OR AS A CONSEQUENCE OF):

c. Arteriosclerotic heart

DUE TO (OR AS A CONSEQUENCE OF):

d. Ulcerative Colitis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

CERTIFIER (SEE INSTRUCTIONS)

FILED

29a. CERTIFIER (Check only one)

[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

JUN 07 1990

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

[signature] AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER: R. Hovanessian MD [signature]
29c. LICENSE NUMBER: 0102358
29d. DATE SIGNED (Month, Day, Year): 8/8/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Dr. Hovanessian 7863 Broadway Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): AUG. 10 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED

000474

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)

#47448 Transfer to Hol 8808

17

SBH06-004 State Form 10110 (R/10-87) DEATH/PD 1