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Please Return To:

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SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA/S.S. NO.
LAKE COUNTY
FILED
APR 25 10 51 AM '91
ROBERT SCOTT FREELAND
RECORDER

NANNIE BRADLEY, being first duly sworn upon her oath, deposes and says:

1. That she was married to WILLIAM BRADLEY who died a resident of Gary, Lake County, Indiana, on April 14, 1991, as evidenced by a Certified Death Certificate attached hereto and made a part hereof.

2. That at the time of his death, WILLIAM BRADLEY and NANNIE BRADLEY, Husband and Wife, held title under a Quit-Claim Deed to the following-described Real Estate, to-wit:

Lot 36, Chicago-Tolleston Land and Investment Company's Second Oak Park Addition to Tolleston, in the City of Gary, Lake County, Indiana.
Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder!

KEY 46-1987-36

3. That the Affiant and the Decedent, WILLIAM BRADLEY, were Husband and Wife continuously from the time they acquired title to the above-described Real Estate, to-wit: July 29, 1950, to the time of his death on April 14, 1991.

4. That the Estate of WILLIAM BRADLEY, decedent, was not of sufficient value to be subject to Federal Estate Taxes or Indiana Inheritance Taxes.

FURTHER AFFIANT SAYETH NOT.



Nannie Bradley
NANNIE BRADLEY

Subscribed and sworn to before me, a Notary Public, this 23rd day of April, 1991

Mary P. Coons

MARY P. COONS, Notary Public
Resident of Porter County

My Commission Expires:
January 6, 1995

This Instrument Prepared by: ARNOLD KREVITZ, Attorney At Law
500 East 86th Avenue
Merrillville, IN 46410
(219) 769-1300

FILED

APR 25 1991

Anna N. Anton
AUDITOR LAKE COUNTY

800
01501

INDIANA STATE BOARD OF HEALTH

Local No. 0827-91

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) William Henry Bradley		2. SEX Male	3a. TIME OF DEATH 12:00P _M	3b. DATE OF DEATH (Month, Day, Yr) April 14, 1991
4. SOCIAL SECURITY NUMBER 306-03-2739	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) October 20, 1901
7. BIRTHPLACE (City and State or Foreign Country) Birmingham, Alabama	8a. WAS DECEDENT A U.S. VETERAN? No			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) Southlake Care Center		9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Nannie Webb	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Skilled Labor		12b. KIND OF BUSINESS/INDUSTRY Steel Industry
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 2451 Adams Street
13e. ZIP CODE 46407	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? U.S.A.	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) Black		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		
18. FATHER'S NAME (First, Middle, Last) George Bradley		19. MOTHER'S NAME (First, Middle, Maiden Surname) Lulu Brantley		
20a. INFORMANT'S NAME (Type/Print) Nannie Bradley		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2451 Adams Street, Gary, Indiana, 46407		20c. Relationship Wife
21a. METHOD OF DISPOSITION <input checked="" 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) April 19, 1991 Green Memorial Park		21c. LOCATION—City or Town, State Hobart, Indiana
22a. EMBALMER'S NAME Samuel Smith		22b. EMBALMER'S LICENSE NO. FDE01019692		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: <i>Samuel Smith</i>		24b. LICENSE NUMBER (of Licensee) FDE01019692		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Divinity Memorial Chapel 3820 Pulaski Street East Chicago, Indiana 46312-FD3001570
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 DUE TO (OR AS A CONSEQUENCE OF) Lung Cancer				
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.				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		28b. DATE OF AUTOPSY PERFORMED APR 20 1991
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>Dr. S. Shaw</i>		
29c. MEDICAL LICENSE NO. 01032180		29d. DATE SIGNED (Month, Day, Year) 4/17/91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. S. Shaw 3520 Fairview Ave. Lake Station IN 46405				
31. HEALTH OFFICER'S SIGNATURE <i>Dr. S. Shaw</i>				
32. DATE FILED (Month, Day, Year) APR 17 1991				
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <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. 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.		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

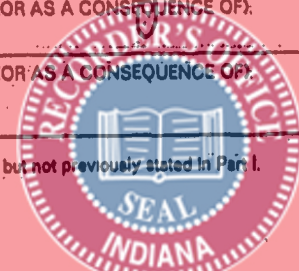
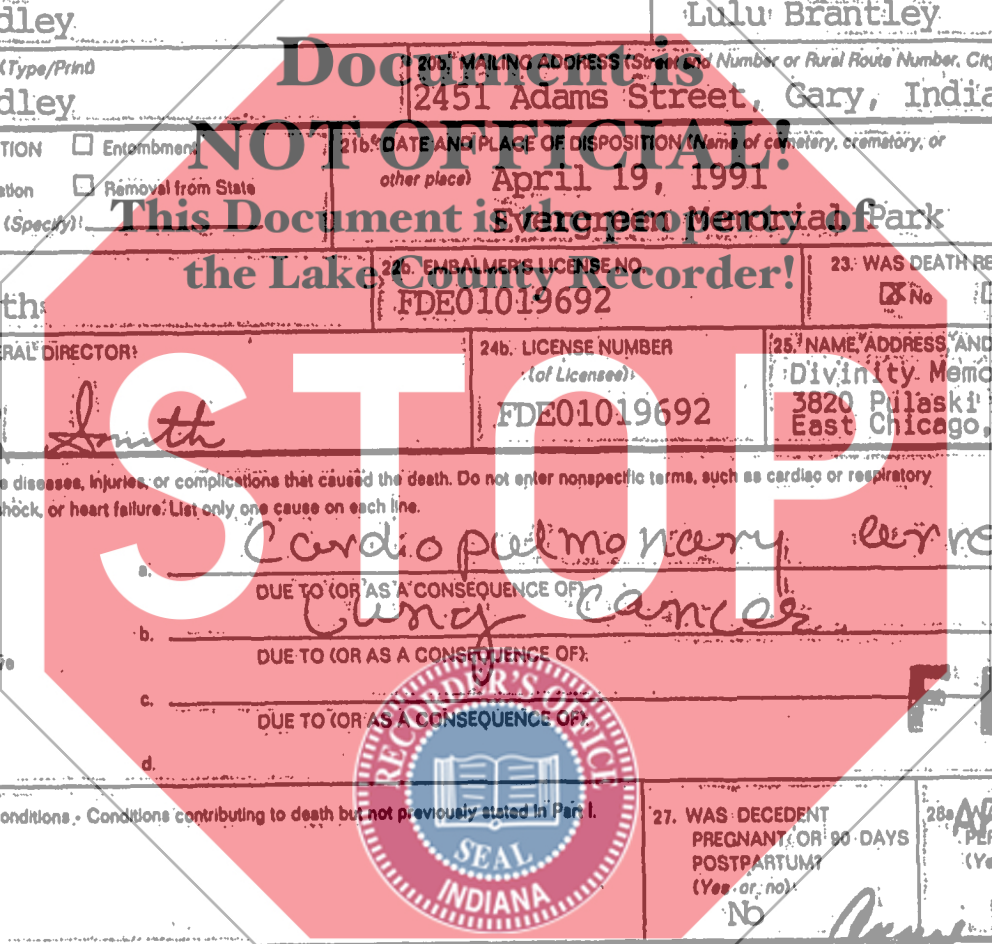
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

KEY 46-197-36
24 OAK PARK RD
LOT 36 BLOCK 39



FILED