

3  
STATE OF INDIANA )

COUNTY OF LAKE )

SS:

RETURN TO: MATTHEW P. DOGAN  
565 W. Ridge Rd. Gary, Ind. 46408

91042861

A F F I D A V I T

Comes now Danny Lee Bryan of the County of Porter, State of Indiana, and being duly sworn upon his oath, deposes and says:

1. That this affiant is the son of Myrtle Bryan Allard, also known as Myrtle B. Allard, also known as Myrtle E. Allard, <sup>intestate,</sup> who died, a resident of Lake County, Indiana, on March 13, 1991.

2. That the decedent owned the following described real estate in the County of Lake, State of Indiana, in her name alone:

Lots 7 and 8, Block 1, Grandview Addition to Hobart, as shown in Plat Book 20, page 37, in Lake County, Indiana. Also known as 1905 East 39th Avenue, Hobart, Indiana 46342. (Key No. 17-179-7 and 8)

Said real estate has a fair market value of Eight Thousand (\$8,000.00) Dollars.

3. That the value of the gross estate of the decedent, less liens and encumbrances, does not exceed the sum of Eight Thousand (\$8,000.00) Dollars.

4. That over forty-five (45) days have elapsed since the death of the decedent.

5. That no application or petition for the appointment of a personal representative has been granted in any jurisdiction.

6. That Danny Lee Bryan, as the person acting on behalf of the distributees of this estate, is entitled to the right to sell said real estate for purposes of settling the estate of Myrtle Bryan Allard without probate, pursuant to I.C. 29-1-8-3

7. That the only asset of this estate is the above-described real estate:

Value of real estate \$ 8,000.00

That the expenses of decedent's estate are as follows:

Sale of real estate:	
Title Expense	\$ 245.00
Tax Prorate	550.00
Warranty Deed	30.00
Attorney's Fee	300.00
	<hr/>
	1,125.00

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.

AUG 21 1991

*Clara N. Antox*  
AUDITOR LAKE COUNTY

01155

1000



STATE OF INDIANA  
CLERK OF SUPERIOR COURT  
FILED FOR RECORD  
AUG 22 10 32 AM '91

Administrative Expense:	
Funeral Expense	\$ 3,501.25
Attorney's Fee-Estate	300.00
Court Costs	55.00
Medical Expense of Last illness - in excess of	<u>5,000.00</u>
	\$ 8,856.25

TOTAL EXPENSE OF ESTATE	-	<u>9,981.25</u>
TOTAL DEFICIT IN EXCESS OF	-	<u>\$1,981.25</u>

8. The following are the children of the decedent who are entitled to distribution of decedent's estate:

- Magdeline Copptinger, Adult;
- Peggy Jo Koehler, Adult;
- John Thomas Bryan, Adult;
- Nancy Ruth Geleott, Adult;
- Shirley Allen, Adult;
- Billy Wayne Bryan, Adult;
- Danny Lee Bryan, Adult;

However, the estate is insolvent and there will be no distribution to the heirs or to the general creditors of the decedent.

9. There are no Indiana Inheritance Taxes due and owing in this estate.

10. This Affidavit is given so that Danny Lee Bryan, the person acting on behalf of the distributees of this estate, can sell or liquidate the real estate and pay the expenses and claims of creditors as provided in I.C. 29-1-14-9.

Further affiant sayeth not.



*Danny Lee Bryan*  
 \_\_\_\_\_  
 Danny Lee Bryan

STATE OF INDIANA )  
 )  
 COUNTY OF LAKE )

SS:

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 30th day of April, 1991.

*Matthew P. Dogan*  
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 Matthew P. Dogan, Notary Public

My Commission expires:  
 January 2, 1994

Resident of Lake County

This instrument prepared by: MATTHEW P. DOGAN  
 Attorney at Law  
 626 West Ridge Road  
 Gary, Indiana 46408

Res. L. 7 and 8, Bl. 1, Grandview Add. to Hobart, as shown in  
Pl. Book 20, page 37, Lake Co., Ind. (Key No. 17-179-7 and 8)

INDIANA STATE BOARD OF HEALTH

5cc p

Local No. 0603-91 CERTIFICATE OF DEATH State No. ....

TYPE/PRINT  
IN:  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle, Last) <b>MYRTLE E. ALLARD</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>11:00A M</b>	3b DATE OF DEATH (Month Day Yr) <b>March 13, 1991</b>
4 SOCIAL SECURITY NUMBER <b>310-36-5484</b>	5a AGE—Last Birthday (Years) <b>83</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>JAN 29, 1908</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>COOTER, MISSOURI</b>	8a WAS DECEASENT A US VETERAN? <b>No</b>			
8b YEAR LAST SERVED IN US ARMED FORCES? <b>N/A</b>		8c PLACE OF DEATH (Specify hospital, nursing home, etc.) <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Home <input type="checkbox"/> Other (Specify)		

DECEDENT

9a FACILITY NAME (if not institution give street and number) <b>316 N. COLORADO ST.</b>	9c CITY/TOWN OR LOCATION OF DEATH <b>HOBART</b>	9b COUNTY OF DEATH <b>LAKE</b>
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10 MARITAL STATUS <b>Widowed</b>	11 SURVIVING SPOUSE (if wife give maiden name) <b>NONE</b>	12a DECEASENT'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>N/A</b>
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13a RESIDENCE—STATE <b>INDIANA</b>	13b COUNTY <b>LAKE</b>	13c CITY/TOWN OR LOCATION <b>HOBART</b>	13d STREET AND NUMBER <b>1905 E. 39TH AVE.</b>
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13e ZIP CODE <b>46342</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	15 WAS DECEASENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (Specify race)	16 RACE—American Indian, Black, White, etc. (Specify) <b>WHITE</b>	17 DECEASENT'S EDUCATION (Specify only highest grade completed) <b>9</b>
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PARENTS

18 FATHER'S NAME (First Middle Last) <b>THOMAS BOOKER</b>	19 MOTHER'S NAME (First Middle Last) <b>ELIZABETH SARAH</b>
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INFORMANT

20a INFORMANT'S NAME (Type Print) <b>SHIRLEY ALLEN</b>	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>316 N. COLORADO ST. HOBART, IN 46342</b>	20c Relationship <b>Daughter</b>
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DISPOSITION

21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Conation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>MAR 16, 1991 EVERGREEN MEMORIAL PARK HOBART, IN 46342</b>	21c LOCATION—City or Town, State <b>HOBART, IN 46342</b>
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22a EMBALMER'S NAME <b>JAMES W. GHOLSTON</b>	22b EMBALMER'S LICENSE NO. <b>FDO1004194</b>	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
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24a SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>	24b LICENSE NUMBER (of Licensee) <b>FDO1006463</b>	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>REES FUNERAL HOME 600 W. OLD RIDGE RD, HOBART, IN 46342</b>
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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. <b>Concussion of the Calvar with Retestasis to Skull</b>	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last	

27 WAS DECEASENT PREGNANT OR 90 DAYS POSTPARTUM? <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>N/A</b>
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CERTIFIER

29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER	29b SIGNATURE AND TITLE OF CERTIFIER <i>Alexander S. Williams, M.D.</i>	29c MEDICAL LICENSE NO. <b>01028410</b>	29d DATE SIGNED (Month Day Year) <b>3-18-91</b>
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HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type Print) <b>NAZZAL OBAID, MD, 8895 BROADWAY, MERRILLVILLE, IN 46410</b>	31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>	32 DATE FILED (Month Day Year) <b>March 19, 1991</b>
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CORONER USE ONLY

33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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
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)	

35 DATE OF MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.	<b>1155-A</b>
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#17-179-7  
Grandview Add. Pts 7+8-Bl 1

