

Mail tax bills to: 4232 Drummond St.  
East Chicago, IN 46312

Tax Key No.: 30-491-19 U#24

92013154

# WARRANTY DEED

STATE OF INDIANA, S.W.C.  
LAKE COUNTY  
FILED FOR RECORD  
MAR 4 8 50 AM '92  
ROBERT L. COOPER, RECORDER

This indenture witnesseth that **MARY L. POLLARD**

of Lake County in the State of Indiana


Convey and warrant to **MARY L. POLLARD and TIMOTHY POLLARD,**  
as joint tenants with right of survivorship

of Lake County in the State of Indiana  
for and in consideration of **Ten Dollars and other good and valuable considerations**  
the receipt whereof is hereby acknowledged, the following **Real Estate** in Lake County  
in the State of Indiana, to wit:

**Document is NOT OFFICIAL!**

The North 5 feet of Lot 18 and the South 30 feet of Lot 19, Block 15, Park Addition to Indiana Harbor as shown in Book 5, page 32, in Lake County, Indiana. **This Document is the property of the Lake County Recorder!**

The grantor certifies that she is the surviving wife of Albert Lee Pollard who died in Lake County, Indiana on the 19th day of November, 1991; that she and the said Albert Lee Pollard were husband and wife when they, as tenants by the entireties, became owners of the above described real estate and remained husband and wife continuously thereafter until the death of her husband, at which time she became the sole owner of the above real estate; and also, that the Estate of Albert Lee Pollard was not subject to Federal Estate Tax.



86-92-00571

TICOR TITLE INSURANCE  
Crown Point, Indiana

State of Indiana, Lake County, ss:  
Before me, the undersigned, a Notary Public in and for said County and State, this 25th day of February 1992 personally appeared:

**MARY L. POLLARD**

Dated this \_\_\_\_\_ Day of February, 1992

Mary L. Pollard  
MARY L. POLLARD

DULY ENTERED FOR TAXATION SUBJECT TO  
FINAL ACCEPTANCE FOR TRANSFER.

FEB 28 1992

Robert M. Austin  
AUDITOR LAKE COUNTY

And acknowledged the execution of the foregoing deed. In witness whereof, I have hereunto subscribed my name and affixed my official seal. My commission expires 2/24/93 1993

Yolanda Argandona  
Yolanda Argandona  
Notary Public

Resident of Lake County.

This instrument prepared by JOHN E. CHEVIGNY Attorney at Law

900  
K  
01600

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 3491061527

State No.

TYPE/PRINT IN PERMANENT BLACK INK

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 1 DECEASED—NAME (First Middle Last)<br><b>Albert L. Pollard</b>  |   | 2 SEX<br><b>Male</b>   | 3a TIME OF DEATH<br><b>2:20 A.M.</b>   | 3b DATE OF DEATH (Month Day Year)<br><b>November 19, 1991</b>   |  |
| 4 SOCIAL SECURITY NUMBER<br><b>309-24-8256</b>   | 5a AGE—Last Birthday (Years)<br><b>63</b>   | 5b UNDER 1 YEAR<br>Months Days   | 5c UNDER 1 DAY<br>Hours Minutes  | 6 DATE OF BIRTH (Month Day Year)<br><b>Sept. 12, 1928</b>   |  |
| 7 BIRTH PLACE (City and State or Foreign Country)<br><b>Russell County, Alabama</b>  | 8a WAS DECEASED A US VETERAN?<br><b>Yes</b>   |  |  |   |  |
| 8b YEAR LAST SERVED IN US ARMED FORCES?<br><b>1952</b>   | 9a PLACE OF DEATH (Check only one. See instructions.)<br>HOSPITAL <input checked="" type="checkbox"/> Outpatient<br><input type="checkbox"/> ER Outpatient <input type="checkbox"/> COA<br>OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Residence |  |  |   |  |
| 9b FACILITY NAME (If not institution give street and number)<br><b>St. Catherine Hospital</b>  |   | 9c CITY TOWN OR LOCATION OF DEATH<br><b>East Chicago</b>   |  | 9d COUNTY OF DEATH<br><b>Lake</b>   |  |
| 10 MARITAL STATUS (Specify)<br><b>Married</b>  | 11 SURVIVING SPOUSE (If wife give maiden name)<br><b>Mary Hannah</b>  | 12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br><b>Switchman (Retired)</b>           |  | 12b KIND OF BUSINESS INDUSTRY<br><b>LTV Steel</b>   |  |
| 13a RESIDENCE—STATE<br><b>Indiana</b>  | 13b COUNTY<br><b>Lake</b>   | 13c CITY TOWN OR LOCATION<br><b>East Chicago</b>   |  | 13d STREET AND NUMBER<br><b>4232 Drummond St.</b>   |  |
| 13e ZIP CODE<br><b>46312</b>   | 13f INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes<br>13g ON A FARM?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  | 14 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 15 WAS DECEASED OF HISPANIC ORIGIN?<br><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)<br><b>Black</b>   |  |
| 17 DECEASED'S EDUCATION (Specify only highest grade completed)<br><b>Elementary Secondary (0-12) Grade (14-15+)</b>  |   | 17 DECEASED'S EDUCATION<br><b>9th Grade</b>  |  |   |  |
| 18 FATHER'S NAME (First Middle Last)<br><b>Geny Pollard</b>  |   | 19 MOTHER'S NAME (First Middle Maiden Surname)<br><b>Mandy Brundige</b>  |  |   |  |
| 20a INFORMANT'S NAME (Type/Print)<br><b>Mary Pollard</b>   |   | 20b MAILING ADDRESS (Street and Number or R.F.D. Route Number, City or Town, State, Zip Code)<br><b>4232 Drummond St., East Chicago, Indiana</b> |  | 20c Relationship<br><b>Wife</b>   |  |
| 21a METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)  |   | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, etc.)<br><b>Fern Oaks Cemetery</b>   |  | 21c LOCATION—City or Town, State<br><b>Griffith, Indiana</b>  |  |
| 22a EMBALMER'S NAME<br><b>Tracy Cheri Williams</b>   |   | 22b EMBALMER'S LICENSE NO.<br><b>FT08600238</b>  |  | 23 WAS DEATH REPORTED TO CORONER?<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                      |  |
| 24a SIGNATURE OF FUNERAL DIRECTOR<br><i>Tracy Cheri Williams</i>   |   | 24b LICENSE NUMBER (of Licensee)<br><b>FT08600238</b>  |  | 25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME<br><b>Hinton-Williams Funeral Home FH83C0150<br/>4859 Alexander Ave. East Chicago, In.</b> |  |
| 26 PART I Enter the disease, 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.<br><b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF)<br><b>HYPOTENSIVE SECONDARY TO SEIZURE</b><br>DUE TO (OR AS A CONSEQUENCE OF)<br><b>DIPYROSOMAL COMA</b><br>DUE TO (OR AS A CONSEQUENCE OF)   |   |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death)<br><b>PNEUMONIA</b>  |   |  |  |   |  |
| Conditions if any which give rise to the immediate cause stating the underlying cause last<br><b>FEB 23 1992</b>   |   |  |  |   |  |
| PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I<br><b>Arterio Sclerosis</b>  |   |  |  |   |  |
| 27a CERTIFIER (Check only one)<br><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<br><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<br><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 |   | 28a WAS AN AUTOPSY PERFORMED?<br><b>no</b>   |  |   |  |
| 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>no</b>  |   | 29a DATE SIGNED (Month Day Year)<br><b>11/25/91</b>  |  |   |  |
| 29b SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Anton</i>  |   | 29c MEDICAL LICENSE NO.<br><b>01025435</b>   |  |   |  |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br><b>T. RAYKOVICH MD 2075 INDIANAPOLIS BLVD WHITING, IN</b>   |   |  |  |   |  |
| 31 HEALTH OFFICER'S SIGNATURE<br><i>T. Raykovich</i>   |   |  |  | 32 DATE FILED (Month Day Year)<br><b>11-26-91</b>   |  |
| 33 MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined<br><input type="checkbox"/> Suicide <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<br><b>DEC 02 1991</b> |
| 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)<br><b>00052</b>  |  |   |  |
| 34g DATE PRONOUNCED DEAD (Month Day Year)  |   | 34h MOTOR VEHICLE ACCIDENT? (Yes or no) (If yes specify driver, passenger, pedestrian etc)<br><b>00052</b>                                       |  |   |  |

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

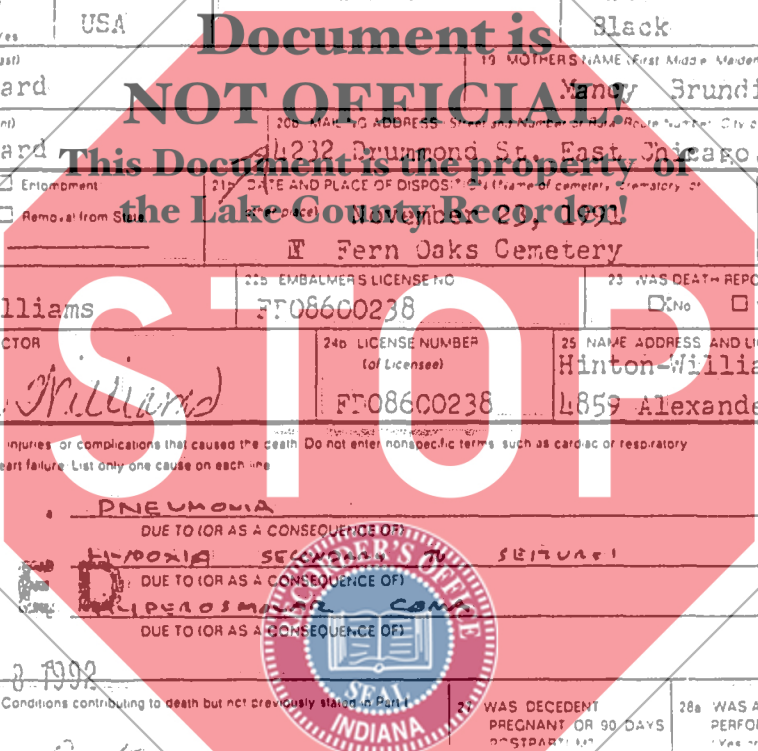
CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

30-491-19 Reg # 30-439-32

TA-Yes 3928 Wyo Morse St, ECh; 46312 Inland, Subdu- L.25 BL.3



FILED DEC 2 2 28 PM '91