

Mail Tax Bills to:  
4434 Strbutus Lane  
East Chicago, IN 46312

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92037676

A F F I D A V I T

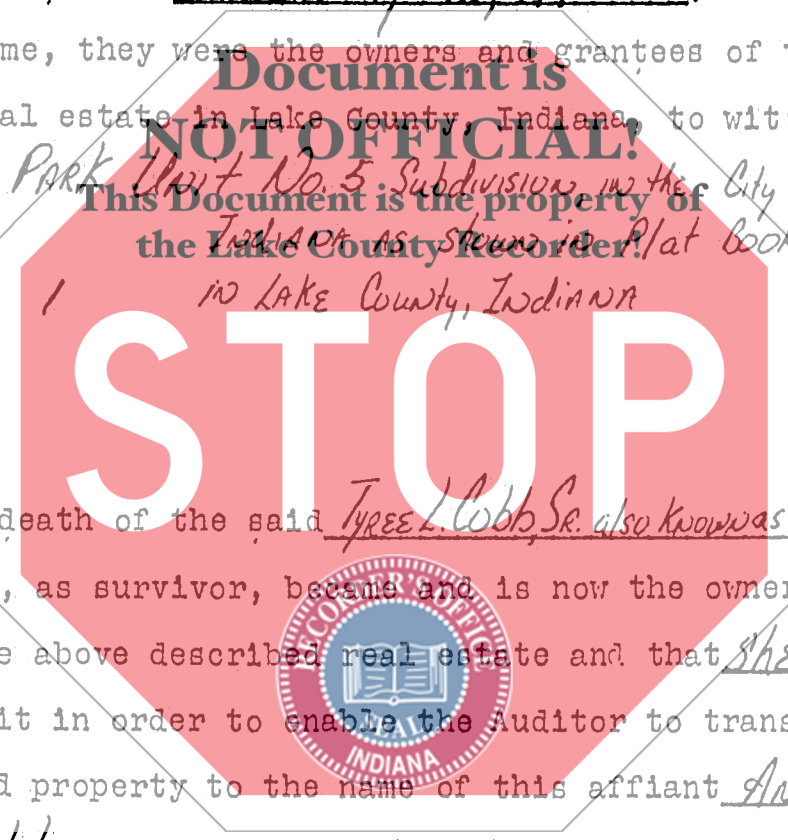
STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

↓ Annie Pearl Cobb, being duly sworn upon HER  
oath says:

THAT she is the surviving spouse of Tyree L. Cobb Sr. also known as  
Tyree L. Cobb, her husband his wife.

AFFIANT further states that Tyree L. Cobb Sr. also known as Tyree L. Cobb  
departed this life on FEBRUARY 15, 1992, that during  
their lifetime, they were the owners and grantees of the following  
described real estate in Lake County, Indiana, to wit:

Lot 18, in Parcel 1 PRAIRIE PARK Unit No. 5 Subdivision in the City of East Chicago,  
Indiana as shown in Plat Book 38 at Page 8.  
Lot 18  
PARCEL 1  
in LAKE County, Indiana



THAT on the death of the said Tyree L. Cobb Sr. also known as Tyree L. Cobb,  
this affiant, as survivor, became and is now the owner in fee  
simple of the above described real estate and that she makes  
this affidavit in order to enable the Auditor to transfer the  
title of said property to the name of this affiant ANNIE  
PEARL COBB for the purpose of taxation.

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
JUN 11 11 19 1992  
ROBERT H. HENDRICKS  
CLERK

FILED

JUN 11 1992

Annie Pearl Cobb  
(Spouse)

Anna N. Anton  
Subscribed and sworn to before me this 11<sup>th</sup> day of June, 1992.

My commission expires  
05-16-92

Mary Ellen Keil  
(Notary Public)  
Resident Lake County, In

This affidavit was prepared by Louisa D. Powell Esq.

007828.00

3 Kites  
3 coll

Key# 30-605-18  
Prairie Park Unit#5  
L. 18

92-0118

INDIANA STATE BOARD OF HEALTH

Local No. ....

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (First Middle Last) <b>Tyree L. Cobb Sr.</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>8:30 P.M.</b>	3b. DATE OF DEATH (Month Day Yr) <b>February 15, 1992</b>
4. ROOM, RESORT, OR MOBILE HOME <b>477-189-1997</b>	5a. AGE—Last Birthday (Yr/Mo/Da) <b>66</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) <b>December 4, 1925</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Midway, Alabama</b>	8a. WAS DECEDENT A US VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN US ARMED FORCES? <b>1946</b>	8c. PLACE OF DEATH (Check any and See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	

DECEDENT

9a. FACILITY NAME (If not residential, give street and number) <b>Methodist Hospital Northlake Campus</b>	9b. CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>	9c. COUNTY OF DEATH <b>Lake</b>
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10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Annie Williams</b>	12a. DECEDENT'S USUAL OCCUPATION (One kind of work done during most of working life. Do not use retired) <b>Lead Power</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Inland Steel Co.</b>
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13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>East Chicago</b>	13d. STREET AND NUMBER <b>4434 Arbutus Lane</b>
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13e. ZIP CODE <b>46312</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.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>Black</b>	17. DECEDENT'S EDUCATION (Specify any highest grade completed) Elementary/Secondary (0-12) <b>7th Grade</b> College (1-4 or 5+)	
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PARENTS

18. FATHER'S NAME (First Middle Last) <b>Frank M. Cobb</b>	19. MOTHER'S NAME (First Middle Maiden Surname) <b>Tommie Lou King</b>
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INFORMANT

20a. INFORMANT'S NAME (Type/Print) <b>Annie Cobb</b>	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4434 Arbutus Lane, East Chicago, Indiana</b>	20c. Relationship <b>Wife</b>
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DISPOSITION

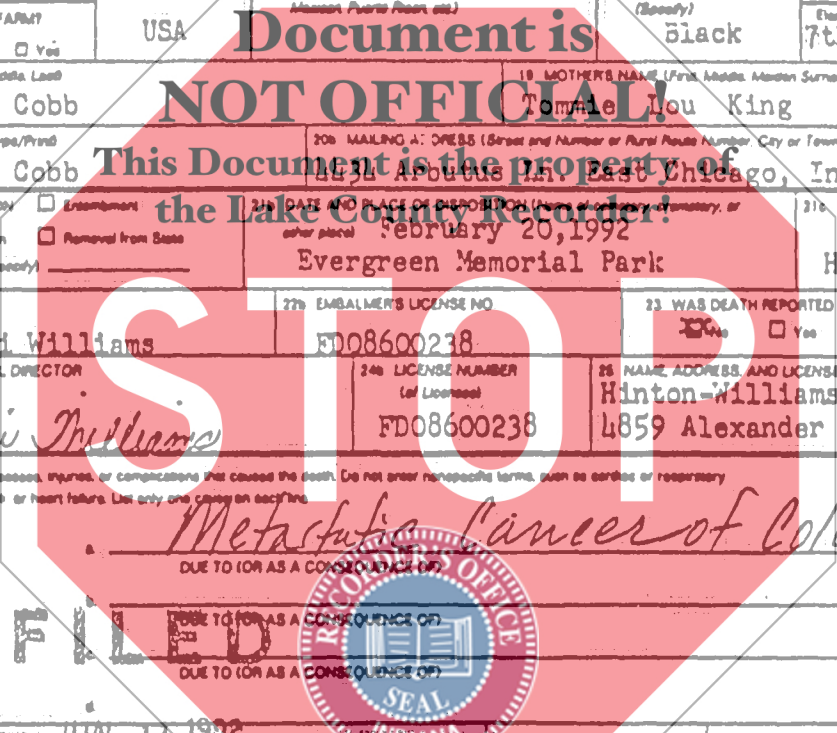
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, or other place) <b>February 20, 1992 Evergreen Memorial Park</b>	21c. LOCATION—City or Town, State <b>Hobart, IN.</b>
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22a. EMBALMER'S NAME <b>Tracy Cheri Williams</b>	22b. EMBALMER'S LICENSE NO. <b>FD08600238</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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24a. SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>	24b. LICENSE NUMBER (of Licensee) <b>FD08600238</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Hinton-Williams Funeral Home FH830015; 4859 Alexander Ave. East Chicago, In.</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>Metastatic Cancer of Colon</b>	IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>7 mos</b>
26. PART II. Other significant conditions - Conditions contributing to death but not previously listed in Part I. <b>None</b>	APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE



CERTIFIER

27a. 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.
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27b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara L. Fuller</i>	27c. MEDICAL LICENSE NO. <b>01034701</b>	27d. DATE SIGNED (Month Day, Year) <b>2/18/92</b>
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HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Barbara L. Fuller, M.D. 3229 Broadway, Gary, IN 46409</b>	31. HEALTH OFFICER'S SIGNATURE <i>Barbara L. Fuller</i>	32. DATE FILED (Month Day, Year) <b>FEB 18 1992</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"/> 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 P.O. or 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.
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*[Handwritten signature]*  
HEALTH COMMISSIONER  
CITY OF GARY, IND.  
DATE MAR. 11 1992