93021387

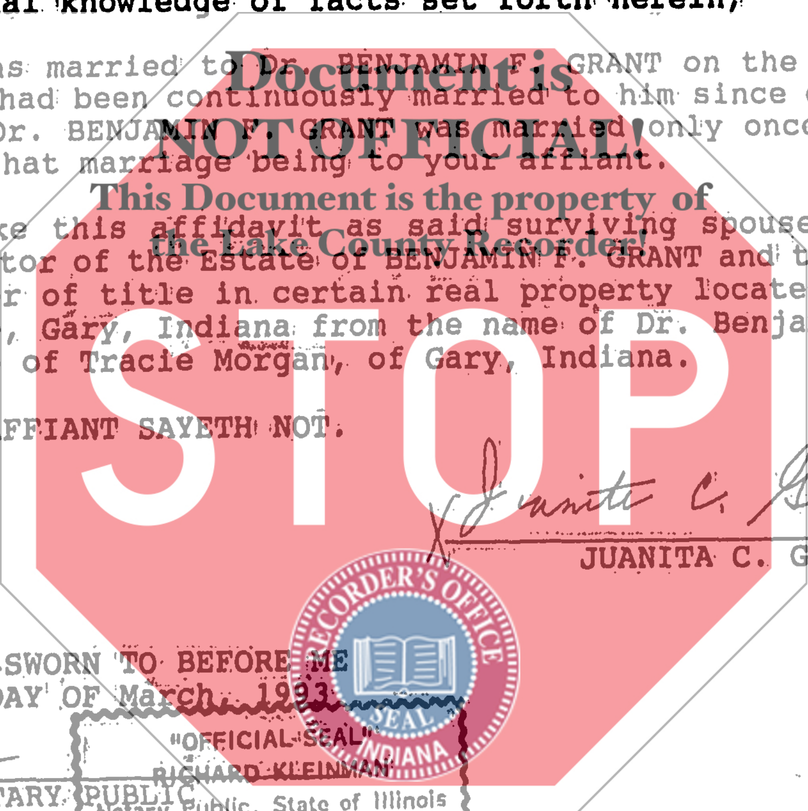
N

STATE OF ILLINOIS)
) SS.
COUNTY OF C O O K)

AFFIDAVIT REGARDING MARRIAGE

I, JUANITA C. GRANT, being first duly sworn on oath, depose and state that if called upon to testify in the above-captioned matter, I could competently testify to the following facts:

1. I am the surviving spouse of Dr. BENJAMIN F. GRANT, who died December 20, 1992 and also am named as the executor of the Last Will and Testament of BENJAMIN F. GRANT and in those capacities I have personal knowledge of facts set forth herein;



2. I was married to Dr. BENJAMIN F. GRANT on the date of his death, and had been continuously married to him since our marriage in 1945. Dr. BENJAMIN F. GRANT was married only once during his lifetime, that marriage being to your affiant.

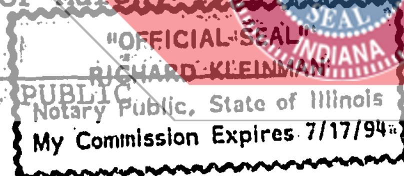
3. I make this affidavit as said surviving spouse and as the named executor of the Estate of BENJAMIN F. GRANT and to facilitate the transfer of title in certain real property located at 1279 W. 16th Avenue, Gary, Indiana from the name of Dr. Benjamin F. Grant to the name of Tracie Morgan, of Gary, Indiana.

FURTHER AFFIANT SAYETH NOT.

X Juanita C. Grant
JUANITA C. GRANT

SIGNED AND SWORN TO BEFORE ME
THIS 22 DAY OF March, 1993

[signature]
NOTARY PUBLIC



RECORDER'S OFFICE SEAL INDIANA

STATE OF IND. LAKE COUNTY FILED

APR 6 8 54 AM '93
SAMUEL ORLICH
RECORDER

FILED
MAR 29 1993
Anna N. Anton
AUDITOR LAKE COUNTY

Bernard Kleinman
79 W Monroe St Ste 700
Chgo IL. 60603

01502

5ca 3vet. 2 C.

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 92-0908 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. Decedent—Name (First Middle Last): BENJAMIN F. GRANT
- 2. Sex: MALE
- 3a. Time of Death: 3:10 p.m.
- 3b. Date of Death (Month Day Yr): DECEMBER 20, 1992
- 4. Social Security Number: 577-22-6372
- 5a. Age—Last Birthday (Years): 85
- 5b. Under 1 Year (Months / Days):
- 5c. Under 1 Day (Hours / Minutes):
- 6. Date of Birth (Mo. Day, Yr): JANUARY 8, 1907
- 7. Birthplace (City and State or Foreign Country): MOUND CITY, ILLINOIS
- 8a. Was Decedent a U.S. Veteran?: YES
- 8b. Year Last Served in U.S. Armed Forces?: 1956
- 9a. Place of Death (Check only one): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
- 9b. Facility Name (If not institution, give street and number): ST. MARY MEDICAL CENTER
- 9c. City, Town or Location of Death: GARY
- 9d. County of Death: LAKE
- 10. Marital Status (Specify): MARRIED
- 11. Surviving Spouse (If wife, give maiden name): JUANITA CRONE
- 12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired): MEDICAL
- 12b. Kind of Business/Industry: PHYSICIAN
- 13a. Residence—State: INDIANA
- 13b. County: LAKE
- 13c. City, Town or Location: GARY
- 13d. Street and Number: 4675 JEFFERSON PL.
- 13e. Zip Code: 46408
- 13f. Inside City Limits: [ ] No [X] Yes
- 13g. On a Farm?: [X] No [ ] Yes
- 14. Citizen of What Country?: U.S.A.
- 15. Was Decedent of Hispanic Origin?: [X] No [ ] Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
- 16. Race—American Indian, Black, White, etc. (Specify): BLK.
- 17. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 5+

PARENTS

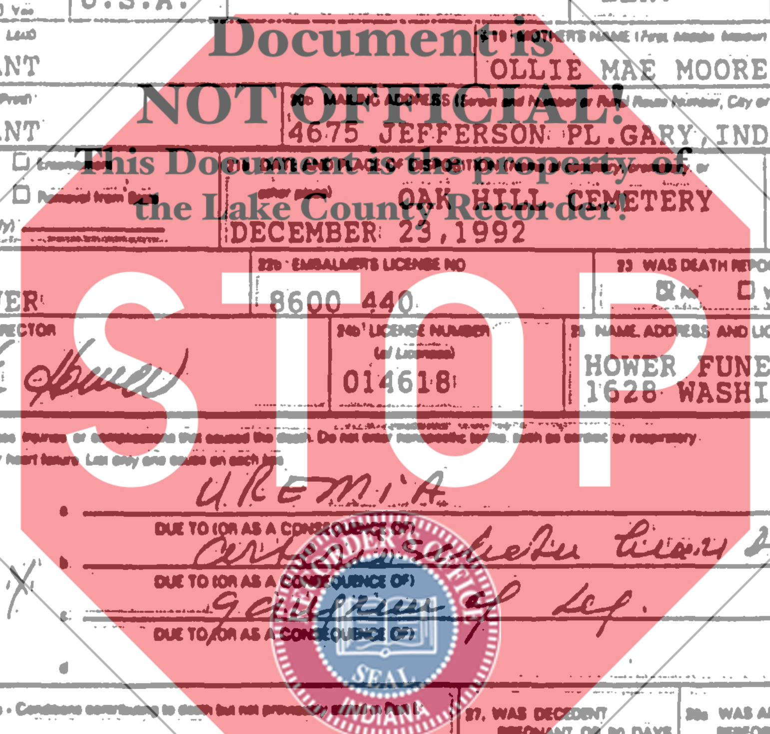
- 18. Father's Name (First Middle Last): RICHARD GRANT
- 19. Mother's Name (First Middle Maiden Surname): OLLIE MAE MOORE

INFORMANT

- 20a. Informant's Name (Type/Print): JUANITA GRANT
- 20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4675 JEFFERSON PL. GARY, IND. 46408
- 20c. Relationship: WIFE

DISPOSITION

- 21a. Method of Disposition: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
- 21b. Place of Disposition (Name of cemetery, crematory or other place): OAK HILL CEMETERY — DECEMBER 23, 1992
- 21c. Location—City or Town, State: GARY, INDIANA
- 22a. Embalmer's Name: JOHN V. HOWER
- 22b. Embalmer's License No.: 8600 440
- 23. Was Death Reported to Coroner?: [X] No [ ] Yes
- 24a. Signature of Funeral Director: *[signature]*
- 24b. License Number (of Licensee): 014618
- 25. Name, Address and License Number of Funeral Home: HOWER FUNERAL HOME 3002518, 1628 WASHINGTON ST. GARY, IND.



CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter 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. UREMIA
- Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: X
  - b. Due to (or as a consequence of): Arteriosclerotic Liver Disease
  - c. Due to (or as a consequence of): gangrene of leg
  - d. Due to (or as a consequence of):

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

- 27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no): NO
- 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

- 29a. Certifier (Check only one): X
  - [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated.
  - [ ] 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.
  - [ ] 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: X R A Hovanessian MD
- 29c. Medical License No.: X 01027583
- 29d. Date Signed (Month Day Year): X 12/23/92
- 30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): Dr. Raffy Hovanessian, M.D. X 7963 Broadway, Merrillville, Indiana 46410

HEALTH OFFICER

- 31. Health Officer's Signature: *[signature]*
- 32. Date Filed (Month Day Year): DEC 28 1992

CORONER USE ONLY

- 33. Manner of Death: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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.

FILED

MAR 29 1993

Dana N. Antos — AUDITOR LAKE COUNTY

01503

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD