RETURN TO:
SEARS
2500 LAKE COOK RD SUITE CL-A
RIVERWOODS, IL 60015

STATE OF INDIANA)
)
COUNTY OF LAKE) SS:

93046294

AFFIDAVIT OF SURVIVORSHIP

MARY CHANDLER, being of legal age, and duly sworn on HER oath, deposes and says:

That MARY CHANDLER is the owner in fee simple title of the following described real estate located in LAKE County, Indiana, to-wit:

LOTS TWENTY (20) AND TWENTY- ONE (21) IN BLOCK SIX (6), IN GARY PARK, IN THE CITY OF GARY, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 6, PAGE 25, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

K 25-48-225-20

JUL 19 9 23 AM 93
RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

Affiant further states that MARY CHANDLER and SAMUEL P. CHANDLER now deceased were husband and wife at the time they acquired title to aforesaid real estate until the death of SAMUEL P. CHANDLER on February 28 19 92, at which time this affiant acquired title to said real estate as a surviving tenant by the entireties. Indiana State Board of Health Medical Certificate of Death # issued .

There has not been any administration upon the estate of the said , deceased, nor is any administration contemplated.

The estate of SAMUEL P. CHANDLER was not subject to any Federal Estate Tax.

Affiant makes this affidavit for the purpose of causing the proper transfer of the real estate in the Offices of the Auditor of LAKE County, Indiana.

X Mary Chandler
MARY CHANDLER

Subscribed and sworn to before me a Notary Public, in and for said County, this 30th day of June, 19 93.

My commission expires 10/10/93

FILED
JUL 16 1993
Auditor N. Astorga
AUDITOR LAKE COUNTY

X James A. Ross
Notary JAMES A. ROSS
I live in Lake County, IN

RETURN TAX STATEMENTS TO:
MARY CHANDLER
1200 W 25th AVE
GARY, INDIANA 46407

This instrument prepared by Lori Eaton

30210

Form BRP100

$ 00

Sec 1 C

30

Local No. 92-0183

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Samuel Phillip Chandler
2 SEX: Male
3a TIME OF DEATH: 8:30 p.m
3b DATE OF DEATH (Month Day Yr): February 28,1992
4 SOCIAL SECURITY NUMBER: 317-09-8355
5a AGE—Last Birthday (Years): 77
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): January 10,1915
7 BIRTHPLACE (City and State or Foreign Country): Terry,Mississippi
8a WAS DECEDENT A US VETERAN?: Yes
8b YEAR LAST SERVED IN US ARMED FORCES?: 1945
8c PLACE OF DEATH (Check only one See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing home [ ] Other (Specify) [ ] Residence
9a FACILITY NAME (If not institution give street and number): St. Mary's Medical Center
9b CITY TOWN OR LOCATION OF DEATH: Gary
9c COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Mary D. Peterson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Electrician
12b KIND OF BUSINESS/INDUSTRY: USX
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1200 W.25th Ave.
13e ZIP CODE: 46407
13f INSIDE CITY LIMITS [ ] No [X] Yes
13g ON A FARM? [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First Middle Last): Sam Chandler
19 MOTHER'S NAME (First Middle Maiden Surname): Julia Bozeman

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mary D. Chandler
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 1200 W.25th Ave. Gary, IN. 46407
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): March 6,1992 Ridgelawn Cemetery
21c LOCATION—City or Town State: Gary,Indiana
22a EMBALMER'S NAME: Roosevelt Allen Sr.
22b EMBALMER'S LICENSE NO: 01051696
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Roosevelt Allen Sr.
24b LICENSE NUMBER (of Licensee): 08700646
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Directors,Inc. 2959 W.11th Ave. Gary,IN. 46404

CAUSE OF DEATH

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

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Pulmonary embolism
DUE TO (OR AS A CONSEQUENCE OF):
b. acute Bronchopneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c. septicemia
DUE TO (OR AS A CONSEQUENCE OF):
d. Tracheostomy status

Conditions if any which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death

FILED
JUL 16 1992
LAKE COUNTY CORONER

PART II Other significant conditions Conditions contributing to death but not previously stated in Part I: renal failure Shock Dehydration Hypertension Alzheimer's Disease

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] 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) on manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER: Fred S Cho M.D
29c MEDICAL LICENSE NO: 26083
29d DATE SIGNED (Month Day Year): 2/28/92

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): FRED S. CHO, M.D 9129 Southwood Dr. Munster, IN 46321
31 HEALTH OFFICER'S SIGNATURE: Robert E Foster MD MPH&C
32 DATE FILED (Month Day Year): MAR. 1 3 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