

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

95 FEB 28 AM 10:03

RECORDER

95010718

DECEASED JOINT TENANTS AFFIDAVIT

The undersigned, being duly placed under oath, deposes and states:

1. The undersigned is the surviving joint tenant of the following property legally described as:

Lots Fourteen (14) and Fifteen (15) in Block Two (2), J.L. Apperson's 1st Addition, in the City of Gary, as shown in Plat Book 10, page 2, in the Recorder's Office of Lake County, Indiana.

2. That my co-tenant Beatrice Pennington, died on the 8th day of January, 1995, without having first conveyed her interest in the above-described real estate.



Melvin Pennington
MELVIN PENNINGTON

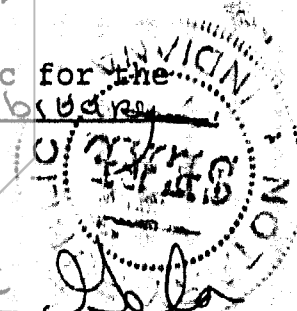
Subscribed and sworn to before me a notary public for the State of Indiana, County of Lake this 20th day of February 1995.

Resident of Lake County

My Commission Expires: 1-20-96



James E. DeLoe
Notary Public



FILED

FEB 24 1995

SAM ORLICH
AUDITOR LAKE COUNTY

001062

860

David Saks
76936 Indpls Blvd. N.M. 46324

* ATTENTION ESTATE: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 95-0021

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

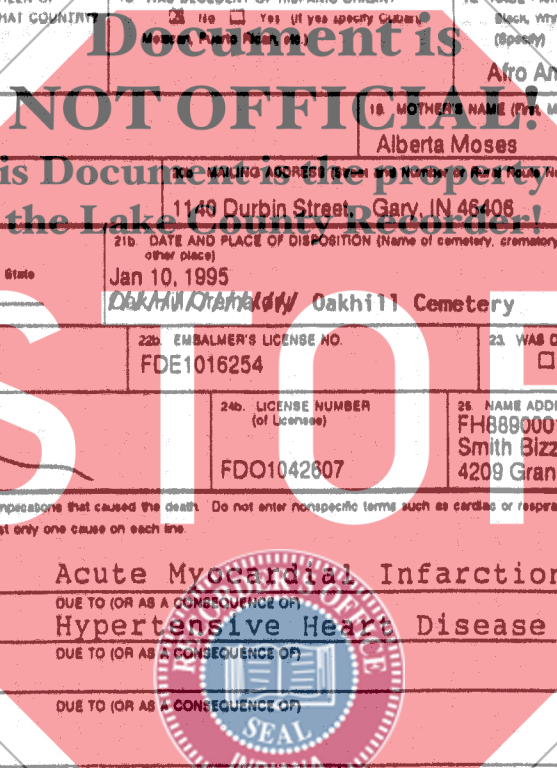
DISPOSITION

CAUSE OF DEATH

| | | | | | |
|--|---|--|---|--|--|
| 1. DECEASED-NAME (First Middle Last) Beatrice PENNINGTON | | 2. SEX Female | 3a. TIME OF DEATH 7:45PM | 3b. DATE OF DEATH (Month Day Yr) January 8, 1995 | |
| 4. SOCIAL SECURITY NUMBER 177142888317-42-8538 | | 5a. AGE - Last Birthday (Years) 50 | 5b. UNDER 1 YEAR (Months Days) | 5c. UNDER 1 DAY (Hours Minutes) | |
| 6. DATE OF BIRTH (Mo Day Yr) Jan 29, 1935 | | 7. BIRTHPLACE (City and State or Foreign Country) Huntsboro, AL 36860 | | | |
| 8a. WAS DECEDENT A U.S. VETERAN? No | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A | 8c. PLACE OF DEATH (Check only one - See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Methodist Northlake | | 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) Meivin Pennington | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife | 12b. KIND OF BUSINESS INDUSTRY Domestic | | |
| 13a. RESIDENCE - STATE IN | 13b. COUNTY Lake | 13c. CITY TOWN OR LOCATION Gary | 13d. STREET AND NUMBER 1140 Durbin Street | | |
| 13e. ZIP CODE 46406 | 13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14. CITIZEN OF WHAT COUNTRY USA | 15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Country) Afro Amer | 16. RACE - American Indian, Black, White, etc. (Specify) Afro Amer | |
| 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) 05 | | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) 05 | |
| 18. FATHER'S NAME (First, Middle, Last) John Key | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alberta Moses | | | |
| 20a. INFORMANT'S NAME (Type/Print) Meivin Pennington | | 20b. MAILING ADDRESS (Street and Rural Route Number, City or Town, State, Zip Code) 1140 Durbin Street, Gary, IN 46408 | | 20c. Relationship Husband | |
| 21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Jan 10, 1995 Oakhill Cemetery | | 21c. LOCATION - City or Town State Gary, IN | |
| 22a. EMBALMER'S NAME Sherman G. Banks | | 22b. EMBALMER'S LICENSE NO. FDE1016254 | 23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i> | | 24b. LICENSE NUMBER (of License) FDO1042607 | 25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH88900011 Smith Bizzell & Warner 4209 Grant Street, Gary, IN 46408 | | |
| 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. | | | | Approximate Interval Between Onset and Death | |
| a. Acute Myocardial Infarction | | | | 6 minutes | |
| b. Hypertensive Heart Disease | | | | 10 years | |
| c. _____ | | | | _____ | |
| d. _____ | | | | _____ | |
| 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 | | |
| 29a. 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. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | |
| 29c. MEDICAL LICENSE NO. 01028821 | | 29d. DATE SIGNED (Month Day Year) 01/10/95 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. George T. Clardy, 650 Grant Street, Gary, IN 46407 (46404) | | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> | | | | 32. DATE FILED (Month Day Year) JAN 10 1995 | |
| 33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <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) 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. No | | | |

FILED
FEB 24 1995

SAM ORLICH
AUDITOR LAKE COUNTY



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