Ticor-M.O.
195281
Anderson

2

# TICOR TITLE INSURANCE

## AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE )

Inez R. Anderson, being first duly sworn upon oath, deposes and says:

1. That F. Laurence Anderson, Jr. died on March 6, 1991, 19 91 at Methodist (Northlake) Hospital Gary, Indiana.

2. That F. Laurence Anderson, Jr. and Inez R. Anderson were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 40 in Maruqette Manor, in the City of Gary, as per plat thereof, recorded in Plat Book 29 page 111, in the Office of the Recorder of Lake County, Indiana.

25-44-516-40



3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) ~~(her)~~ death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Inez R. Anderson
Inez R. Anderson

Subscribed and sworn to before me, a Notary Public, this 13th day of October, 19 95.

FILED

OCT 17 1995

SAM ORLICH
AUDITOR LAKE COUNTY

Paula Barrick Notary Public

My Commission expires:
10-2-97

County of Residence:
Lake

This Instrument prepared by Inez R. Anderson

95062721

95 OCT 18 AM 9:39

MARGARETTE OPPELAND
RECORDER

LAKE COUNTY
FILED FOR RECORD

000957

11.00

Jtotal

# INDIANA STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

Local No. 91-0200 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

| 1. DECEASED—NAME (First, Middle, Last) | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr.) |
|---|---|---|---|
| F. Laurence Anderson | Male | 5:45 p.m. | March 6, 1991 |

| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR Months / Days | 5c. UNDER 1 DAY Hours / Minutes | 6. DATE OF BIRTH (Mo. Day, Yr.) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 304-14-8035 | 73 | | | October 8,1917 | Utica,Mississippi |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? | 9. PLACE OF DEATH (Check only one. See instructions.) |
|---|---|---|
| Yes | 1946 | HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence |

| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| Methodist Hospital Northlake | Gary | Lake |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | Inez R Rempson | Attorney | Self-employed |

| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Gary | 6525 Birch Place |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? | 16. RACE—American Indian, Black, White, etc. | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) |
|---|---|---|---|---|---|
| 46403 | 13g. ON A FARM ☒ No ☐ Yes | USA | ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | Black | Elementary/Secondary (0-12): — College (1-4 or 5+): 7 years |

PARENTS

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| F. Laurence Anderson | Addie Hendley |

INFORMANT

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| Inez R. Anderson | 6525 Birch Place Gary,Indiana 46403 | Wife |

DISPOSITION

| 21a. METHOD OF DISPOSITION | 21b. PLACE OF DISPOSITION (Name of Cemetery, Crematory, or Other Place) | 21c. LOCATION—City or Town, State |
|---|---|---|
| ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Removal from State | March 11, 1991 Evergreen Cemetery | Hobart, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO. | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| Roosevelt Allen Sr. | #01051696 | ☒ No ☐ Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| [signature] | 08700646 | 83007704 Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary,Indiana 46404 |

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. — Approximate Interval Between Onset and Death

| | |
|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) a. | Acute Respiratory Failure |
| DUE TO (OR AS A CONSEQUENCE OF) b. | Extensive Cerebral Infaretion |
| DUE TO (OR AS A CONSEQUENCE OF) c. | Dehydration |
| DUE TO (OR AS A CONSEQUENCE OF) d. | Dysphagia |

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

Aspiration Pneumonia
Malnutrition
Status Post Bilateral Above Knee Amputation

| 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|
| no | no | no |

CERTIFIER

29a. CERTIFIER (Check only one)
- ☒ 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 | 29c. MEDICAL LICENSE NO. | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| G.B. Mitchell | 01018611 | 3-14-91 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Georgia B. Mitchell, M.D. 3195 Broadway Gary, IN 46409

HEALTH OFFICER

| 31. HEALTH OFFICER'S SIGNATURE | 32. DATE FILED (Month, Day, Year) |
|---|---|
| [signature] | MAR 18 1991 |

CORONER USE ONLY

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide | | | | |

| 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. |
|---|---|
| | |

SBH06-004 State Form 10110 (R2/3-8) DEA CERT/PD 1