12086

COMMUNITY TITLE COMPANY
— An Indiana Corporation —
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

COMMUNITY TITLE COMPANY

2

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

REGINA MOORE, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, JESSIE MOORE died (without leaving a will) (~~XXXXXXXXXXXXXX~~) on SEPT. 25, 1994 at COMMUNITY HOSPITAL, MUNSTER, IN.

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOTS 32 AND 33 IN BLOCK 7 IN SCHUG PARK SOUTH BROADWAY ADDITION TO GARY, AS PER PLAT THEREOF, RECORDED MAY 27, 1909 IN PLAT BOOK 8 PAGE 9, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 3661 MARYLAND ST., GARY, IN. 46409

96030081

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

96 MAY -7 AM 11:20

MARGARET BUD
RECORDER

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.

REGINA MOORE

FILED
MAY
1996
AUDITOR
SAM ORECH
LAKE COUNTY

Subscribed and sworn to before me, a Notary Public this 25th day of March, 19 96.

Notary Public
Daniel W. Slusser

My Commission expires:
8/3/96

County of Residence:
LAKE

1/92

This Instrument prepared by RICHARD PARKS, ATTORNEY AT LAW

000311

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2280-94 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Jessie Moore Jr.
2. SEX: Male
3a. TIME OF DEATH: 10:15 P.M.
3b. DATE OF DEATH (Month, Day, Yr.): September 25, 1994
4. *SOCIAL SECURITY NUMBER: 432-46-0535
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR (Months, Days): 5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day Yr.): Jan. 9, 1929
7. BIRTHPLACE (City and State or Foreign Country): Rison, Arkansas
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? -----
8c. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9a. FACILITY NAME (If not institution, give street and number): Community Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Munster
9c. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Regina Sims
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Tractor Driver (Retired)
12b. KIND OF BUSINESS/INDUSTRY: LTV Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 3601 Maryland Street
13e. ZIP CODE: 46409
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 7th Grade; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Jessie Moore Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Brandon

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Regina Moore
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3601 Maryland St. Gary, Indiana 46409
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): September 29, 1994 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO: FD086C0238
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b. LICENSE NUMBER (of Licensee): FD08600238
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams Funeral Home FH83001520, 4859 Alexander Ave. East Chicago, In.

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. Squamous cell Cancer of Right
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE [illegible] HEALTH DEPARTMENT

MAR 29 1996

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

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): -----

CERTIFIER

29a. CERTIFIER (Check only one):
☐ CERTIFY NO 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 date, time and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara L. Fuller, MD
29c. MEDICAL LICENSE NO: 01034701
29d. DATE SIGNED (Month, Day, Year): 9/27/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Barbara L. Fuller, M.D. 741 West 45th St. Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams M.D.
32. DATE FILED (Month, Day, Year): September 28, 1994

AUDITOR'S RECEIPT LAKE COUNTY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

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