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97 MAR 12 PM 3:18

MORRIS W. CARTER
RECORDER

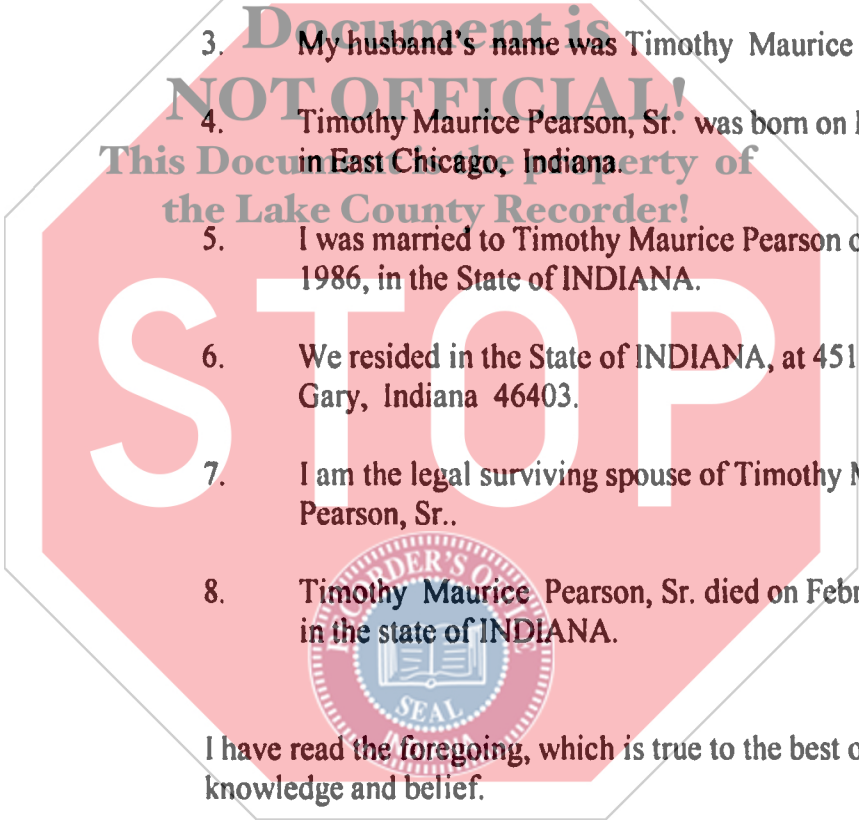
3
STATE OF ILLINOIS,)
)SS
COUNTY OF COOK)

AFFIDAVIT

I, Vickie Renee Pearson, being duly sworn on oath states as follows:



1. My maiden name was Vickie Renee Woods.
2. I was born on June 9, 1959, in Chicago, Illinois.
3. My husband's name was Timothy Maurice Pearson, Sr..
4. Timothy Maurice Pearson, Sr. was born on May 21, 1956, in East Chicago, Indiana.
5. I was married to Timothy Maurice Pearson on June 21, 1986, in the State of INDIANA.
6. We resided in the State of INDIANA, at 4511 E. 6th Place, Gary, Indiana 46403.
7. I am the legal surviving spouse of Timothy Maurice Pearson, Sr..
8. Timothy Maurice Pearson, Sr. died on February 8, 1997, in the state of INDIANA.



I have read the foregoing, which is true to the best of my knowledge and belief.

Further Affiant Saith Not.

Vickie Renee Pearson
Vickie Renee Pearson, Surviving Legal Spouse
of Timothy Maurice Pearson, Sr.

1300
CS

599-A

PROPERTY TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER.

MAR 12 1997

SAM ORLICK
AUDITOR LAKE COUNTY

→ 1140 E. 91st St. Chicago Ill. 60619

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 32

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

CERTIFIER

HEALTH OFFICER

#46-560-10
#46-561-23

1. DECEASED—NAME (First, Middle, Last) Timothy M. Pearson, Sr		2. SEX Male	3a. TIME OF DEATH 7:11 P.M.	3b. DATE OF DEATH (Month, Day, Year) February 8, 1997	
4. SOCIAL SECURITY NUMBER 310-68-3304	5a. AGE—Last Birthday (Years) 40	5b. UNDER 1 YEAR Month: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Month, Day, Year) May 21, 1956	
7. BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		
9a. FACILITY NAME (If not institution, give street and number) St. Catherine Hospital		9b. CITY, TOWN OR LOCATION OF DEATH East Chicago		9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Vickie Woods	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Burner		12b. KIND OF BUSINESS/INDUSTRY Inland Steel	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION East Chicago	13d. STREET AND NUMBER 3730 Pennsylvania Avenue		
13e. ZIP CODE 46312	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 1 Year		17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)			
18. FATHER'S NAME (First, Middle, Last) Charles P. Pearson		19. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Louise Lindsey			
20a. INFORMANT'S NAME (Type/Print) Vickie Pearson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3730 Pennsylvania Ave., East Chicago, IN 46312		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) February 15, 1997 Evergreen Memorial Park		21c. LOCATION—City or Town, State Hobart, Indiana	
22a. EMBALMER'S NAME Tracy Cheri Williams		22b. EMBALMER'S LICENSE NO. FDO8600238		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b. LICENSE NUMBER (of Licensee) FDO8600238		25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Hinton-Williams Funeral Home 83001520 4859 Alexander Avenue East Chicago, Indiana 46312	
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. a. Asphyxia DUE TO (OR AS A CONSEQUENCE OF)				Approximate Interval Between Onset and Death Unknown	
IMMEDIATE CAUSE (Final disease or condition resulting in death) b. Due to obstruction of airway DUE TO (OR AS A CONSEQUENCE OF)					
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last c. _____ DUE TO (OR AS A CONSEQUENCE OF)					
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) Yes	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes		
29a. CERTIFIER (Check only one) Deputy		<input 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 checked="" 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>Charles M. Melyon</i>		29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month, Day, Year) February 10, 1997		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307					
31. HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy M. Pearson</i>				32. DATE FILED (Month, Day, Year) 2-13-97	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
		34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)	34d. LOCATION (Street and Number or Rural Route Number, City or Town, State) 000000		
34g. DATE PRONOUNCED DEAD (Month, Day, Year) February 8, 1997		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. No			

