Shirley Lunsford
6721 Harrison ct.
Merr. 46410

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97-300-L-4 081897:mf

FILED

OCT 20 1997

SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

AFFIDAVIT OF SURVIVORSHIP

Shirley Ann Lunsford, being first duly sworn upon her oath, deposes and says as follows:

1. That she currently resides at 6721 Harrison Court, Merrillville, Indiana.

2. That affiant is the daughter of Gareldean I. Clay, who died testate a resident of Lake County, Indiana on the 12th day of February, 1997, and attached to this Affidavit as Exhibit "A" is a copy of her Death Certificate.

3. That affiant owned real estate with said decedent and Mary Louise Alonso as joint-tenants with right of survivorship at the time of decedent's death, said real estate being commonly known as 149 Kelly Street, Hobart, Indiana, and legally described as follows:

97071072

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 OCT 20 AM 10:46
HOPE S. CARTER
RECORDER

Lot 11, Van Black's Addition to Hobart, as shown in Plat book 23, page 36, in Lake County, Indiana

4. That no administration of the estate of Gareldean I. Clay is pending, or contemplated, and the gross value of said estate is insufficient to require administration or require the filing of a U.S. Estate Tax Return.

5. That inheritance tax found to be due has been paid.

6. That the purpose of this Affidavit is to establish clear title to said real estate and enable the Lake County Auditor to

001156 1400

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transfer upon its records ownership of said real estate in the name of this Affiant and Mary Louise Alonso for purposes of taxation.

Further Affiant sayeth not.

IN WITNESS WHEREOF, the said Shirley Lunsford has hereunto set her hand and seal this 18th day of August, 1997.

Shirley Lunsford

Shirley Lunsford

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Subscribed and sworn to before me a Notary Public in and for said County and State, this 18th day of August, 1997.

Margaret A. Irala

Notary Public

Resident of Lake County

My Commission Expires: 10-12-99

50

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

Local No. 350-97

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

43471

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

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)
GARELDEAN CLAY	Female	4:13PM	February 12, 1997

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)
313-14-7147	90			Sep 13, 1906	Bismarck, Illinois

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES	8c. PLACE OF DEATH (Check only one. See instructions)
No	N/A	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
St. Mary Medical Center	Hobart	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
Widowed	NONE	Medical Records	Medical

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hobart	149 Kelley Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE - American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46342	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John Burton Ingram	Hester Carter

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
Shirley Lunsford	6721 Harrison Court, Merrillville, IN 46410	Daughter

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c. LOCATION - City or Town State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Feb 15, 1997 Calumet Park Cemetery	Merrillville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FD01006463	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FD01006463	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. Cardio Respitory Arrest	20 minutes
	DUE TO (OR AS A CONSEQUENCE OF)	
	b. Carcinoma Colon	1 year
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	c. Anemia	1 year
	DUE TO (OR AS A CONSEQUENCE OF)	
	d. Arteriosclontic Heart Diease	10 years

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Degenerative Arthritis	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)
	01031797	February 14, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)

Shashikant R. Rane M[illegible] N. Michigan Avenue, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE [illegible] M.D

32. DATE FILED (Month Day Year) February 14, 1997

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.

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

[illegible] COUNTY HEALTH COMMISSIONER