

STATE OF INDIANA )  
 )ss:  
COUNTY OF LAKE )  
97086099

STATE OF INDIANA  
LIN. REC. MATTER OF THE OF THE  
FILED FOR RECORD  
ESTATE OF BEATRICE JEFFERY, DECEASED  
97 DEC 15 PM 3:00

**SMALL ESTATES AFFIDAVIT FOR THE TRANSFER OF  
REAL PROPERTY**

1. That the above named decedent died intestate on the 22nd day of January, 1990, while domiciled in Lake County.
2. That 45 days have elapsed since the death of the decedent.
3. That no application or petition for the appointment of personal representative is pending or has been granted in any jurisdiction nor is any administration contemplated.
4. That the following named persons are the only heirs of the decedent, her children:

John Jeffery  
Eden, North Carolina

Margaret McFerrin  
Missouri

Hattie Preyer  
Missouri

Tommy L. Jeffery  
5144 Jefferson St.  
Gary, IN 46408

DULY ENTERED FOR TAXATION SUBJECT TO  
FINAL ACCEPTANCE FOR TRANSFER.

DEC 15 1997

AUDITOR LAKE COUNTY

5. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of the allowance provided by I.C. 29-1-8-1, the costs and expenses of administration and reasonable funeral expenses.

6. That among the decedent's probate assets is a parcel of real estate which the decedent owned 50% of, located in Lake County Indiana, more particularly described as follows:

Key #41-175-17  
Lot 17 in Block 4, Broadway Home Acres Subdivision in the  
City of Gary as recorded in Plat Book 22, Page 17 in the office  
of the Recorder of Lake County.

That the Fair Market value for said real estate at the time of her death was

000054

1300  
1193

Thirty Thousand (\$30,000.00) That there exists a mortgage balance on said property in the amount of Twenty-eight Thousand (\$28,000.00) dollars.

NET ESTATE (50% of equity in house) \$1000.00

7. That the following are creditors of the decedent:

Rees and Kleine (attorney fees)	\$200.00
Kaufman Funeral Home	\$200.00
Treasurer of Lake County (50% of real property taxes)	<u>\$1978.00</u>

TOTAL ESTATE DEBT \$2398.00

TOTAL VALUE OF THE ESTATE (VALUE LESS DEBT) (-\$1398.00)

8. That the individuals entitled to the real estate as a result of the decedent's death are the decedent's heirs at law, those listed in paragraph 4 above.

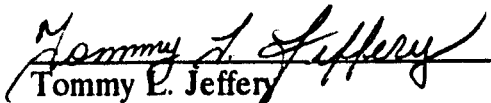
9. That the gross value of the estate of the decedent, Beatrice G. Jeffery, as determined for the purposes of Federal Estate taxes, was less than the value required for the filing of a Federal Estate Tax Return. There was no Federal Estate Tax Due.

10. That the decedent's estate was not subject to Indiana Inheritance Tax.


11. That the estate continues to accumulate debt as a result of the ongoing real property taxes, repairs to the home and other related expenses.

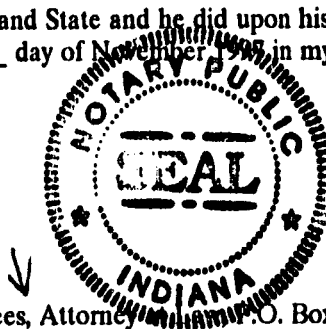
Wherefore the affiant prays the Recorder of Lake County removes the name of Beartice G. Jeffery from the title to said property and replace it with the four heirs of the decedent.

Further the affiant sayeth not.

  
Tommy L. Jeffery

Before me a Notary Public in and for said County and State and he did upon his oath attest to the truth of the forgoing statements and he did sign this on this 7 day of November, 1999, in my presence.

  
Patricia A. Rees  
Notary Public  
My Commission Expires: 7-5-99  
Resident of Lake County



This Instrument Prepared by Patricia A. Rees, Attorney, P.O. Box 488, Hobart, In 46342

90-0085

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

pl No. ....

PE/PRINT IN PERMANENT INK

IDENT

ENTS

ORMANT

POSITION

USE OF ATH

RTIFIER

ALTH ICER

RONER E ONLY

1 DECEASED—NAME (First Middle Last) <b>Beatrice Jeffery</b>				2 SEX <b>Female</b>		3a TIME OF DEATH <b>3:28p. M</b>		3b DATE OF DEATH (Month, Day, Yr) <b>January 22, 1990</b>		
4 SOCIAL SECURITY NUMBER		5a AGE—Last Birthday (Years) <b>77</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo. Day, Yr) <b>July 19, 1912</b>		
7 BIRTHPLACE (City and State or Foreign Country) <b>Tenn.</b>		8a WAS DECEDENT A US VETERAN? <b>No</b>		8b YEAR LAST SERVED IN US ARMED FORCES? <b>None</b>		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b FACILITY NAME (If not institution, give street and number) <b>St. Mary Medical Center</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>		9d COUNTY OF DEATH <b>Lake</b>				
10 MARITAL STATUS (Specify) <b>Widowed</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>None</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Farmer</b>			12b KIND OF BUSINESS/INDUSTRY <b>None</b>			
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN, OR LOCATION <b>Gary</b>		13d STREET AND NUMBER <b>5144 Jefferson Street</b>				
13e ZIP CODE <b>46408</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>Black Amer.</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th. Grade</b> College (1-4 or 5+)
18 FATHER'S NAME (First Middle Last)					19 MOTHER'S NAME (First Middle Maiden Surname) <b>Fannie Mae Hicks</b>					
20a INFORMANT'S NAME (Type/Print) <b>Margaret McFerrin</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>921 Ralston St., Gary, Indiana 46404</b>				20c Relationship <b>Sister</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>January 29, 1990 Fern Oaks</b>				21c LOCATION—City or Town, State <b>Griffith, Indiana</b>			
22a EMBALMER'S NAME <b>CELESTE P. KAUFMAN</b>			22b EMBALMER'S LICENSE NO. <b>FDE 1033626</b>			23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a SIGNATURE OF FUNERAL DIRECTOR <i>Celeste P. Kaufman</i> Celeste P. Kaufman			24b LICENSE NUMBER (of Licensee) <b>FDE: 1033626</b>		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>KAUFMAN FUNERAL HOMES, INCORPORATED 421 West Fifth Avenue, Gary, IN 46402 FDH No: 3002411</b>					
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. <b>CARDIOPULMONARY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF) <b>CONGESTIVE HEART FAILURE</b>								Approximate Interval Between Onset and Death		
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) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
29a CERTIFIER (Check only one) <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 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. <b>01032180</b>		29d DATE SIGNED (Month, Day, Year) <b>1/31/90</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Surendra Shah, Lake Station</b> <b>3520 Fairview Ave., Lake Station, Indiana</b>					31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) <b>FEB. 1 1990</b>	
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)	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.							