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**FILED**

STATE OF INDIANA )  
 )  
 ) SS:  
COUNTY OF LAKE )  
  
IN THE MATTER OF )  
MAXINE E. JONES, )  
Deceased. )

DEC 23 1997

**SAM ORLICH**  
**AUDITOR LAKE COUNTY**

**AFFIDAVIT OF HEIRSHIP**

LaChaundra Laster, being duly sworn upon her oath, deposes and states as follows:

1. Maxine E. Jones, the above-named decedent died intestate on the 23<sup>rd</sup> of October, 1996 while residing in Lake County, Indiana
2. No petition for the appointment of personal representative is pending in any Court in this state and forty-five days have elapsed since the death of the decedent.
3. The affiant, LaChaundra Laster, residing at 350 Polk Street, Gary, IN 46402, is the adult daughter of the decedent.
4. The only heirs of the decedent are as follows:  
LaChaundra Laster-adult daughter
5. The value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of the allowances provided I.C. 29-1-4-1, the costs and expenses of administration and reasonable funeral expenses.
6. Among decedent's probate assets is a parcel of real estate which was owned by the decedent and located in Lake County, Indiana, more particularly described as follows:

Gary Land Companies 1<sup>st</sup> Subdivision, South 21 1/4 feet of Lot 33, Block 113, North 15 feet, Lot 34, Block 113

Commonly known as 350 Polk Street, Gary, IN 46402

Key No. 44-113-30

7. There are no creditors of the estate of the decedent.
8. The gross value of the estate of the decedent, MAXINE E. JONES, as determined for purposes of Federal taxes was less than the value required for the filing of a

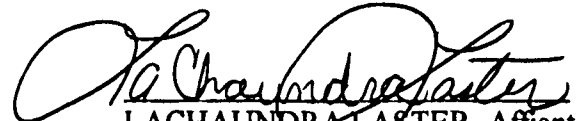
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MORRIS W. CARTER  
FILED FOR RECORD  
STATE OF INDIANA  
LAKE COUNTY  
DEC 26 AM 11:43

001462

1300  
2901

Federal Estate Tax Return and the decedent's estate was not subject to a Federal Estate or Indiana Inheritance Tax.

  
LACHAUNDRA LASTER, Affiant

Subscribed and sworn to before me, a Notary Public, this 12<sup>th</sup> day of March, 1997.

  
NOTARY PUBLIC

MAIL TO  
↓  
William Clyde Jones  
700 West Ridge Road  
Carmy, In. 46408

\* 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

Local No. **36-0711**

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED-NAME (First Middle Last) <b>Maxine Jones</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>12:39AM</b>	3b DATE OF DEATH (Month Day Yr) <b>October 23, 1996</b>
4 SOCIAL SECURITY NUMBER <b>316-24-2767</b>	5a AGE - Last Birthday (Years) <b>71</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>Apr 30, 1925</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Tiptonville, TN-38079</b>	8a PLACE OF DEATH (Check only one (See instructions))			
8a HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient	8b OTHER <input type="checkbox"/> Nursing home <input type="checkbox"/> Other (Specify)			
9a FACILITY NAME (If not institution, give street and number) <b>Methodist Northlake</b>	9b CITY TOWN OR LOCATION OF DEATH <b>Gary</b>	9c COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Divorced</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>Food handler</b>	12b KIND OF BUSINESS INDUSTRY <b>Food Service</b>	
13a RESIDENCE - STATE <b>IN</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Gary</b>	13d STREET AND NUMBER <b>352 Polk Street</b>	
14 ZIP CODE <b>46402</b>	15 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	16 CITIZEN OF WHAT COUNTRY? <b>USA</b>	17 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	18 RACE - American Indian, Black, White, etc. (Specify) <b>Afro Amer</b>
19 FATHER'S NAME (First, Middle, Last) <b>Gentry Jones</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hattye Hardy</b>		
20a INFORMANT'S NAME (Type Print) <b>Juanita Charleston</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2287 Pennsylvania Street, Gary, IN 46407</b>		20c Relationship <b>Daughter</b>
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) <b>Oct 31, 1996 Evergreen Memorial</b>		21c LOCATION - City or Town State <b>Hobart, IN</b>
22a EMBALMER'S NAME <b>Sherman G. Banks</b>		22b EMBALMER'S LICENSE NO. <b>FDE1016254</b>	22c WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ruth R. Skarnes</i>		24b LICENSE NUMBER (of License) <b>FDO9100591</b>	24c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>FHB6E00011 Smith Bizzell &amp; Warner 4209 Grant Street, Gary, IN 46408</b>	
25 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) <b>Cardiorespiratory Arrest</b>				
DUE TO (OR AS A CONSEQUENCE OF) <b>Acute Myocardial Infarction</b>				
CONDITIONS CONTRIBUTING TO THE IMMEDIATE CAUSE (List all conditions contributing to the immediate cause, stating the underlying cause last) <b>Hypertension &amp; Aneurysm</b>				
<b>DEC 23 1997</b>				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
<b>SAM ORLICH AUDITOR LAKE COUNTY</b>		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) <b>No</b>
29a. CERTIFIER (Check only one) <input checked="" 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>Edith Cannon MD</i>		29c. MEDICAL LICENSE NO. <b>01037499</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print) <b>Dr. Edith Cannon, 1619 West 5th Avenue, Gary, IN 46404.</b>				29d. DATE SIGNED (Month Day Year) <b>10/25/96</b>
31. HEALTH OFFICER'S SIGNATURE <i>Edith Cannon MD</i>			32. DATE FILED (Month Day Year) <b>OCT 30 1996</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be Determined	34a. DATE OF INJURY (Month Day Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) <b>No</b>	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) <b>0014675</b>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <b>No</b>		