

Please Return To:

ARNOLD KREVITZ
Attorney At Law
500 East 86th Avenue
Merrillville, IN 46410
(219) 769-1300

FILED

APR 6 1998

SURVIVORSHIP AFFIDAVIT

SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MARY WILLIAMS, being first duly sworn upon her oath,
deposes and says:

1. That she was married to RUBEN WILLIAMS who died a resident of Gary, Lake County, Indiana, on January 19, 1995, as evidenced by a Certified Death Certificate attached hereto and made a part hereof.

2. That at the time of his death, RUBEN WILLIAMS and MARY WILLIAMS, Husband and Wife, held title under a Warranty Deed to the following-described Real Estate, to-wit:

KEY # 47-176-1
Lots 1 and 2 in Block 3 in Van Liew and Funkey's First Subdivision in the City of Gary, as per plat thereof, recorded in Plat Book 21 page 10 in the Office of the Recorder of Lake County, Indiana. Commonly known as 4807 West 7th Avenue, Gary, Indiana 46406

3. That the Affiant and the Decedent, RUBEN WILLIAMS, were Husband and Wife continuously from April 29, 1968, the date they acquired title to the above-described Real Estate to the date of his death on January 19, 1995.

4. That the Estate of RUBEN WILLIAMS, decedent, was not of sufficient value to be subject to Federal Estate Taxes or Indiana Inheritance Taxes.

FURTHER AFFIANT SAYETH NOT.

Mary Williams
MARY WILLIAMS

2nd day of April 1998.
Subscribed and sworn to before me, a Notary Public, this

Arnold Krevitz
ARNOLD KREVITZ, Notary Public
Resident of Lake County

My Commission Expires:

01/24/2001

This Instrument Prepared by:

ARNOLD KREVITZ, Attorney At Law
500 East 86th Avenue
Merrillville, IN 46410
(219) 769-1300

98021115
98 APR - 6 PM 1:11
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

R
#1CSK
CK#14314 000383
1200 KM

3 units 2C
ATTENTION ESTATE: Disclosure of the
we need to pursue our responsibilities
voluntarily and there will be no penalty for
usual

RETURN TO ARNOLD KREVITZ, 500 E. 86th Ave., Merrillville
INDIANA STATE DEPARTMENT OF HEALTH KEY#47-176-1 46410

Local No. **98-0062** CERTIFICATE OF DEATH State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Ruben Williams		2 SEX Male	3a TIME OF DEATH 5:32p.	3b DATE OF DEATH (Month Day Year) Jan 19, 1995	
4 *SOCIAL SECURITY NUMBER 422-38-3266	5a AGE—Last Birthday (Years) 63	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) March 8, 1931	7 BIRTHPLACE (City and State or Foreign Country) Hatchechubbee, AL
8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? Army	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution give street and number) 4807 W. 7th Ave.		9c CITY TOWN OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Mary Scott	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Skilled Labor	12b KIND OF BUSINESS/INDUSTRY Hammond Valve CO.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 4807 W. 7th Ave.		
13e ZIP CODE 46406	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) 10th
18 FATHER'S NAME (First Middle Last) Jerry Williams		19 MOTHER'S NAME (First Middle Maiden Surname) Angela Covington			
20a INFORMANT'S NAME (Type/Print) Mary Lee Williams		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 4807 W. 7th Ave Gary, IN 46406		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) January 25, 1995 Fern Oaks Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Samuel Smith, Jr.		22b EMBALMER'S LICENSE NO 01019692	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Samuel Smith Jr.</i>		24b LICENSE NUMBER (of Licensee) 01019692	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Divinity Funeral Home 3820 Pulaski Street East Chicago, Indiana 83001570 46312		
26 PART I Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a <i>Acute myocardial infarction</i> b <i>Coronary artery disease</i> Conditions if any which gave rise to the immediate cause stating the underlying cause last c d		APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE FILED APR 6 1995 SAM ORLICH AUDITOR LAKE COUNTY			
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 WAS AN AUTOPSY AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
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>M. Williams</i>		29c MEDICAL LICENSE NO 25594	29d DATE SIGNED (Month Day Year) 1/24/95		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) MIGUEL Gambetta, M.D., 4326 FIR St. Ste 410, East Chicago, IN 46312					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32 DATE FILED (Month Day Year) JAN 25 1995
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		33a DATE OF INJURY (Month Day Year)	33b INJURY	33c INJURY AT WORK? (Yes or no)	33d DESCRIBE HOW INJURY OCCURRED
		34a PLACE OF INJURY—At home farm street factory, office building etc. (Specify)		34b LOCATION (Street and Number or Rural Route Number, City or Town, State)	
34c DATE PRONOUNCED DEAD (Month Day Year)		34d MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

000384