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STATE OF INDIANA

COUNTY OF LAKE

99029332

IN RE: JIMMY C. TRAYLOR, Decedent

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99 APR -6 PM 2:13

MORRIS W. CARTER
RECORDER

AFFIDAVIT FOR TRANSFER OF REAL PROPERTY

Rochonda Campbell, having been first duly sworn upon her oath states:

1. That the above-named decedent died intestate on June 18, 1995, while domiciled in Lake County, Indiana. A copy of the Death Certificate is attached to this Affidavit as Exhibit "A".

2. That forty-five (45) days have elapsed since the death of the decedent.

3. That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction nor is any administration contemplated.

4. That the following named person is the sole heir of the decedent's estate:

Rochonda Campbell of 9009 Manchester, Kansas City, Missouri 64138; Daughter

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 IC § 29-1-4-1, 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 was owned by the decedent located in Lake County, Indiana, more particularly described as follows:

LOT THIRTY-SEVEN (37) AND THE NORTH TWELVE FEET (N. 12') OF LOT THIRTY-SIX (36), IN BLOCK THIRTY (30), IN IRONWOOD UNIT, IN THE CITY OF GARY, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 21, PAGE 4, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

APR 06 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

1300
Jr
000365
5306

INDIANA STATE DEPARTMENT OF HEALTH
is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. **95-0464**

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


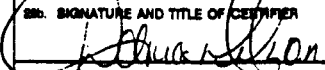
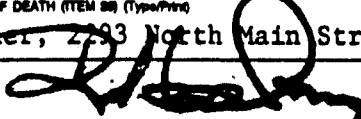
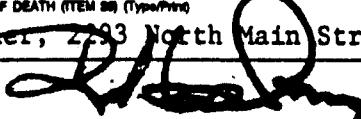
INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEDENT-NAME (First Middle Last) Jimmy C TRAYLOR		2. SEX Male	3a. TIME OF DEATH 9:00PM	3b. DATE OF DEATH (Month Day Yr) June 18, 1995			
4. SOCIAL SECURITY NUMBER 303-56-7699	5a. AGE - Last Birthday (Years) 47	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Nov 23, 1947	7. BIRTHPLACE (City and State or Foreign Country) GARY INDIANA CONO, MS		
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	9a. PLACE OF DEATH (Check only one. See instructions)					
HOSPITAL <input type="checkbox"/> Inpatient		OTHER <input type="checkbox"/> Nursing Home		<input type="checkbox"/> Other (Specify)			
<input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA		<input checked="" type="checkbox"/> Residence					
9b. FACILITY NAME (If not institution, give street and number) 2135 Ohio Street		9c. CITY TOWN OR LOCATION OF DEATH Gary	9d. COUNTY OF DEATH Lake				
10. MARITAL STATUS (Specify) Divorced	11. SURVIVING SPOUSE (If wife, give maiden name) NONE	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steel Worker	12b. KIND OF BUSINESS INDUSTRY Manufacturing				
13a. RESIDENCE - STATE IN	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Gary	13d. STREET AND NUMBER 2135 Ohio Street				
13e. ZIP CODE 46407	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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 (Specify) Afro Amer	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
18. FATHER'S NAME (First Middle, Last) Ivory Traylor		19. MOTHER'S NAME (First Middle, Maiden Surname) Rachel Hunt					
20a. INFORMANT'S NAME (Type/Print) Rochonda S Campbell		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5708 E. 84th Terrace Apt. B, Kansas City, MO 64132		20c. Relationship Daughter			
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) Jun 23, 1995 Evergreen Memorial		21c. LOCATION - City or Town State Hobart, IN			
22a. EMBALMER'S NAME Sherman G. Banks		22b. EMBALMER'S LICENSE NO. FDE1016254	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) FDO1042607	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH8890011 Smith Bizzell & Warner 4209 Grant Street, Gary, IN 46408				
26. PART I Enter the disease injuries or complications that caused the death. Do not enter non-specific 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) Vascular collapse a. DUE TO (OR AS A CONSEQUENCE OF) Due to arteriosclerotic heart and vascular disease b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.		26. 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 AUTOPTSY PERFORMED? (Yes or no) No	28b. WERE AUTOPTSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
29a. CERTIFIER (Check only one) Deputy		29b. SIGNATURE AND TITLE OF CERTIFIER  Donna Melyon, Deputy Coroner, 2193 North Main Street, Crown Point, Indiana 46307				29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month Day Year) June 20, 1995
30. HEALTH OFFICER'S SIGNATURE 		31. HEALTH OFFICER'S SIGNATURE 		32. DATE FILED (Month Day Year) JUN 20 1995			
33. MANNER OF DEATH <input checked="" 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)					
35a. DATE PRONOUNCED DEAD (Month, Day, Year) June 18, 1995		35b. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.					