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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99083259

99 OCT -8 AM 8:45

AFFIDVIT

MORRIS W. CARTER
RECORDED

Comes now the undersigned and after having been duly sworn states that:

1. My name is Virgla Huntley.
2. That I owned the following described real estate together with Velma Hill, also known as Velma Brown Collier:

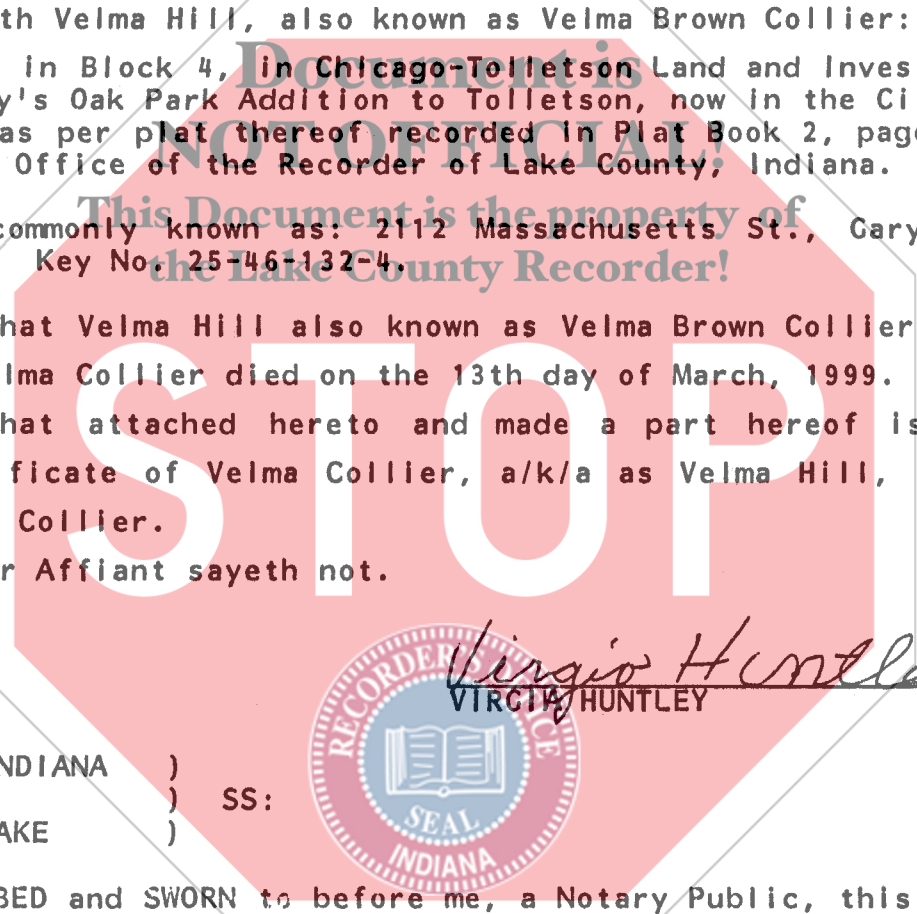
Lot 4, in Block 4, in Chicago-Tolletson Land and Investment Company's Oak Park Addition to Tolletson, now in the City of Gary, as per plat thereof recorded in Plat Book 2, page 35, in the Office of the Recorder of Lake County, Indiana.

More commonly known as: 2112 Massachusetts St., Gary, IN 46407. Key No. 25-46-132-4.

3. That Velma Hill also known as Velma Brown Collier also known as Velma Collier died on the 13th day of March, 1999.

4. That attached hereto and made a part hereof is the Death Certificate of Velma Collier, a/k/a as Velma Hill, a/k/a Velma Brown Collier.

Further Affiant sayeth not.



STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SUBSCRIBED and SWORN to before me, a Notary Public, this 14th day of September, 1999, in and for aforementioned State and County.

My Commission Expires:

6/22/08

County of residence: PORTER

Elva Redigonda
ELVA REDIGONDA, Notary Public

PREPARED BY:

Gregory S. Reising
Attorney at Law
607 So. Lake St.
Gary, IN 46403
219/938-8080

FILED

OCT 07 1999

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PETER BENJAMIN
LAKE COUNTY AUDITOR

11.00
E.P.
11 256

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 99-0211

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) Velma Collier		2 SEX Female	3a TIME OF DEATH 2:10 P M	3b DATE OF DEATH (Month, Day, Yr) March 13, 1999
4 *SOCIAL SECURITY NUMBER 432-32-8211	5a AGE—Last Birthday (Years) 82	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) July 4, 1916
7 BIRTHPLACE (City and State or Foreign Country) Lexa, Arkansas	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 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) Methodist Hospital Northlake		9c CITY, TOWN OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife give maiden name) N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 2134 Front Street	
13e ZIP CODE 46407	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U S A	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) Elementary/Secondary (0-12) 9th College (1-4 or 5+) 9th		18 FATHER'S NAME (First, Middle, Last) Joe Brown		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Amanda (Unknown)		20a INFORMANT'S NAME (Type/Print) Jearlean Williams		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 East 21st Avenue, Gary, Indiana 46407		20c Relationship Daughter		
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) March 20, 1999 Oak Hill Cemetery		21c LOCATION—City or Town, State Gary, Indiana
22a EMBALMER'S NAME Roosevelt Allen Sr.		22b EMBALMER'S LICENSE NO. #01051696	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR Carmelita Perry		24b LICENSE NUMBER (of Licensee) #29700070	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a Severe Congestive Cardiac DUE TO (OR AS A CONSEQUENCE OF) b Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF) c Generalized arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF) d Conditions if any which gave rise to the immediate cause stating the underlying cause last Approximate Interval Between Onset and Death				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Large Malignant Tumor @ Lung				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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 [Signature]		29c MEDICAL LICENSE NO. IN 25043	29d DATE SIGNED (Month, Day, Year) 3/18/99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) K. R. HINDRICK (for Tim) 8300 Broadway, Gary, Indiana				
31 HEALTH OFFICER'S SIGNATURE [Signature]				32 DATE FILED (Month, Day, Year) MAR 24 1999
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <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)
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY—At home, farm, street, etc. or other LOCATION (Street and Number or Rural Route Number, City or Town, State) FILED		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. OCT 07 1999		

PETER BENJAMIN LAKE COUNTY AUDITOR

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