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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
*North Bishop II  
44+ low  
3226 Main St  
E. Chicago - IN 46312*

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99 OCT -8 AM 8:47

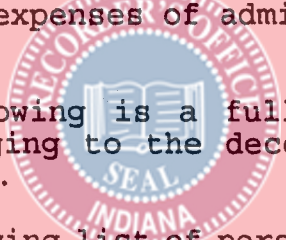
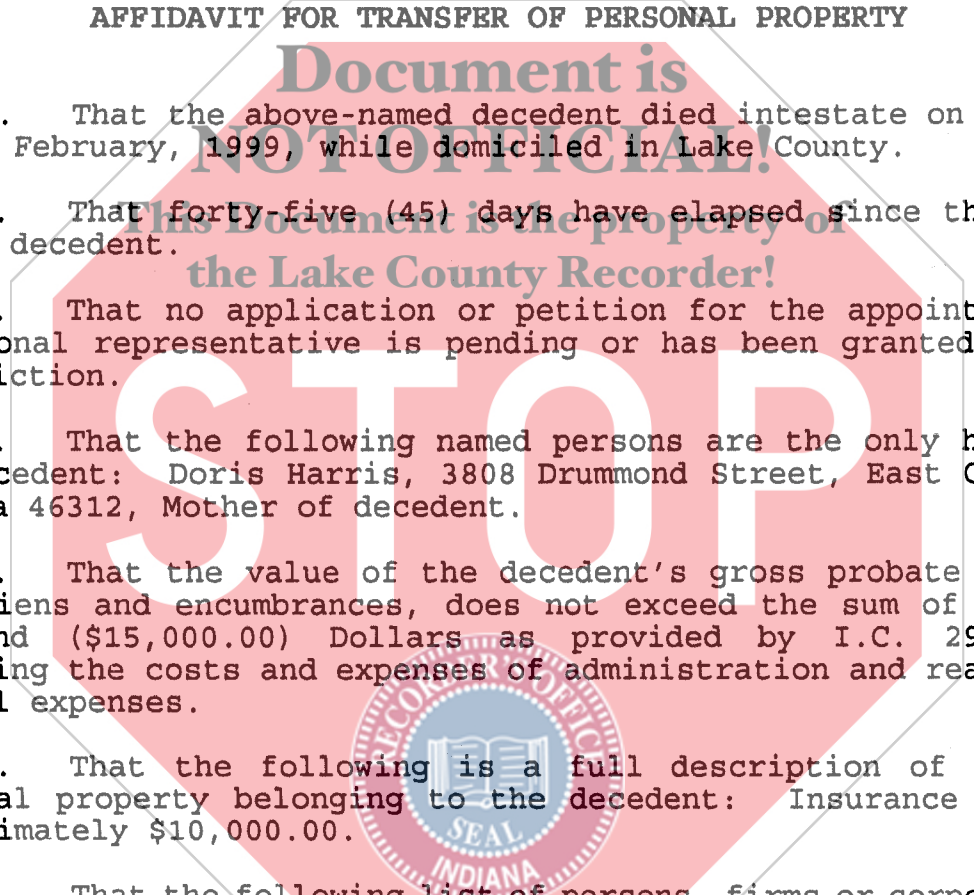
STATE OF INDIANA )  
                          )SS:  
COUNTY OF LAKE )

IN RE:

MORRIS W. CARTER  
RECORDER  
THEODORE HARRIS, DECEDENT  
S.S.#305-72-4601

AFFIDAVIT FOR TRANSFER OF PERSONAL PROPERTY

1. That the above-named decedent died intestate on the 6th day of February, 1999, while domiciled in Lake County.
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.
4. That the following named persons are the only heirs of the decedent: Doris Harris, 3808 Drummond Street, East Chicago, Indiana 46312, Mother of decedent.
5. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of Fifteen Thousand (\$15,000.00) Dollars as provided by I.C. 29-1-8-1, including the costs and expenses of administration and reasonable funeral expenses.
6. That the following is a full description of all the personal property belonging to the decedent: Insurance Policy, approximately \$10,000.00.
7. That the following list of persons, firms or corporations are the only creditors of the estate and the amount set opposite each name is the sum due said creditor, so far as the same is known to the affiant: There are no known creditors of the estate.
8. That by reason of the above-stated matters, the affiant requests that the above-enumerated personal property of the decedent, Theodore Harris, be transferred to her pursuant to the laws of intestate succession as provided in Indiana Code, in accordance with provisions of I.C. 29-1-8-1 and I.C. 29-1-8-2.



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*4/300  
OF  
# 175*

PETER BENJAMIN  
LAKE COUNTY AUDITOR

25x10

WHEREFORE, the Affiant herein hereby requests that The Lafayette Life Insurance Company presently in possession of the above-enumerated personal property, namely, insurance proceeds, transfer the same to said affiant, pursuant to the Indiana Code, and that distribution of said property to the affiant herein shall release said Lafayette Life Insurance Company from any liability with regard to the proper application and disbursement of said personal property; and

That the affiant herein, Doris Harris, hereby charges herself with the responsibility of proper disbursement of the funds according to the provisions of the Indiana Code, and hereby agrees to hold harmless said Lafayette Life Insurance Company from any liability with regard to the transfer of said personal property.

*Doris Harris*  
DORIS HARRIS - AFFIANT  
NOT OFFICIAL  
This Document is the property of  
the Lake County Recorder!

SUBSCRIBED AND SWORN TO before me, a Notary Public, this 18<sup>th</sup> day of August, 1999.

*Violet Plaza*  
Violet Plaza - Notary Public  
Resident of Lake County

My Commission Expires:

VIOLET PLAZA  
NOTARY PUBLIC STATE OF INDIANA  
LAKE COUNTY  
MY COMMISSION EXP. MAR. 19, 2008

This Instrument Prepared By: CORINTH BISHOP II, Atty. #18311-45  
3826 Main Street  
East Chicago, Indiana 46312



\* 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. 47

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

RESUB  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>Theodore C. Harris</b>		2. SEX <b>Male</b>	3a TIME OF DEATH <b>9:07 P<sub>M</sub></b>	3b DATE OF DEATH (Month, Day, Yr) <b>February 6, 1999</b>	
4 *SOCIAL SECURITY NUMBER <b>305-72-4601</b>	5a AGE—Last Birthday (Years) <b>40</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Aug. 6, 1958</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>	8a WAS DECEDENT A U.S. VETERAN? <b>no</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? -----		
9a FACILITY NAME (If not institution, give street and number) <b>St. Catherine Hospital</b>		9c CITY, TOWN, OR LOCATION OF DEATH <b>East Chicago</b>		9d COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Never Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) -----	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Bailiff</b>		12b. KIND OF BUSINESS/INDUSTRY <b>East Chicago City Court</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>East Chicago</b>		13d. STREET AND NUMBER <b>3808 Drummond Street</b>	
13e ZIP CODE <b>46312</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) <b>Black</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> year College (1-4 or 5+)		
18 FATHER'S NAME (First, Middle, Last) <b>Eli Harris</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Doris Bozeman</b>			
20a INFORMANT'S NAME (Type/Print) <b>Doris Harris</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3808 Drummond St. East Chicago, IN 46312</b>		20c. Relationship <b>Mother</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>February 12, 1999 Evergreen Memorial Park</b>		21c. LOCATION—City or Town, State <b>Hobart, Indiana</b>	
22a. EMBALMER'S NAME <b>Tracy Cheri Williams</b>		22b. EMBALMER'S LICENSE NO. <b>FD08600238</b>	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b LICENSE NUMBER (of Licensee) <b>FD08600238</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Hinton-Williams Funeral Home 83001520 4859 Alexander Ave. East Chicago Indiar</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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. <b>Severe cardiomegaly with heart failure</b>		<b>Unknown</b>	
b. _____		DUE TO (OR AS A CONSEQUENCE OF)			
c. _____		DUE TO (OR AS A CONSEQUENCE OF)			
d. _____		DUE TO (OR AS A CONSEQUENCE OF)			
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 PRIOR TO CAUSE OF DEATH? (Yes or no) <b>Yes</b>	
		28b. WERE AUTOPSY FINDINGS CORROBORATIVE OF CAUSE OF DEATH? (Yes or no) <b>Yes</b>			
29a. CERTIFIER (Check only one) <b>Deputy</b>		<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 checked="" 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>N/A</b>	29d. DATE SIGNED (Month, Day, Year) <b>April 1, 1999</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Donna Melyon, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy Ray Kouch</i>				32 DATE FILED (Month, Day, Year) <b>4-8-99</b>	
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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
		34a 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) <b>February 6, 1999</b>		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		<b>000523</b>	