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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99083593

99 OCT -8 PM 12:03

MORRIS W. CARTER
RECORDER

SURVIVORSHIP AFFIDAVIT

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

Crown Point, INDIANA
(City)

66542

STATE OF INDIANA, COUNTY OF Lake, SS:

Vernon Howlett, being first duly sworn, on oath

states that he is of lawful age and resides in the County of

Lake, State of Indiana. That he is the

surviving spouse of Johnnie Howlett

who died on the 19th day of May, 1999, and that as such

surviving spouse, is the owner of the following real estate located

in Lake County, Indiana:

Lots 24 and 25 in Block 22, in Gary Heights, in the City of Gary, as shown in Plat Book 20, page 13, Lake County, Indiana.

That all debts, funeral expenses and doctor bills of said decedent have been fully paid and satisfied, and that said decedent's estate has not been and is not to be administered upon.

That the decedent and this affiant were husband and wife at the time they took title to the above described real estate and that they remained such continuously until the death of said decedent.

9/30/99
Date

Vernon Howlett
Affiant

Before me, Nancy Steininger, a Notary Public in and for said County, personally appeared Vernon Howlett this 30th day of September, 1999 and acknowledged the foregoing document to be his/her voluntary act and deed.

Nancy Steininger
Notary Public

My commission expires: _____
Resident of _____ County

NANCY STEININGER
Notary Public, State of Indiana
Resident of Lake County
My Commission Expires: 01/10/07

This document prepared by: Vernon Howlett

FILED

OCT 07 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

11-
000565
[Signature]

25x10

* 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. 276-99

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Johnnie Mae Howlett		2 SEX Female	3a TIME OF DEATH 8:30 a.m.	3b DATE OF DEATH (Month Day Year) May 19, 1999
4 *SOCIAL SECURITY NUMBER 317-16-6384	5a AGE—Last Birthday (Years) 88	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Year) June 7, 1910
7 BIRTHPLACE (City and State or Foreign Country) Texecana, Arizona	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 <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	

DECEDENT

9b FACILITY NAME (If not institution give street and number) Southlake Nursing And Rehabilitation		9c CITY TOWN OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Vernon Howlett	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife	12b KIND OF BUSINESS/INDUSTRY Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 4220 West 11th Avenue
13e ZIP CODE 46404	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) 12th	18 FATHER'S NAME (First Middle Last) Jett Neal	

PARENTS

19 MOTHER'S NAME (First Middle Maiden Surname) Pinkie Waddell		20a INFORMANT'S NAME (Type/Print) Vernon Howlett	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4220 West 11th Avenue Gary, Indiana 46404	20c Relationship Husband
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INFORMANT

21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) May 24, 1999 Evergreen Cemetery	21c LOCATION—City or Town State Hobart, Indiana
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DISPOSITION

22a EMBALMER'S NAME Rosenwald Allen JR.	22b EMBALMER'S LICENSE NO 29400047	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24 SIGNATURE OF FUNERAL DIRECTOR <i>Carmelita Perry</i>	24b LICENSE NUMBER (of Licensee) 29700070	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy and Allen Funeral Directors 2959 West 11th Avenue Gary, Indiana 46404 83007704

CAUSE OF DEATH

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. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF) b. <u>Alzheimer's disease</u> DUE TO (OR AS A CONSEQUENCE OF) c. <u>Seizure disorder</u> DUE TO (OR AS A CONSEQUENCE OF) d.	Approximate Interval Between Onset and Death
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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 AUTO PERFORMED? (Yes or No) NO	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
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CERTIFIER

29a CERTIFIER (Check only one) <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 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>A. Munching</i>	29c MEDICAL LICENSE NO 01032180	29d DATE SIGNED (Month Day Year) 5/21/1999
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HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Surendra J. Shah MD 5825 Broadway Suite A Merrillville IN 46410	31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>	32 DATE FILED (Month Day Year) 5/23/99
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33 MANNER OF DEATH <input 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 INJURY
34e PLACE OF INJURY—At home farm street factory office building etc (Specify)		34f LOCATION (Street and Number, Route Number, or Town State) SEP 30 1999		
34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian <i>Alexander S. Williams MD</i> LAKE COUNTY HEALTH COMMISSIONER			