

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99086105 
TICOR TITLE INSURANCE

99 OCT 20 AM 8:59
MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Annie L. Harvey, being first duly
sworn upon oath, deposes and says:

1. That Willis L. Harvey died on
MARCH 23, 1999, 19 at ST. MARY'S MEDICAL CENTER

HOBART, IN
2. That Willis L. Harvey and Annie L. Harvey
were duly and legally married at the time they acquired title as husband and
wife to the following described real estate:

Lot 46 and the North 15 feet of Lot 45 in Block 4 in Pleitner's First
Addition to Gary, as per plat thereof, recorded in Plat Book 10 page 29,
in the Office of the Recorder of Lake County, Indiana.

Key No. 46-377-48.

3. That the marital relationship which existed between them at the time they
acquired title to said real estate remained in effect and unbroken until the
date of (his) (~~her~~)/death.

4. That all funeral expenses in connection with the death of said decedent
have been paid in full.

5. That all of the assets of said decedent which would be includable for
Federal Estate Tax purposes, including joint bank accounts and life insurance
on decedent's life were not sufficient to necessitate payment of Federal Estate
Tax.

Further affiant sayeth not.

Annie L. Harvey
Annie L. Harvey

Subscribed and sworn to before me, a Notary Public, this 15th day of
October, 1999.

Shannon Stiener
Shannon Stiener Notary Public

My Commission Expires:
3-14-07

County of Residence:
Lake

FILED
OCT 19 1999
PETER BENJAMIN
LAKE COUNTY AUDITOR

This Instrument prepared by Annie L. Harvey

11.00
E.P.
11

001179

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.

12cc + Free Vats

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 159305
TYPE/PRINT IN PERMANENT BLACK INK

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

1 DECEASED—NAME (First, Middle, Last) Willis Lee Harvey			2 SEX Male		3a TIME OF DEATH 3:29 A M		3b DATE OF DEATH (Month, Day, Yr) March 23, 1999					
4 SOCIAL SECURITY NUMBER 432-56-1655		5a AGE—Last Birthday (Years) 66		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) January 14, 1932		7 BIRTHPLACE (City and State or Foreign Country) Collins, Arkansas		
8a WAS DECEDENT A U.S. VETERAN? YES		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1954		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 type="checkbox"/> Residence								
9b FACILITY NAME (If not institution, give street and number) St. Mary's Medical Center					9c CITY, TOWN, OR LOCATION OF DEATH Hobart			9d COUNTY OF DEATH Lake				
10 MARITAL STATUS Married		11 SURVIVING SPOUSE (If wife, give maiden name) Annie L. Griffin			12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Inspector			12b KIND OF BUSINESS/INDUSTRY LTV Steel Corp.				
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Gary			13d STREET AND NUMBER 4203 Pennsylvania Street					
13e ZIP CODE 46409		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) College (1-4 or 5+) 12th		
18 FATHER'S NAME (First, Middle, Last) John Harvey					19 MOTHER'S NAME (First, Middle, Maiden Surname) Willie Mae Moore							
20a INFORMANT'S NAME (Type/Print) Annie L. Harvey				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4203 Pennsylvania Street, Gary, Indiana 46409				20c Relationship Wife				
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) March 27, 1999 Ridgelawn 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 <i>Carmelita V. Berry</i>				24b LICENSE NUMBER (of Licensee) #29700070		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404						
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 (PHRASES THE ABOVE IS A TITLE) acute cardiorespiratory arrest LET A COPY OF THE CERTIFICATE BE FILED WITH THE HEALTH DEPT. Cerebral hemorrhage Hypertensive Cardiovascular Disease APR 14, 1999 DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)								Approximate Interval Between Onset and Death				
PART II Other significant conditions, conditions contributing to death but not previously stated in Part I <i>Alexander S. Williams, M.D.</i> LAKE COUNTY HEALTH COMMISSIONER					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 <i>Amuel</i>			29c MEDICAL LICENSE NO. 01026051			29d DATE SIGNED (Month, Day, Year) 4/13/99				
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 3229 Broadway Gary, Ind. Suite 104 Dr. Dave'										32 DATE FILED (Month, Day, Year) 4/14/99		
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) FILED		34d DESCRIBE HOW INJURY OCCURRED				
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) OCT 19 1999				34e LOCATION (Street and Number or Rural Route Number, City or Town, State)								
34g DATE PRONOUNCED DEAD (Month, Day, Year)			34h MOTOR VEHICLE ACCIDENT? (Yes or no) PETER BENJAMIN LAKE COUNTY AUDITOR									

DECEDENT

PARENTS

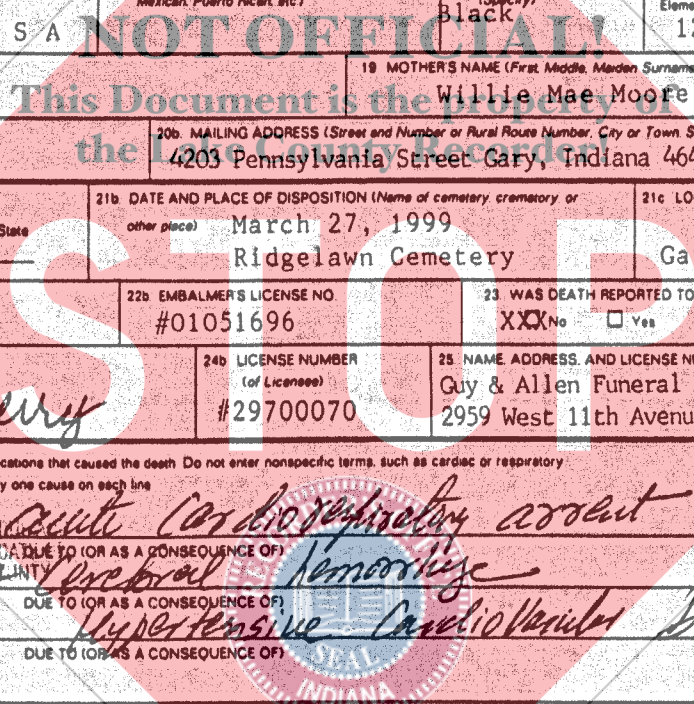
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



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