Carolyn E. Mosby
2606 W. 63rd Ave #2A
Merrillville, Ind 46410

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA) 9908747 IN RE: CAROLYN MOSBY, Deceased
) SS:
COUNTY OF LAKE)

FILED

MORRIS W. CARTER
RECORDER OCT 25 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT FOR TRANSFER OF REAL PROPERTY

Carolyn E. Mosby, having been first duly sworn upon her oath states:

1. That the above-named decedent died intestate on January 19, 1990, 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 persons are the only heirs of the decedent's estate:

Carolyn E. Mosby, 2606 W. 63rd Ave., Merrillville, IN, daughter
William E. Jordan III, 328 Garfield St., Gary, IN, son

and they are entitled to the entire undivided interest of the real estate.

5. That the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of the following: Twenty Five Thousand Dollars ($25,000.00), 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 19 in Block 32 in Gary Land Company's Fourth Subdivision, in the City of Gary, as per plat thereof, recorded in Plat Book 14 page 15, in the Office of the Recorder of Lake County, Indiana
Commonly known as 328 Garfield Street, Gary, IN 46404

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DS

15 CK 5885

7. There are no known creditors of the estate and no claims have been made against the decedent's estate.

8. That the individuals entitled to the real estate as a result of the decedent's death are:

Carolyn E. Mosby, 2606 W. 63rd Ave., Merrillville, IN
William E. Jordan III, 328 Garfield St., Gary, IN

9. That the gross value of the estate of the decedent, Carolyn Mosby, as determined for the purposes of Federal Estate taxes, was less than the value required for the filing of a Federal Estate Tax Return. As a consequence thereof, the decedent's estate was not subject to Federal Estate Tax.

10. That the decedent's estate was not subject to Indiana Inheritance Tax.

AFFIANT FURTHER SAITH NOT.

Carolyn E. Mosby
CAROLYN E. MOSBY

STATE OF INDIANA)
) **SS:**
COUNTY OF LAKE)

Subscribed and sworn to before me, a Notary Public in and for said County and State, on Oct 21, 1999.

My Commission Expires:

Robert L. Lewis
Notary Public

Typed/Printed name of Notary Public

Robert L. Lewis
Notary Public State of Indiana
Lake County
My Commission Expires 08/28/06

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

cal No. .....90-0056........... State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): CAROLYN A. BROWN (JORDAN) MOSBY
2 SEX: FEMALE
3a TIME OF DEATH: 6:36 P
3b DATE OF DEATH (Month Day Yr): JANUARY 19, 1990
4 SOCIAL SECURITY NUMBER: 309-30-6296
5a AGE—Last Birthday (Years): 57
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr): MAY 10, 1932
7 BIRTHPLACE (City and State or Foreign Country): NASHVILLE, TENNESSEE
8a WAS DECEDENT A US VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: ---
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
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): ---
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): STATE SENATOR
12b KIND OF BUSINESS/INDUSTRY: STATE OF INDIANA
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN, OR LOCATION: GARY
13d STREET AND NUMBER: 328 GARFIELD STREETXXXX
13e ZIP CODE: 46404
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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+): 1 YR.

PARENTS

18 FATHER'S NAME (First, Middle, Last): ALVIN T. BROWN
19 MOTHER'S NAME (First, Middle, Maiden Surname): MARY E. SNELLING

INFORMANT

20a INFORMANT'S NAME (Type/Print): WILLIAM E. JORDAN III
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1355 MARSHALL STREET GARY, IN. 46404
20c Relationship: SON

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JANUARY 24, 1990 EVERGREEN PARK-
21c LOCATION—City or Town, State: HOBART, INDIANA
22a EMBALMER'S NAME: REV. DIANE E. WEEMS
22b EMBALMER'S LICENSE NO: 0-100-151-0
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Rev. Diane E. Weems
24b LICENSE NUMBER (of Licensee): 0-100-151-0
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANDREW SMITH FUNERAL HOME, INC. 934 E. 21ST. AVENUE-83002550 GARY, IN. 46407

CAUSE OF DEATH

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

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	BRONCHIAL PNEUMONIA	ONE WEEK
DUE TO (OR AS A CONSEQUENCE OF): b	MIDLINE GERM CELL TUMOR OF MEDIASTINUM	2 1/2 YRS.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF): c		
DUE TO (OR AS A CONSEQUENCE OF): d		

FILED OCT 25 1990

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: x
27 WAS DECEDENT PREGNANT 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): x

PETER BENJAMIN LAKE COUNTY AUDITOR

CERTIFIER

29a CERTIFIER (Check only one): ☒ CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place, and due to the cause(s) as stated. ☐ 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. ☐ 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: K. P. Sarma MD
29c MEDICAL LICENSE NO.: 01027669
29d DATE SIGNED (Month, Day, Year): 01-26-90
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): KOPPOLU P. SARMA, M.D. 300 WEST 61ST AVE. HOBART, IN 46342

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month, Day, Year): JAN. 26 1990

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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, 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):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc

001560

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

SLC

Local No. 88 0231

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME FIRST	MIDDLE	LAST	2 SEX	3 DATE OF DEATH (Mo., Day, Yr.)
JOHN	OLIVER	MOSBY	M	APRIL 1, 1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
170-14-8523	76			11-27-11	PHILADELPHIA, PENN

8 YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
NO	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARY'S MERCY HOSPITAL	GARY	LAKE

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	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)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	CAROLYN BROWN	RETIRED	SELF-EMPLOYED

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	GARY	328 GARFIELD STREET

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) [X] No [ ] Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
YES	NO	46404		BLACK	HIGH SCHOOL	

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
WILLIAM MOSBY	RHONDA KING

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
CAROLYN MOSBY	328 GARFIELD GARY, INDIANA	WIFE

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	4-7-88 EVERGREEN PARK	HOBART, INDIANA

21a SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER (or Certificate)	22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
	1012356	ANDREW SMITH FUNERAL HOME 934 E. 21ST. AVE. 000120356

PRONOUNCING PHYSICIAN ONLY

(Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death) 23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title	23b LICENSE NUMBER	23c. DATE SIGNED (Month, Day, Year)
	0103480 8	4/7/88

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH	25. DATE PRONOUNCED DEAD (Month, Day, Year)	26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
10:30P M		NO

SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Congestive Heart Failure	
	DUE TO OR AS A CONSEQUENCE OF:	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Renal Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

CAUSE OF DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28. WAS AUTOPSY PERFORMED? (Yes or no)

29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED OCT 25 1988 PETER BENJAMIN LAKE COUNTY EXAMINER LAKE COUNTY AUDITOR

SEE INSTRUCTIONS

CERTIFIER

30a CERTIFIER (Check only one)

[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

30b SIGNATURE AND TITLE OF CERTIFIER	30c. LICENSE NUMBER	30d. DATE SIGNED (Month, Day, Year)
	~~015146~~ 0103480 8	4/23/88

30e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: James T. Hedrick, M.D.

32. DATE FILED (Month, Day, Year): APR 7 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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
			001561

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)