2000 007807

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

FREDDIE B. STANDIFER, being first duly sworn upon oath, deposes and says:

1. That LONZO STANDIFER died on OCTOBER 2, 1997 at 4353 KENTUCKY, GARY, IND.

2. That LONZO STANDIFER and FREDDIE B. STANDIFER were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

4353 KENTUCKY ST., GARY, INDIANA

LOT 7, Block 8, SCARSDALE 1ST. ADDITION TO GARY
PLAT BOOK 25, PAGE 77, LAKE COUNTY, INDIANA

K14-7-142-7

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 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.

Freddie B Standifer
Freddie B. Standifer

Subscribed and sworn to before me, a Notary Public, this 26 day of JANUARY, 2000.

PANDORA L. HAMILTON
Notary Public State of Indiana
My Commission Expires 5/18/2008

Pandora L Hamilton
Notary Public

My Commission expires:
5-18-2008

County of Residence:
LAKE

00177

This Instrument prepared by JOANN BLAIR

11.00
E.P.
T.

Return:
Bank One
115 S Lou St
Crown Point IN

9200044
TICOR TITLE INSURANCE
Crown Point, Indiana TOTAL P.02

25×

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

Local No. 97 0694 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Lonzo Standifer
2. SEX: Male
3a. TIME OF DEATH:
3b. DATE OF DEATH (Month, Day, Yr.): Oct. 2, 1997
4. SOCIAL SECURITY NUMBER: 307-30-3751
5a. AGE—Last Birthday (Years): 67
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Month, Day, Yr.): JAN. 4, 1930
7. BIRTHPLACE (City and State or Foreign Country): Tupelo, Mississippi
8a. WAS DECEDENT A U.S. VETERAN? YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1953
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): 4353 Kentucky Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Freddie Hurst
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Security Guard
12b. KIND OF BUSINESS/INDUSTRY: Dynamic Security
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 4353 Kentucky Street
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
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): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Leonard Standifer
19. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Sampson

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Freddie Standifer
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4353 Kentucky St. Gary, IN 46408
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Oct. 8, 1997 Evergreen Memorial
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Paul Anthony Robinson
22b. EMBALMER'S LICENSE NO.: 1017284
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Paul Anthony Robinson
24b. LICENSE NUMBER (of Licensee): 1017234
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 1950000; HOUSE OF ROBINSON FUNERAL DIRECTORS, 1900 W. 15th AVE GARY, IN 46404

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter terminal events 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. Lung Cancer
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): b. ; DUE TO (OR AS A CONSEQUENCE OF): c. ; DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR IN 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):

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:
29c. MEDICAL LICENSE NO.: 01030831
29d. DATE SIGNED (Month, Day, Year): 10/10/97

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Peter G. Mavrelis, M.D. 8895 Broadway, Merrillville, IN 46410
31. HEALTH OFFICER'S SIGNATURE: M.D.
32. DATE FILED (Month, Day, Year): OCT. 10 1997

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.

25 x 10