INDIANA STATE BOARD OF HEALTH

2

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

SURVIVORSHIP AFFIDAVIT

2000 010971

2000 FEB 16

MORRIS W. CARTER

COMES NOW the affiant, Glenda M. Garriott who being first sworn and upon his/her oath and under penalties for perjury, solemnly swears and states that:

1.He/She is the legal title owner of the real estate located at 2605 W. 49th Avenue, Hobart, IN 46342 more particularly described as follows, to wit:

The East 134.3 feet of the North 497 feet of the Eats 10 acres of the West 25 acres of the NE ¼ of the SW ¼ of Section 36, Township 36 North, Range 8 West of the 2nd P.M. and the West 15.7 feet of the North 497 feet of the East 5 acres of the West 30 acres of the NE ¼ of the SW ¼ of Section 36, Township 36 North, Range 8 West of the 2nd P.M., Lake County, Indiana

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2. She acquired title to the aforementioned real estate with her husband Warranty Deed dated September 18, 1964 and recorded October 29, 1964 as Instrument No. 591317 in the Office of the Recorder of Lake County, Indiana.

3. She and her husband, Russell A. Garriott held title as Husband and wife until the date of his death on 9-18-90

4. By virtue of the operation of law in the she is the survivor of them, the affiant should now be shown as the sole owner of the real estate.

5. The total value of my late husband's estate, including the proceeds of life insurance, and interests in jointly owned real estate was not large enough to be subject to federal estate tax.

Affiant makes these statements to induce the appropriate governmental authorities to cause the title to the real estate to be shown in the sole name of the affiant and that all tax records are shown accordingly.

STOP
RECORDER'S OFFICE INDIANA

February 4, 2000

Glenda M Garriott
Glenda M. Garriott

FILED
FEB 16 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

STATE OF INDIANA)
SS:
COUNTY OF Lake)

Before me, a Notary Public, in and for said State and County, personally appeared the affiant herein Glenda M. Garriott who acknowledge the truthfulness of the contents herein.

Witnessed this 4th day of February 2000

Notary Public
My Commission Expires: ____________
Resident of ______________ County

Kathryn D. Glor
8-28-2008 Expires
Resident of Porter Co.

HFS Bank
5200 Central Ave.
Portage, IN 46368

Prepared By: Glenda M. Garriott

00902

10.00
E.P.

741 735

Local No. 1929-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	RUSSELL A. GARRIOTT
2. SEX	MALE
3a. TIME OF DEATH	1:47 P.M
3b. DATE OF DEATH (Month, Day, Yr)	SEPTEMBER 18, 1990
4. SOCIAL SECURITY NUMBER	306-38-6795
5a. AGE—Last Birthday (Years)	52
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	MAY 16, 1938
7. BIRTHPLACE (City and State or Foreign Country)	GARY, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?	NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	NO
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	HOBART
9d. COUNTY OF DEATH	LAKE
10. MARITAL STATUS (Specify)	MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name)	GLENDA SWANSON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	SUPERVISOR
12b. KIND OF BUSINESS/INDUSTRY	NORTHERN INDIANA PUBLIC SERVICE COMPANY
13a. RESIDENCE—STATE	INDIANA
13b. COUNTY	LAKE
13c. CITY, TOWN, OR LOCATION	HOBART
13d. STREET AND NUMBER	2605 W. 49th AVENUE
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	College: 3

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	RUSSELL I. GARRIOTT
19. MOTHER'S NAME (First, Middle, Maiden Surname)	THELMA I. CLAPP

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	GLENDA GARRIOTT
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2605 W. 49th AVENUE, HOBART, INDIANA 46342
20c. Relationship	WIFE

DISPOSITION

Field	Entry
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)	SEPTEMBER 21, 1990 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State	MERILLVILLE, INDIANA
22a. EMBALMER'S NAME	DAVID SEMPLINSKI
22b. EMBALMER'S LICENSE NO.	8600386
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James F. Burns
24b. LICENSE NUMBER (of Licensee)	1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	BURNS FUNERAL HOME FDH# 3002380, 701 E. 7th STREET, HOBART, INDIANA 46342

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac arrest

DUE TO (OR AS A CONSEQUENCE OF):
b. Ischemic Cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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

Field	Entry
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)	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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Nazzal Obaid M.D.
29c. MEDICAL LICENSE NO.	01028410
29d. DATE SIGNED (Month, Day, Year)	9-21-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	NAZZAL OBAID, M. D., 8895 BROADWAY, MERRILLVILLE, INDIANA 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Ruth Johnson
32. DATE FILED (Month, Day, Year)	September 21, 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE ... HEALTH DEPT.

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RECORDER'S OFFICE SEAL INDIANA

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