STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 014132 2000 MAR 1 11:30:47

RECORDER

FILED

FEB 29 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

EDNER WILINS A/K/A EDNA WILKINS, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Paul Wilkins died (without leaving a will) (leaving a will) on June 17 1999 at Methodist Hospital Southlake

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

2600 West Jackson Street, Gary, IN 46403

LOTS 1 AND 2 IN BLOCK 63 IN CHICAGO-TOLLESTON LAND AND INVESTMENT COMPANY'S SECOND OAK PARK ADDITION TO TOLLESTON, IN THE CITY OF GARY, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 2 PAGE, 36, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA. ESCEPT THEREOFROM THAT PART TAKEN FOR THE WIDENING OF THE ALLEY.

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) ~~xxxx~~ 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.

Edna Wilkins
EDNER WILKINS A/K/A EDNA WILKINS

Subscribed and sworn to before me, a Notary Public, this 28th day of February, 2000.

COMMUNITY TITLE COMPANY
FILE NO 2 19077

Tracie A Kraszyk
Notary Public

TRACIE A. KRASZYK
Notary Public, State of Indiana
County of Porter
My Commission Expires Jan. 12, 2008

6180 Comp 1/31

* 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

Local No. 15-26-99 CERTIFICATE OF DEATH State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED--NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Paul E. Wilkins	Male	3:20 P M	June 17, 1999

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 (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
312-05-4001	98			November 30, 1911	McKinnon, Tennessee

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions.)
Yes	N/A	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
Methodist Hospital Southlake	Merrillville	Lake

10 MARITAL STATUS (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	Edna Wright	Steelworker	US Steel

13a RESIDENCE--STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	1715 Carolina Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE--American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)
46407	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	Afro-American	Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Van Wilkins	Jennie Sommers

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Edna Wilkins	1715 Carolina Street Gary, Indiana 46407	Wife

DISPOSITION

21a METHOD OF DISPOSITION	Entombment / Removal from State	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION--City or Town, State
[X] Burial [ ] Cremation [ ] Donation [ ] Other (Specify)		June 24, 1999 Fern-Oak Cemetery	Griffith, IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Sherman Banks III	FDO 1016254	[✓] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Sherman Banks	FDO 1016254	Smith Bizzell & Warner Funeral Home, FH19600034 4209 Grant St, Gary, IN, 46408

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)	(DUE TO, OR AS A CONSEQUENCE OF) Myocardial Infarction	3 Days
	DUE TO (OR AS A CONSEQUENCE OF) Coronary Atherosclerosis	Years
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	c. JUN 29 1999 DUE TO (OR AS A CONSEQUENCE OF)	

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

Bacteremia MRSA Spinal Stenosis

Prostate Cancer

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No)	28a WAS AN AUTOPSY PERFORMED? (Yes or No)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
	N	N

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	29d DATE SIGNED (Month, Day, Year)
William J Pierce MD	25010	6/29/99

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Dr. W. Pierce 210 E. 90th Dr. Merrillville IN. 738-2008.

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S Gilliland MD

32 DATE FILED (Month, Day, Year): June 29, 1999

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK (Yes or no)	34d DESCRIBE HOW INJURY Ooccurred
Natural; Pending Investigation; Accident; Suicide; Could not be Determined; Homicide				

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.

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