

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 018051

2000 MAR 16 AM 9:56

State of Indiana)
)
)
County of Lake)
)

In Re: Idell Gibson, Deceased
December 8, 1999
738 Lincoln Street, Gary, Indiana 46402

Affidavit For Transfer of Real Property

1. That the above named decedents died intestate on date.
2. That forty-five (45) days have elapsed since the death of decedent.
3. That no application or petition for the appointment of personal representation is pending or has been granted in any jurisdiction, nor is any administration contemplated.
4. That the following named person is the legal heir of decedent: Louis Gibson, Husband, 738 Lincoln Street, Gary, Indiana,
5. That the value of the decedent's estate does not exceed the sum of the allowance provided by IC 29-8:1 and reasonable funeral expenses.
6. That the decedent's assets is a parcel or real estate which was owned by the decedent, located at 738 Lincoln Street, Gary, Indiana described as:

Lot 15, Block 5, Resubdivision Gary Land Company's Third Subdivision, In the City of Gary as shown in Plat Book 13, Page 8, In the Office of the Recorder of Lake County, Indiana.
7. That the following list of persons, firms, or corporations are the only creditors of the estate and the amount set opposite each name is the sum due said creditor so far as the same is: NONE
8. That the individuals entitled to real estate as a result of the decedent's death is the heir at law provided under the laws of intestate.
9. That the gross value of estate of decedents, Idell Gibson as determined for purposes of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return. As 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.

FILED

MAR 16 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

13.00
1784
1137A

EXHIBIT A

SURVIVORSHIP AFFIDAVIT

Re: Idell Gibson, Deceased
December 8, 1999

STATE OF INDIANA) Legal: Lot 15, Block 5, Resubdivision Gary Land
) Company's Third Subdivision, shown in Plat Book
) 13, Page 8, in the Office of the Recorder of Lake
) SS: County, Indiana.
) Tax Unit 25 Key No. 44-138-16
County of Lake)

This Document is the property of
the Lake County Recorder!

On this 14th day of March, 2000 before me personally appeared Louis Gibson,
Husband of Deceased, to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below Affiant's signature:
2. Affiant is Heir, Husband of Idell Gibson decedent(s), owner: (Interest of Affiant in the above premises as "owner" "heir of owner" etc.)
3. Said premises were formerly owned by Idell Gibson
4. Said Idell Gibson, deceased December 8, 1999, intestate in Lake County, Indiana,
5. The total value of the taxable estate of said deceased including, tenancies by entireties individual ownerships of both real and personal property, and insurance does not exceed the sum of \$25,000.00, and to the best of Affiant's knowledge there is no Inheritance tax liability by reason of the death of said decedent;
6. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? No (if yes identify the divorce proceedings: N/A _____);
7. Affiant's relationship to the deceased was Husband

Signature *Louis Gibson*
Louis Gibson
Address: *778 Linnian*

Subscribed and sworn to before me by the Affiant this 14th day of March, 2000 (year)

Nike Auschuld, My Commission expires: 07/31/2000 county of Lake
Notary

* 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

State No.

Local No. 99-0853

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

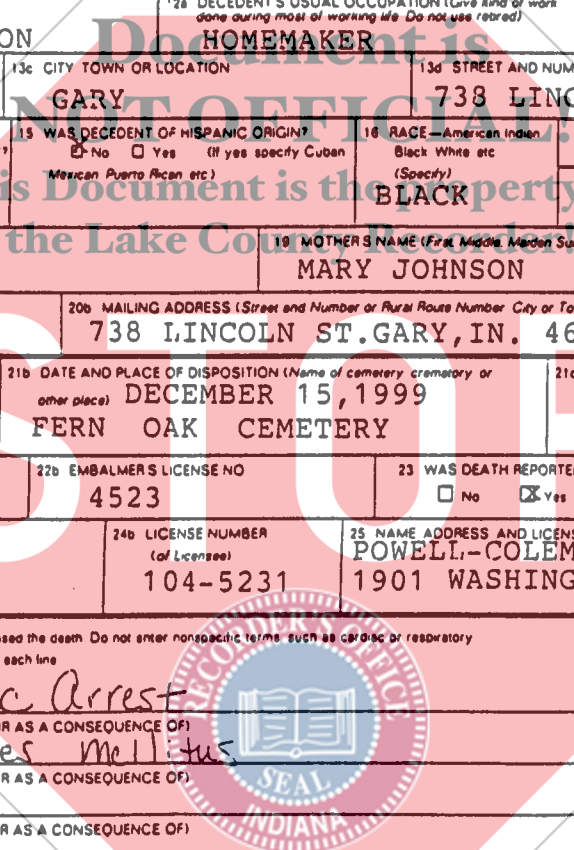
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) IDell GIBSON		2 SEX FEMALE	3a TIME OF DEATH 11:25 a	3b DATE OF DEATH (Month Day Yr) DECEMBER 8, 1999	
4 *SOCIAL SECURITY NUMBER 306-56-8586	5a AGE—Last Birthday (Years) 59	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) FEBRUARY 8, 1940	
7 BIRTHPLACE (City and State or Foreign Country) LEEDED, AL.	8a WAS DECEDENT A U.S. VETERAN? NONE				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE		9a PLACE OF DEATH (Check only one See instructions) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> 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) NORTHLAKE METHODIST HOSPITAL		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) LOUIS GIBSON	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		12b KIND OF BUSINESS/INDUSTRY HOME	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION GARY	13d STREET AND NUMBER 738 LINCOLN ST.		
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) 11th College (11-4 or 5+)		18 FATHER'S NAME (First Middle Last) WILSON JOHNSON JR.			
19 MOTHER'S NAME (First Middle Maiden Surname) MARY JOHNSON		20a INFORMANT'S NAME (Type/Print) PATRICIA JAMES			
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 738 LINCOLN ST. GARY, IN. 46404		20c Relationship MOTHER			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) DECEMBER 15, 1999 FERN OAK CEMETERY		21c LOCATION—City or Town State GRIFFIN, IN	
22a EMBALMER'S NAME LEON COLEMAN JR.		22b EMBALMER'S LICENSE NO. 4523	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Leon Coleman</i>		24b LICENSE NUMBER (of Licensee) 104-5231	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME POWELL-COLEMAN FUNERAL HOME 1901 WASHINGTON ST. GARY, IN. 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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardiac Arrest					
b. Diabetes mellitus					
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					
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		
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>James J. Shih</i>			29c MEDICAL LICENSE NO. 01032130	29d DATE SIGNED (Month Day Year) 12-14-99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Surenwada J. Shih MD 5825 Barclayway Louisville TN 46410					
31 HEALTH OFFICER'S SIGNATURE <i>James J. Shih</i>			32 DATE FILED (Month Day Year) DEC 15 1999		
33 MANNER OF DEATH <input checked="" 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) MAR 16 2000	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no) NO	
34d PLACE OF INJURY—At home farm street factory office building etc (Specify) PETER BENJAMIN LAKE COUNTY AUDITOR		34e DESCRIBE HOW INJURY OCCURRED			
34g DATE PRONOUNCED OF D (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc NO			



FILED

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