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2000 033506

STATE ... LAKE ... FILED ...
2000 MAY 15 AM 10: 45
MORRIS W. CARTER RECORDER

FILED
MAY 12 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT

State of Indiana)
) SS:
County of PORTER)

LELA A. GREEN, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, JAMES LEE GREEN died (without leaving a will) ~~(leaving a will)~~ on MARCH 31, 1998 at METHODIST HOSPITAL NORTHLAKE.

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

   LOT 2 IN BLOCK 33 IN GARY LAND COMPANY'S FOURTH SUBDIVISION, IN THE CITY OF GARY, AS PER PLAT THEREOF, RECORDED DECEMBER 10, 1919 IN PLAT BOOK 14 PAGE 15, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

   COMMONLY KNOWN AS: 365 GARFIELD, GARY, IN 46404

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 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.

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Lela A. Green
LELA A. GREEN

COMMUNITY TITLE COMPANY
FILE NO L 19262 MV

Subscribed and sworn to before me, a Notary Public, this 9th day of MAY, 2000.

Tracie A. Kraszyk

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

11.00
E.P.

01474

CM

* 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.

12CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 98-0257 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): James Lee Green
2. SEX: Male
3a. TIME OF DEATH: 10:15 P M
3b. DATE OF DEATH (Month, Day, Yr): March 31, 1998
4. *SOCIAL SECURITY NUMBER: 432-56-8199
5a. AGE—Last Birthday (Years): 58
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): July 7, 1939
7. BIRTHPLACE (City and State or Foreign Country): Forest City, Arkansas
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN US ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
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): Lela A. Peters
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Letter Carrier
12b. KIND OF BUSINESS/INDUSTRY: US Postal Service
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 365 Garfield Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: ☐ No [X] Yes
13g. ON A FARM? [X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 12th; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Armster Green
19. MOTHER'S NAME (First, Middle, Maiden Surname): Melvina Willis

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Lela A. Green
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 365 Garfield Street Gary, Indiana 46404
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 4, 1998 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Sr.
22b. EMBALMER'S LICENSE NO: #01051696
23. WAS DEATH REPORTED TO CORONER? [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): #08700298
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiogenic Shock
DUE TO (OR AS A CONSEQUENCE OF)
b. Hypertensive Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Chronic Renal Insufficiency
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

Approximate Interval Between Onset and Death:

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Chronic Obstructive Lung Disease, Prostate carcinoma, B[illegible]

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):

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: [signature]
29c. MEDICAL LICENSE NO: 01037773
29d. DATE SIGNED (Month, Day, Year): 4/20/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Andre Artis 3229 Broadway #154 Gary, Indiana 46408

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] M.D. MPH
32. DATE FILED (Month, Day, Year): APR 27 1998

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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PO 1

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