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SURVIVORSHIP AFFIDAVIT

COMES NOW the affiant, Sadie B Savage who being first sworn and upon his/her oath and under the penalties for perjury, solemnly swears and states that:

1. He/She is the legal title owner of the real estate located at 1440 W 16th Ave Gary IN 46407 more particularly described as follows, to-wit: SEE APPENDIX A

This Document is the property of the Lake County Recorder!

2. He/She acquired title to the afore-mentioned real estate with his/her husband/wife by Warranty Deed dated 4/7/86 and recorded 4/10/86 Instrument No. 848842, in the Office of the Recorder of LAKE County, Indiana.

3. He/She and his/her husband/wife, Leroy Savage, held title by the entireties until the date of his/her death on July 4 1991.

4. By virtue of the operation of law in the he/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/wife'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 be shown accordingly.

PETER BENJAMIN LAKE COUNTY AUDITOR

7-27-00
Date

Sadie B. Savage
(Print Name)

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Before me, a Notary Public, in and for said State and County, personally appeared the affiant herein, Sadie B. Savage, who acknowledged the truthfulness of the contents herein.

Done this 27 day of July, 2000.

My Commission Expires 9-28-2001
Official Seal
Deborah R. Poeta
Notary Public
State of Indiana

Deborah R. Poeta
Notary Public
Resident of Lake County

Prepared by:

#4951
HOLD
NETED

2 cc
3 vet

INDIANA STATE BOARD OF HEALTH

Local No. 91-0511

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) LEROY SAVAGE		2 SEX MALE	3a. TIME OF DEATH 10:51^a M	3b. DATE OF DEATH (Month, Day, Yr.) JULY 4, 1991
4. SOCIAL SECURITY NUMBER 428-05-5360	5a. AGE—Last Birthday (Years) 76	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) JUNE 7, 1915
7. BIRTHPLACE (City and State or Foreign Country) LAKE PROVIDENCE, LA	8a. WAS DECEDENT A U.S. VETERAN? YES—WW 2			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1943		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		

DECEDENT

9b. FACILITY NAME (If not institution, give street and number) ST. MARY MEDICAL CENTER		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) SADIE BENNETT	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) CARPENTER	12b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION GARY	13d. STREET AND NUMBER 1440 W. 16TH AVENUE
13e. ZIP CODE 46407	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input type="checkbox"/> No <input 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) 8th	

PARENTS

18. FATHER'S NAME (First, Middle, Last) ED SAVAGE	19. MOTHER'S NAME (First, Middle, Maiden Surname) DELIER CARTER
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INFORMANT

20a. INFORMANT'S NAME (Type/Print) SADIE B. SAVAGE	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1440 W. 16TH AVENUE GARY, IN. 46407	20c. Relationship WIFE
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DISPOSITION

21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) JULY 10, 1991—FERN OAKS CEMETERY	21c. LOCATION—City or Town, State GRIFFITH, IN.
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CAUSE OF DEATH

22a. EMBALMER'S NAME SADIE B. SAVAGE	22b. EMBALMER'S LICENSE NO. FDE-0-100-151-0	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Rev. Dion E. Weems</i>	24b. LICENSE NUMBER (of Licensee) FDE 0-100-151-0	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANDREW SMITH FUNERAL HOME, INC. 934 E. 21ST. AVENUE-83002550 GARY, IN. 46407
26. PART I. Enter the disease, 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. Comminuted Fracture of left leg with DUE TO (OR AS A CONSEQUENCE OF) b. Decubitus Ulcer formation DUE TO (OR AS A CONSEQUENCE OF) c. Electrolyte Imbalance Acute Septicemia DUE TO (OR AS A CONSEQUENCE OF) d. Cardiopulmonary Arrest, HCVD, CVA with left Hemiparalysis Approximate Interval Between Onset and Death		
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) <input checked="" type="checkbox"/> No	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <input checked="" type="checkbox"/> No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input checked="" type="checkbox"/> No

CERTIFIER

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>David D. Chube M.D.</i>	29c. MEDICAL LICENSE NO. 17944	29d. DATE SIGNED (Month, Day, Year) 7/18/91
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HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) David D. Chube M.D. 1701 Broadway	31. HEALTH OFFICER'S SIGNATURE <i>Robert E. Holt</i>	32. DATE FILED (Month, Day, Year) JUL 18 1991
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DRONER SE ONLY

33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.		

LOT 41, THE EAST 1/2 OF LOT 40 AND THE WEST 1/2 OF LOT 42, IN BLOCK 1, IN MAIN STREET ANNEX
TO LOGAN PARK, IN GARY, LAKE COUNTY, INDIANA.

