

STATE OF INDIANA)

IN RE: NORMA KING, DECEDENT

FILED

COUNTY OF LAKE

2000 SS 055579

2000 AUG -4 PM 2

AUG 4 2000

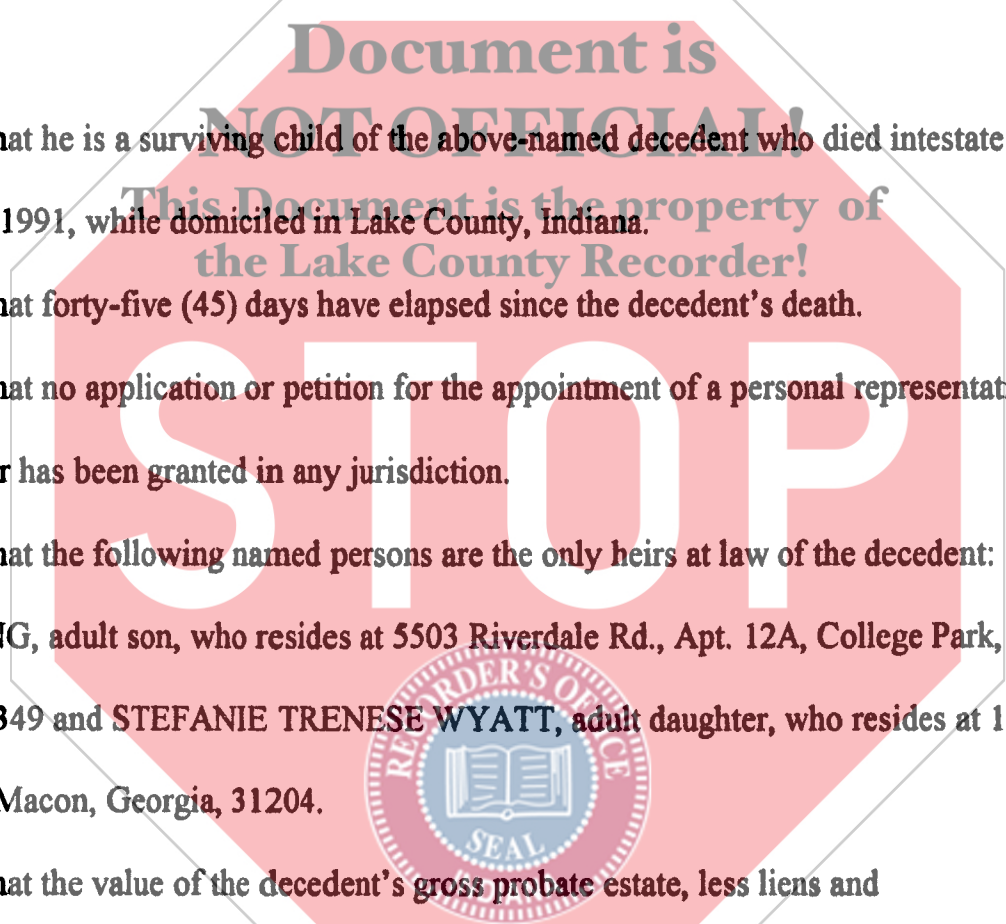
PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT FOR TRANSFER OF REAL PROPERTY

KEVIN KING, the undersigned, being first duly sworn upon his oath deposes and states:

1. That he is a surviving child of the above-named decedent who died intestate on January 13, 1991, while domiciled in Lake County, Indiana.
2. That forty-five (45) days have elapsed since the decedent's death.
3. That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction.
4. That the following named persons are the only heirs at law of the decedent:
KEVIN KING, adult son, who resides at 5503 Riverdale Rd., Apt. 12A, College Park, Georgia, 30349 and STEFANIE TRENSE WYATT, adult daughter, who resides at 1275 Radio Dr., Macon, Georgia, 31204.
5. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of Twenty-Five Thousand Dollars (\$25,000) as provided by Indiana Code § 29-1-8-1.
6. That among the decedent's probate assets is a parcel of real estate which was owned by the decedent located in Lake County, Indiana more particularly described as:

Lot 8 in Block 2 in L. I. Combs & Sons Third Subdivision, in the City of Gary, as per plat thereof, recorded in Plat Book 27, page 96, in the Office of the Recorder of Lake County, Indiana.



Read Deed to Kevin King
5503 Riverdale Rd. #12A
College Park, Ga. 30349

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1300
su
Ctch

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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

No.

State No.

PRINT IN PERMANENT INK

IDENT

TEST

IDENT

SIGNATURE

DATE

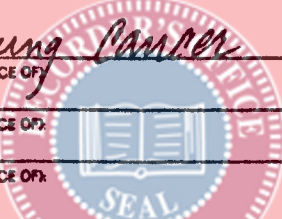
SIGNATURE

SIGNATURE

VERIFICATION

1. DECEASED—NAME (First, Middle, Last) Norma King		2. SEX Female	3a. TIME OF DEATH 5:45 a.m.	3b. DATE OF DEATH (Month, Day, Yr.) January 13, 1991	
4. SOCIAL SECURITY NUMBER 304-42-4151	5a. AGE—Last Birthday (Years) 51	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) February 21, 1939	
7. BIRTH PLACE (City and State or Foreign Country) Gary, Indiana		8a. PLACE OF DEATH (Check only one) (See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c. FACILITY NAME (If not institution, give street and number) Methodist Hospital Northlake			
8d. CITY, TOWN, OR LOCATION OF DEATH Gary		8e. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) James Mounts Jr.	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Laborer	12b. KIND OF BUSINESS/INDUSTRY Can Company		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 319 Chase St.		
13e. ZIP CODE 46404	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" 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) Elementary/Secondary (0-12) 12th College (1-4 or 5+)
18. FATHER'S NAME (First, Middle, Last) Richard Crook Sr.		19. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Noise			
20a. INFORMANT'S NAME (Type/Print) Stephanie Wyatt		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 E. Hardy St. Apt. 18 Inglewood, CA. 90301	20c. Relationship Daughter		
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) January 18, 1991 Oak Hill Cemetery		21c. LOCATION—City or Town, State Gary, IN.	
22a. EMBALMER'S NAME Patrician Owens		22b. EMBALMER'S LICENSE NO. 08700298	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Patrician Owens</i>		24b. LICENSE NUMBER (of Licensee) 08700298	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 83007704 Guy & Allen Funeral Directors, INC. 2959 West 11th Ave. Gary, IN. 46404		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Metastatic Lung Cancer		5 years	
b. DUE TO (OR AS A CONSEQUENCE OF)					
c. DUE TO (OR AS A CONSEQUENCE OF)					
d. DUE TO (OR AS A CONSEQUENCE OF)					
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? 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>Barbara L. Fuller, M.D.</i>		29c. MEDICAL LICENSE NO. 01034701	29d. DATE SIGNED (Month, Day, Year) 1/16/91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Barbara L. Fuller, M.D. 3229 Broadway Gary, IN 46409					
31. HEALTH OFFICER'S SIGNATURE <i>Robert E. Foster</i>			32. DATE FILED (Month, Day, Year) JAN. 22 1991		
33. MANNER OF DEATH <input 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)	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.			

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