Please Return To:

ARNOLD KREVITZ
Attorney At Law
500 East 86th Avenue
Merrillville, IN 46410
(219) 769-1300

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 AUG 25 AM 10:15

MORRIS W. CARTER
RECORDER

2000 061867

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Bernice Sandidge, being first duly sworn upon her oath, deposes and says:

1. That she was married to Jake Sandidge on Date of September 11, 1950, who died a resident of Gary, Lake County, Indiana, on September 29, 1992, as evidenced by a Certified Death Certificate attached hereto and made a part hereof.

2. That at the time of his death, Jake Sandidge and Bernice Sandidge, Husband and Wife, held title under a Warranty Deed to the following-described Real Estate, to-wit:

Lot 4 in Block 6 in Marshalltown Terrace, in the City of Gary, as per plat thereof, recorded in Plat Book 30 page 12, in the Office of the Recorder of Lake County, Indiana.

Commonly known as 2379 Wisconsin Street, Gary, Indiana 46407

Key No. 46-554-4
Unit No. 25

3. That the Affiant and the Decedent, Jake Sandidge, were Husband and Wife continuously from the time they acquired title to the above-described Real Estate on August 17, 1964, to the time of his death on September 29, 1992.

4. That the Estate of Jake Sandidge, decedent, was not of sufficient value to be subject to Federal Estate Taxes or Indiana Inheritance Taxes.

FURTHER AFFIANT SAYETH NOT.

Bernice Sandidge
Bernice Sandidge

Subscribed and sworn to before me, a Notary Public, this 21st day of August, 2000.

Arnold Krevitz
Arnold Krevitz, Notary Public
Resident of Lake County

My Commission Expires:

January 24, 2001

MAY BE ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

AUG 25 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

This Instrument Prepared by:

ARNOLD KREVITZ, Attorney At Law
500 East 86th Avenue
Merrillville, IN 46410
(219) 769-1300

01995

19.00

m.off 123929

INDIANA STATE BOARD OF HEALTH

Local No. 92-0682 — CERTIFICATE OF DEATH — State No. .....

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.)
JAKE SANDIDGE	MALE	13:15p	Sept 29,92

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday	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)
427-03-9810	74			May 28,1918	Sentobia,Miss

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	8c PLACE OF DEATH (Check only one. See instructions)
No	No	HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9a FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
St.Mary Medical Center	Gary	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	Bernice Crawford	Bottlemaker	Steel Mill

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Ind	Lake	Gary	2379 Wisconsin St.

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) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46407	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	Black	8th	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Alex Sandidge	Annie Lewis

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
Bernice Sandidge	2379 Wisconsin St. Gary, Ind 46407	spouse

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____	Oct 3,92 Oakhill Cemetery	Gary,Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
LEON COLEMAN JR.	4523	xx ☐ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Leon Coleman	2364	Powell-Coleman F.H. 1901 Wash.St. Gary,In 83004560

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)	a Severe Anemia	
Conditions if any which gave rise to the immediate cause, stating the underlying cause last	b Chronic Blood loss DUE TO (OR AS A CONSEQUENCE OF)	
	c DUE TO (OR AS A CONSEQUENCE OF)	
	d	

FILED
AUG 25 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
no		

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)
Cornelius Arnold, M.D.	01032158	October 1, 1992

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Cornelius Arnold, M.D. 540 Tyler Street Gary, Indiana

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Cornelius Arnold, M.D.

32. DATE FILED (Month, Day, Year): OCT. 1 1992

CORONER USE ONLY

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 OCCURRED
☐ 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)
	01991

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Official Stamp

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Document Mail Back to Information Sheet

This is where you want the recorded document sent back to when it has completed the recording process.

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Address: 500 E. 86th Ave.

City StZip: Merrillville, IN 46410

Telephone: 219-769-1300

Signature Printed:

Signature Written: Arnold Kravitz

Date of Signature: 8-25-00

MO, ~~Check Number~~: 123929

Check Amount: $12-

Office Use Only

~~C~~k Equals Amount Due ☐Yes ☐No

Total

Initials: Ac

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