3

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2002 045719

2002 MAY 15 AM 12: 36

MORRIS W. CARTER
RECORDER

SURVIVORSHIP AFFIDAVIT

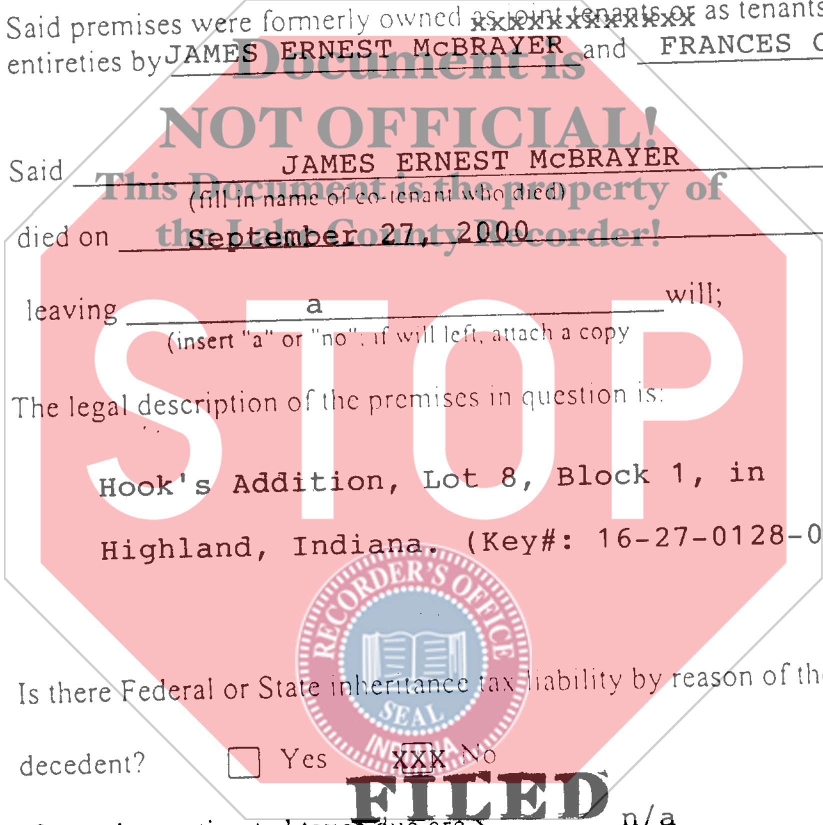
On this May 14, 2002 before me personally appeared
(insert date)
FRANCES C. McBRAYER

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 OWNER
(state interest of affiant in the above premises as "owner"," son of owner", etc.

3. Said premises were formerly owned ~~as joint tenants or~~ as tenants by the entireties by JAMES ERNEST McBRAYER and FRANCES C. McBRAYER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RECORDER'S OFFICE SEAL INDIANA

4. Said JAMES ERNEST McBRAYER
(fill in name of co-tenant who died)
died on September 27, 2000
leaving a will;
(insert "a" or "no"; if will left, attach a copy

5. The legal description of the premises in question is:

Hook's Addition, Lot 8, Block 1, in Highland, Indiana. (Key#: 16-27-0128-0008).

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? ☐ Yes XXX No

FILED

If yes, then estimated taxes due are $ n/a

The taxes due are ☐ paid or ☐ unpaid..

MAY 15 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

001283

OVER

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? NO

(If answer is "Yes" , identify the divorce proceedings:

n/a):

8. Affiant's relationship to the deceased was spouse-wife

Signature: X Frances C. McBrayer

Printed Name FRANCES C. McBRAYER

Address: 2723-37th Street

Highland, Indiana 46322

Subscribed and sworn to before me by the affiant

This MAY 14, 2002.
(insert date)

Mark H. Holtan
Notary Public

Printed Name MARK H. HOLTAN

My County of Residence is: LAKE

In the State of INDIANA

My Commission Expires 9/26/2008

This instrument prepared by MARK H. HOLTAN
2646 Highway Ave.-# 127
Highland, Indiana 46322

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*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.

Local No. 2235-00

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JAMES McBRAYER
2. SEX: MALE
3a. TIME OF DEATH: 1:05 P M
3b. DATE OF DEATH (Month, Day, Yr): SEPTEMBER 27, 2000
4. *SOCIAL SECURITY NUMBER: 402-58-8565
5a. AGE—Last Birthday (Years): 56
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): DECEMBER 19, 1943
7. BIRTHPLACE (City and State or Foreign Country): TOLEDO, OHIO
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 2723 37TH. ST.
9c. CITY, TOWN, OR LOCATION OF DEATH: HIGHLAND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): FRANCES SHELTON
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MACHINIST
12b. KIND OF BUSINESS/INDUSTRY: INLAND STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HIGHLAND
13d. STREET AND NUMBER: 2723 37TH. ST.
13e. ZIP CODE: 46322
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): (UNAVAILABLE)
19. MOTHER'S NAME (First, Middle, Maiden Surname): DIXIE McBRAYER

INFORMANT

20a. INFORMANT'S NAME (Type/Print): FRANCES McBRAYER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2723 37TH. ST. HIGHLAND, IN. 46322
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): SEPTEMBER 30, 2000 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: SCOTT J. PREWITT
22b. EMBALMER'S LICENSE NO: FD01006861
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01006015
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN-MILLER FUNERAL HOME FH83003035 2828 HIGHWAY AVE. HIGHLAND, IN. 46322

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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. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Recent myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF): c. Recent coronary artery bypass surgery
DUE TO (OR AS A CONSEQUENCE OF): d.

Sequentially list conditions, if any, which gave rise to the immediate cause. Enter the underlying cause last.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT
SEP 29 2000

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):

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: [signature]
29c. MEDICAL LICENSE NO: 01042616
29d. DATE SIGNED (Month, Day, Year): 9/28/00
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ANURADHA DIVAKARUNI 1905 CALUMET AVE MUNSTER, IN 4632[illegible]

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Daryl L. Fortson, M.D.
32. DATE FILED (Month, Day, Year): September 29, 2000

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 (R5/1-99)

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