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# TICOR TITLE INSURANCE

AFFIDAVIT

2003 076711

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2003 JUL 24 11 01 AM

MORNING  
RECORD

BYNETTA LANDRUM, being first duly  
sworn upon oath, deposes and says:

1. That Warren G. Landrum Sr died on Feb 5 2003 at Merrillville, In.
2. That Warren G. Landrum Sr and Bynetta Landrum were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

THE ("PROPERTY") KNOWN AS 3906 FERN STREET IN  
7 NORTH TOWNSHIP, LAKE COUNTY, EAST CHICAGO,  
INDIANA 46312. WHICH IS LEGALLY DESCRIBED AS:  
INLAND SUBDIVISION L.32 BL. 1

30-427-32 (24)

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 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.

**This Document is the property of  
the Lake County Recorder!**

Further affiant sayeth not.

Subscribed and sworn to before me, a Notary Public, this 27th day of April, 2003

Bynetta Landrum  
Bynetta Landrum



Notary Public

**FRANCIS D. TRUONG**  
NOTARY PUBLIC  
Orleans Parish, Louisiana  
My Commission is for Life

My Commission expires:

With life

County of Residence:

Orleans, Louisiana

This Instrument prepared by \_\_\_\_\_

## FILED

JUL 23 2003

STEPHEN R. STIGLICH  
LAKE COUNTY AUDITOR

TICOR - SCHERERVILLE  
920030341

001624 TL

11-50

\* 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.

# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

State No. ....

Local No. 308-03

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Warren Landrum, Sr.</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>7:48 A.</b>	3b. DATE OF DEATH (Month, Day, Year) <b>February 5, 2003</b>
4. SOCIAL SECURITY NUMBER <b>310-22-2662</b>	5a. AGE—Last Birthday (Years) <b>80</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>May 10, 1922</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Redbud, Georgia</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>YES</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>		8c. PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> FRO/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital Southlake Campus</b>		9b. CITY, TOWN, OR LOCATION OF DEATH <b>Merrillville</b>		9c. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (County) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Bynetta Harvey</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use "retired") <b>Assistant Roller (retired)</b>		12b. KIND OF BUSINESS/INDUSTRY <b>LT Steel</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>East Chicago</b>		13d. STREET AND NUMBER <b>3906 Fern Street</b>
13e. ZIP CODE <b>46312</b>	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? <b>USA</b>	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) <b>Black</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>		18. FATHER'S NAME (First, Middle, Last) <b>Robert Landrum</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillie Simpson</b>		20a. INFORMANT'S NAME (Type/Print) <b>Bynetta Landrum</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3906 Fern Street East Chicago, In 46312</b>		20c. Relationship <b>Wife</b>		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) <b>February 11, 2003 Oak Hill Cemetery</b>		21c. LOCATION—City or Town, State <b>Gary, Indiana</b>
22a. EMBALMER'S NAME <b>Tracy C. Williams</b>		22b. EMBALMER'S LICENSE NO. <b>FD08600238</b>		23. WAS DEATH REPORTED TO CORC DEPT? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b. LICENSE NUMBER (of Licensed) <b>FD08600238</b>	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Simon-Williams Funeral Home, Inc. 4859 Alexander Avenue East Chicago, Indiana 46312 FEB001520</b>	
25. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter non-causal 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) <b>Cardio-pulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF) <b>end-stage renal disease</b> DUE TO (OR AS A CONSEQUENCE OF) <b>PVD</b> 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) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>
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>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>01025591</b>		29d. DATE SIGNED (Month, Day, Year) <b>2-7-2003</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>ALEXANDER STEMER 761 45th STREET SUITE 103 MONSTER IN 46321</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. Best, D.O.</i>				32. DATE FILED (Month, Day, Year) <b>February 10, 2003</b>
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>FEB 11, 2003</b>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		