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**TICOR TITLE INSURANCE**

MICHAEL A. BROWN  
RECORDER

### SURVIVORSHIP AFFIDAVIT

STATE OF: Indiana )  
) SS:  
COUNTY OF: Lake )

On this 30th day of December, 2004 Before me personally appeared Hurtis Wilson

to me personally known, who being duly sworn on oath did say that:

- Affiant resides at the address given below affiant's signature;
- Affiant is Hurtis Wilson  
(state interest of affiant in the above premises as owner)
- Said premises described as follows: \_\_\_\_\_

Lot 33 in Block 11 in Gary Land Company's Eleventh Subdivision, in the City of Gary, as per plat thereof, recorded in Plat Book 13 page 25, in the Office of the Recorder of Lake County, Indiana.

Document is NOT OFFICIAL!

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- Said premises were formerly owned as joint tenants or as tenants by entireties by Hurtis Wilson and Bernice Wilson
- Said Bernice Wilson (fill in name of co-tenant who died) died on March 19, 2002 leaving NO will; (insert "a" or "no" if a will has been left, attach a copy)
- The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, and insurance does not exceed the sum of \$ 0 and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of the said decedent:
- Where this affidavit relates to a tenancy of the entireties, were the parties ever divorced? NO (If answer is YES, identify the dissolution proceedings.)
- Affiant's relationship to the deceased was Spouse

Signature: Hurtis Wilson  
Address: 1156 Van Buren Gary, IN 46203

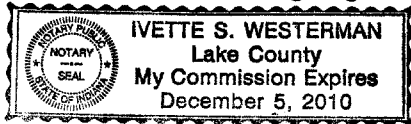
DULY ENTERED FOR TAXATION SUBJECT TO LOCAL ACCEPTANCE AND TRANSFER

State of Indiana )  
County of Lake )

Before me, the undersigned, a Notary Public in and for said County and State, this 30 day of December, 2004 personally appeared Hurtis Wilson

STEPHEN R. STIGLICH  
LAKE COUNTY AUDITOR

and acknowledged the execution of the foregoing Affidavit.



Ivette Westerman  
Notary Public

Resident of Lake County  
My Commission expires: 12/5/10

Prepared by: Hurtis Wilson

924-9312  
**TICOR MO**

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11/19

\* 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.

3CC + 3 Free VETS  
INDIANA STATE DEPARTMENT OF HEALTH

Local No. 02 0209

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (First, Middle, Last) Bernice R. Wilson				2. SEX Female		3a. TIME OF DEATH 4:29 P M		3b. DATE OF DEATH (Month, Day, Yr) March 19, 2002	
4. *SOCIAL SECURITY NUMBER 414-32-0758		5a. AGE—Last Birthday (Years) 80		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) November 13, 1921	
7. BIRTHPLACE (City and State or Foreign Country) Union City, Tennessee		8a. WAS DECEDENT A U.S. VETERAN? YES		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		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			
9b. FACILITY NAME (If not institution, give street and number) Methodist Hospital Northlake				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) Hurtis Wilson		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife			12b. KIND OF BUSINESS/INDUSTRY Domestic		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Gary			13d. STREET AND NUMBER 1156 Van Buren Street		
13e. ZIP CODE 46407		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U S A		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. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 + )		18. FATHER'S NAME (First, Middle, Last) James Clay				19. MOTHER'S NAME (First, Middle, Maiden Surname) Lena (Clay)			
20a. INFORMANT'S NAME (Type/Print) Hurtis Wilson				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1156 Van Buren Street Gary, Indiana 46407				20c. Relationship Husband	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) March 23, 2002 Evergreen Cemetery				21c. LOCATION—City or Town, State Hobart, Indiana	
22a. EMBALMER'S NAME Roosevelt Allen Jr.				22b. EMBALMER'S LICENSE NO. #01051701		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Roosevelt Allen Jr.</i>				24b. LICENSE NUMBER (of Licensee) #08700646		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704			
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) ASCVD									
a. DUE TO (OR AS A CONSEQUENCE OF):									
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? (Yes or no) NO			28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>Alan L. Jackson, MD</i>						29c. MEDICAL LICENSE NO. # 01052086 A		29d. DATE SIGNED (Month, Day, Year) 3-22-2002	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ALAN L. JACKSON, MD 5500 Hohman Avenue #3A Hammond, Indiana 46320									
31. HEALTH OFFICER'S SIGNATURE <i>Alan L. Jackson, MD</i>								32. DATE FILED (Month, Day, Year) MAR 25 2002	
33. MANNER OF DEATH <input checked="" 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.					

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER