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STATE OF LAKE
COUNTY
FILED FOR RECORD

2005 017959

2005 MAR 11 AM 8:57

MICHAEL A. BROWN
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT OF SURVIVORSHIP

SYLVESTER WORTHMAN, being first duly sworn upon oath, deposes and says:

1. That my mother, Clarice L. Worthmen, died without leaving a Will on September 2, 2001, at Gary, Indiana.

2. That at the time of her death she held an undivided ½ interest to the following described real estate:

25-42-0058-0057

The North 10 feet of Lot 44 and the South 20 feet of Lot 45 in Block 1 in Central Park Addition to Tolleston, in the City of Gary, as per plat thereof, recorded in Plat Book 2 page 48, in the Office of the Recorder of Lake County, Indiana.

3. That all funeral expenses in connection with the death of said decedent have been paid in full.

4. That all the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedents' life, were not sufficient to necessitate payment of Federal Estate Tax.

FURTHER, AFFIANT SAYETH NOT.

Sylvester Worthman

INSTRUMENT PREPARED BY: Larry D. Stassin, 5832 Hohman Ave., Hammond, IN 46320

MAIL TO: Larry D. Stassin, 5832 Hohman Ave., Hammond, IN 46320

FILED

MAR 10 2005

STEPHEN B. STIGLICH
LAKE COUNTY AUDITOR

000778A HS8970 SS

AFFIDAVIT OF SURVIVORSHIP - con't

SUBSCRIBED AND SWORN TO BEFORE me, a Notary Public, this 2nd day of March, 2005.

Barbara A. Alvarez
Notary Public (signature)

Barbara A. Alvarez
(printed name)

My Commission Expires: 9/25/06

County of Residence: Lake

*** 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.

2CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 01 0590

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Clarice L. Worthman
2. SEX: Female
3a. TIME OF DEATH: 5:02 PM
3b. DATE OF DEATH (Month, Day, Yr.): September 2, 2001
4. *SOCIAL SECURITY NUMBER: 401-32-8798
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): August 30, 1927
7. BIRTHPLACE (City and State or Foreign Country): Providence, Kentucky
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
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): 1707 Hayes Street
9c. CITY, TOWN OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Divorced
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 1707 Hayes Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
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 +)

PARENTS

18. FATHER'S NAME (First, Middle, Last): Rufus Sladen
19. MOTHER'S NAME (First, Middle, Maiden Surname): Katie Reid

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Cynthia Jones
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9223 Pottowatomi Trail Gary, Indiana 46403
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 8, 2001 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Rosenwald D, Allen Jr.
22b. EMBALMER'S LICENSE NO.: #29400047
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR
24b. LICENSE NUMBER (of Licensee): #08700298
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave Gary, Indiana 46404 83007704

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Vascular collapse — Approximate Interval Between Onset and Death: Unknown

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF): Due to arteriosclerotic heart and vascular collapse
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)

CERTIFIER

29a. CERTIFIER (Check only one): Deputy
☐ 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.: N/A
29d. DATE SIGNED (Month, Day, Year): September 13, 2001

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Donna Melyon, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307
31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year): SEP 20 2001

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): September 2, 2001
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.