

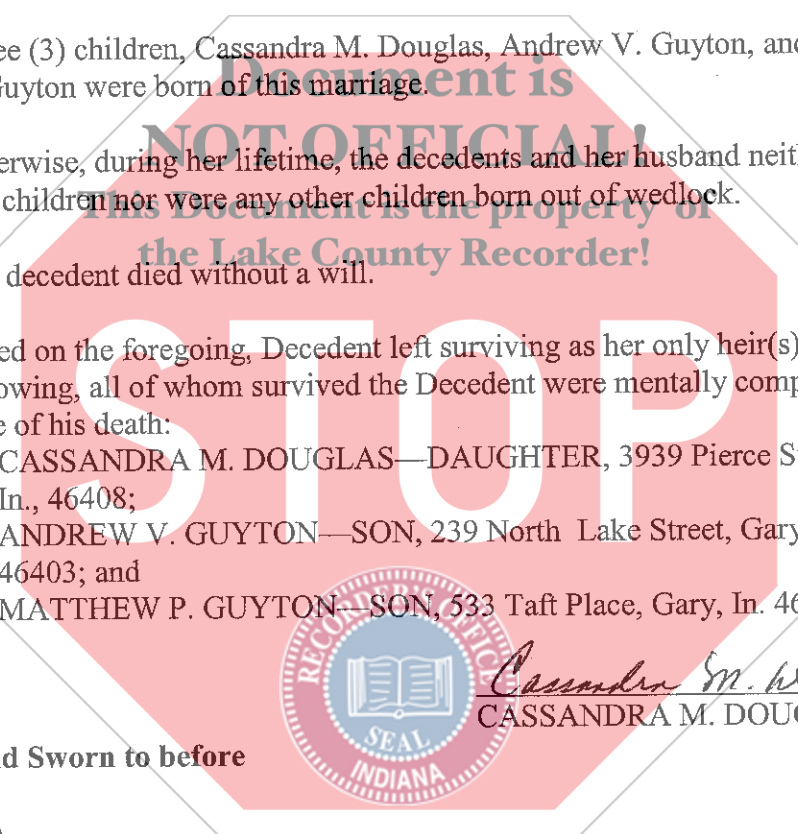
STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
**AFFIDAVIT OF HEIRSHIP**  
(DECEDENT, CHARLENE Z. GUYTON)

2006 012438

2006 FEB 15 PM 12:39

I, Cassandra M. Douglas (CASSANDRA M. DOUGLAS),  
being first duly sworn on oath deposes and states as follows:

- 1) I am of legal age, competent, under no legal disability, and I have personal knowledge of the facts contained herein by reason of being the biological DAUGHTER of the deceased, CHARLENE Z. GUYTON.
- 2) CHARLENE Z. GUYTON died FEBRUARY 19, 2005 at METHODIST HOSPITAL SOUTHLAKE, in LAKE County, INDIANA from complications (cardiac arrest and respiratory failure) due to a long history of chronic obstructive pulmonary disease. (See attached certified copy of the death certificate). Prior to her death, Decedent was a resident of the county of LAKE and state of INDIANA.
- 3) During her lifetime, she married Andrew V. Guyton who predeceased her on November 6, 1998.
- 4) Three (3) children, Cassandra M. Douglas, Andrew V. Guyton, and Matthew P. Guyton were born of this marriage.
- 5) Otherwise, during her lifetime, the decedents and her husband neither adopted any children nor were any other children born out of wedlock.
- 6) The decedent died without a will.
- 7) Based on the foregoing, Decedent left surviving as her only heir(s), the following, all of whom survived the Decedent were mentally competent at the time of his death:
  - a) CASSANDRA M. DOUGLAS—DAUGHTER, 3939 Pierce Street., Gary, In., 46408;
  - b) ANDREW V. GUYTON—SON, 239 North Lake Street, Gary, Indiana 46403; and
  - c) MATTHEW P. GUYTON—SON, 533 Taft Place, Gary, In. 46404.



Cassandra M. Douglas  
CASSANDRA M. DOUGLAS

Subscribed and Sworn to before

me this 9th

day of February, 2006.

Luci D. Fortson  
Notary Public

DULY ENTERED FOR TAXATION SUBJECT TO  
FINAL ACCEPTANCE FOR TRANSFER

FEB 15 2006

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

003320

14-  
FP  
CS

MENTION ESTATE: The Social Security # is requested by this state agency in order to determine its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

File No. 656-05

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

REPRINT IN IMMINENT ACK INK

IDENT

ENTS

FORMANT

POSITION

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TH CER

1. DECEASED—NAME (First, Middle, Last) Charlene Zenobia Guyton		2. SEX Female	3a. TIME OF DEATH 6:50 P M	3b. DATE OF DEATH (Month, Day, Yr) February 19, 2005	
4. *SOCIAL SECURITY NUMBER 313-36-9548	5a. AGE—Last Birthday (Years) 68	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) January 16, 1937	
7. BIRTHPLACE (City and State or Foreign Country) Atlanta, Georgia	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: <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 Southlake		9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	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) Secretary		12b. KIND OF BUSINESS/INDUSTRY Methodist Hospital	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 533 Taft Place	
13e. ZIP CODE 46404	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) 12th		18. FATHER'S NAME (First, Middle, Last) Russell Hancock			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Ruby Ledbetter			20a. INFORMANT'S NAME (Type/Print) Cassandra Douglas		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3639 Pierce Street Gary, Indiana 46408		20c. Relationship Daughter			
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) February 26, 2005 Evergreen Cemetery		21c. LOCATION—City or Town, State Hobart, Indiana	
22a. EMBALMER'S NAME Patrician Owens		22b. EMBALMER'S LICENSE NO. #08700298	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) #08700298	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704		
25. 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. <i>Cardiac respiratory arrest</i>		2-3 days	
b. <i>respiratory failure</i>		c. <i>cardiomyopathy</i>		1-2 weeks	
c. <i>cardiomyopathy</i>		d. <i>cardiomyopathy</i>		3-10 years	
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 		29c. MEDICAL LICENSE NO. 01029166A	29d. DATE SIGNED (Month, Day, Year) 2/24/05		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) HAKAM SAFADI MD 8315 VIRGINIA ST. STE. J MERRILLVILLE IN 46410					
31. HEALTH OFFICER'S SIGNATURE Susan W. Best, D.O.			32. DATE FILED (Month, Day, Year) March 7, 2005		
33. MANNER OF DEATH <input checked="" type="checkbox"/> XXXX <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE JUN 15 2005
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

Prescribed by the  
State Board of Accounts  
(2005)

County form 170

Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security number in attached document.
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.



*Jerome M. Taylor, Esq.*  
Signature of Declarant

*Jerome M. Taylor*  
Printed Name of Declarant