

STATE OF INDIANA

2006 COUNTY OF LAKE 092226

IN RE: GEORGE A. DAVIS, JR., Decedent

2006 OCT 10 PM 2:35

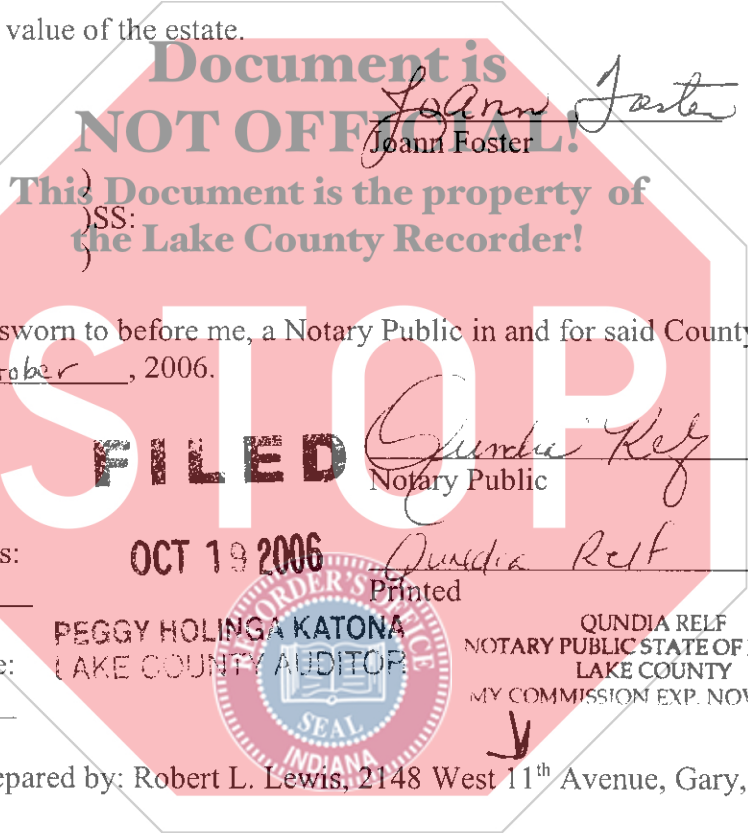
**SURVIVORSHIP AFFIDAVIT**

Joann Foster, being first duly sworn upon her oath deposes and says:

She is the owner in fee simple of the real estate located in Lake County, Indiana, and described as: Lot 23 in block 8, as marked and laid down on the recorded plat of Tarrytown First Subdivision in the City of Gary, Lake County, Indiana, commonly known as 1945 Lane Street. She acquired title with her Godfather, George A. Davis Jr., by deed dated June 29, 1990, and recorded on June 29, 1990.

George A. Davis Jr. died on September 6, 2006. That there is no estate being administered due to the value of the estate.

STATE OF INDIANA )  
COUNTY OF LAKE )



*Joann Foster*  
Joann Foster

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 6<sup>th</sup> day of October, 2006.

*Qundia Relf*  
Notary Public

My Commission expires: 11-8-2008

OCT 19 2006

*Qundia Relf*  
Printed

My County of residence: Lake

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

QUNDIA RELF  
NOTARY PUBLIC STATE OF INDIANA  
LAKE COUNTY  
MY COMMISSION EXP. NOV. 8, 2008

This instrument was prepared by: Robert L. Lewis, 2148 West 11<sup>th</sup> Avenue, Gary, Indiana 46404

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

*Robert L. Lewis*  
Robert L. Lewis, Attorney

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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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local 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) George A Davis Jr.		2 SEX Male	3a TIME OF DEATH 3:10 P M	3b DATE OF DEATH (Month, Day, Yr) September 6, 2006	
4 *SOCIAL SECURITY NUMBER 335-03-8791	5a AGE—Last Birthday (Years) 95	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) February 26, 1911	
7 BIRTHPLACE (City and State or Foreign Co) Helener, Arkansas	8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) Timberview Nursing Home		9c CITY, TOWN, OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Widow	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Custodian		12b KIND OF BUSINESS/INDUSTRY School City of Gar	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 529 Hamlin Street		
13e ZIP CODE 46406	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? USA	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) 12 College (11-4 c)			
18 FATHER'S NAME (First Middle, Last) George A. Davis Sr.		19 MOTHER'S NAME (First Middle, Maiden Surname) Ellen Hubbard			
20a INFORMANT'S NAME (Type/Print) JoAnn Foster		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 Hamlin Street Gary, Indiana 46406		20c Relationship Goddaughter	
21a METHOD OF DISPOSITION <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) September 13, 2006 Oak Hill Cemetery		21c LOCATION—City or Town, State Gary, Indiana	
22a EMBALMER'S NAME Sherman G. Banks III		22b EMBALMER'S LICENSE NO. FD01016254	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) FD01016254	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner FH10500021 4209 Grant Street Gary, IN 46408		
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) Dementia					
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Hert. Dm. Colorectal Metastases - Benign					
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) 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. 01046998	29d DATE SIGNED (Month, Day, Yr) 9-18-2006		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Gladys Ledemle MD 10301 Broadway Memorialville IN 47147					
31 HEALTH OFFICER'S SIGNATURE				32 DATE FILED (Month, Day, Year) SEP 26 2006	
33 MANNER OF DEATH <input type="checkbox"/> Natural <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
		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

