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2007 098030

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2007 DEC 14 AM 11:01

MICHAEL A. BROWN  
RECORDER

DECEASED JOINT TENANTS AFFIDAVIT

The undersigned, being duly placed under oath, deposes and states:

1. The undersigned is the surviving joint tenant of the following property

legally described as:

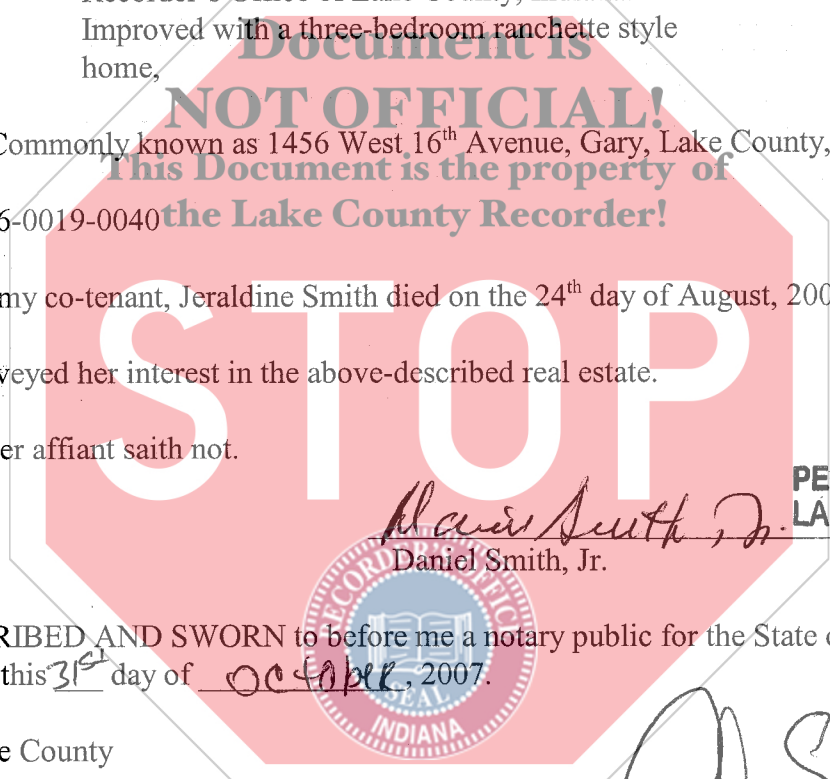
Lots 37 and 38 in Block 1 in Main Street Annex  
to Logan Park, in the City of Gary, as per plat  
thereof, recorded in Plat Book 7 page 2 in the  
Recorder's Office of Lake County, Indiana.  
Improved with a three-bedroom ranchette style  
home,

Commonly known as 1456 West 16<sup>th</sup> Avenue, Gary, Lake County, Indiana.

Parcel No. 25-46-0019-0040

2. That my co-tenant, Jeraldine Smith died on the 24<sup>th</sup> day of August, 2007 without  
having first conveyed her interest in the above-described real estate.

3. Further affiant saith not.



**FILED**  
**DEC 13 2007**

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

*Daniel Smith, Jr.*  
Daniel Smith, Jr.

SUBSCRIBED AND SWORN to before me a notary public for the State of Indiana,  
County of Lake this 31<sup>st</sup> day of October, 2007.

Resident of Lake County

My Commission Expires: 02/11/15

*David Saks*  
Notary Public

**25055**

*1300  
6514  
R*

Mail to: David Saks, 6948 Indianapolis Blvd., Hammond, IN 46324

DAVID SAKS  
NOTARY PUBLIC STATE OF INDIANA  
LAKE COUNTY  
MY COMMISSION EXPIRES 02/11/15

*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*

IN ESTATE: The Social Security # is listed by this state agency in order to determine statutory responsibility. Disclosure is required and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ....

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

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1. DECEASED-NAME (First, Middle, Last) <b>Geraldine Y. Smith</b>				2. SEX <b>Female</b>	3a. TIME OF DEATH <b>2:05 AM</b>	3b. DATE OF DEATH (Month, Day, Year) <b>August 24, 2007</b>	
4. SOCIAL SECURITY NUMBER <b>307-20-4718</b>		5a. AGE - Last Birthday (Years) <b>83</b>	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo, Day, Yr) <b>September 17, 1923</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>McComb, Mississippi</b>	
8a. WAS DECEASED A U.S. VETERAN? <b>No</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) _____ <input checked="" type="checkbox"/> Residence		9b. CITY, TOWN, OR LOCATION OF DEATH <b>Gary</b>			9c. COUNTY OF DEATH <b>Lake</b>
9d. FACILITY NAME (If not institution, give street and number) <b>1456 W. 16th Avenue</b>		10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Daniel Smith Jr.</b>		12. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	
13a. RESIDENCE - STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Gary</b>		13d. STREET AND NUMBER <b>1456 W. 16th Avenue</b>	
13e. ZIP CODE <b>46407</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 DECEASED 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. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____			18. FATHER'S NAME (First, Middle, Last) <b>Walter Jackson</b>				
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Warner</b>			20a. INFORMANT'S NAME (Type/Print) <b>Daniel Smith Jr.</b>				
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <b>1456 W. 16th Avenue Gary, Indiana 46407</b>			20c. Relationship <b>Husband</b>				
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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>August 30, 2007 Evergreen Memorial Park</b>		21c. LOCATION - City or Town, State <b>Hobart, Indiana</b>			
22a. EMBALMER'S NAME <b>Sherman G. Banks III</b>		22b. EMBALMER'S LICENSE NO. <b>FD01016254</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01016254</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Smith Bizzell Warner FH10500021 4209 Grant Street Gary, Indiana 46408</b>			
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)		a. <b>Carcinoma Colon</b>					
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. _____					
		c. _____					
		d. _____					
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>COPD, Pyloic stenosis, anemia, Hypertension Rt.</b>							
27. WAS DECEASED 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)			
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>1026067A</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/28/07</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print) <b>Raymundo Billera M.D. 15496 Broadway Merrillville, IN 46410</b>							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) <b>SEP 03 2007</b>	
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		33a. DATE OF INJURY (Month, Day, Year) <b>10 03 2007</b>	33b. TIME OF INJURY	33c. INJURY AT WORK? (Yes or No)	33d. DESCRIBE HOW INJURY OCCURRED		
34a. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		34b. 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.					

