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REC'D  
LAKE COUNTY  
RECORDERS OFFICE

2008 022481

2008 MAR 31 AM 10:43

MICHAEL A. BROWN  
RECORDER

**SURVIVORSHIP AFFIDAVIT**

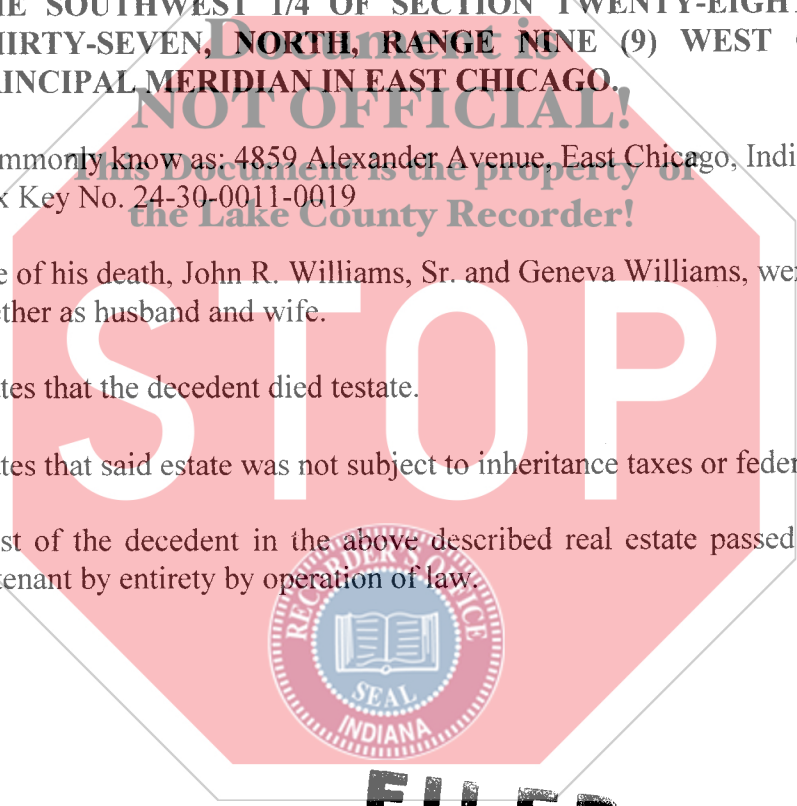
GENEVA WILLIAMS, being first duly sworn, states:

1. Affiant is a resident of Lake County, State of Indiana.
2. Affiant is the surviving spouse of John R. Williams, Sr., who died a resident of Lake County, Indiana on November 23, 2007. A certified copy of his death certificate is attached hereto and incorporated herein.
3. At the time of his death, John R. Williams, Sr. and Geneva Williams, husband and wife, were owners of the following-described real estate located in Lake County, Indiana:

**LOTS THIRTY (30) AND THIRTY-ONE (31) IN BLOCK FIFTEEN (15) IN THE SOUTHWEST 1/4 OF SECTION TWENTY-EIGHT, TOWNSHIP THIRTY-SEVEN, NORTH, RANGE NINE (9) WEST OF THE 2ND PRINCIPAL MERIDIAN IN EAST CHICAGO.**

Commonly know as: 4859 Alexander Avenue, East Chicago, Indiana 46312  
Tax Key No. 24-30-0011-0019

4. At the time of his death, John R. Williams, Sr. and Geneva Williams, were not divorced and were living together as husband and wife.
5. Affiant states that the decedent died testate.
6. Affiant states that said estate was not subject to inheritance taxes or federal estate taxes.
7. The interest of the decedent in the above described real estate passed to Geneva Williams as surviving tenant by entirety by operation of law.



File: 00096862.WPD

**FILED**

MAR 31 2008

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

15<sup>00</sup>  
2795  
3862 AM

Hold for  
Professionals' Title Services

1

8. This Affidavit is made by the undersigned to cause the title to the above described real estate to be transferred to Affiant in her name alone.

Dated this 17<sup>th</sup> day of March, 2008.

Geneva L. Williams  
GENEVA WILLIAMS

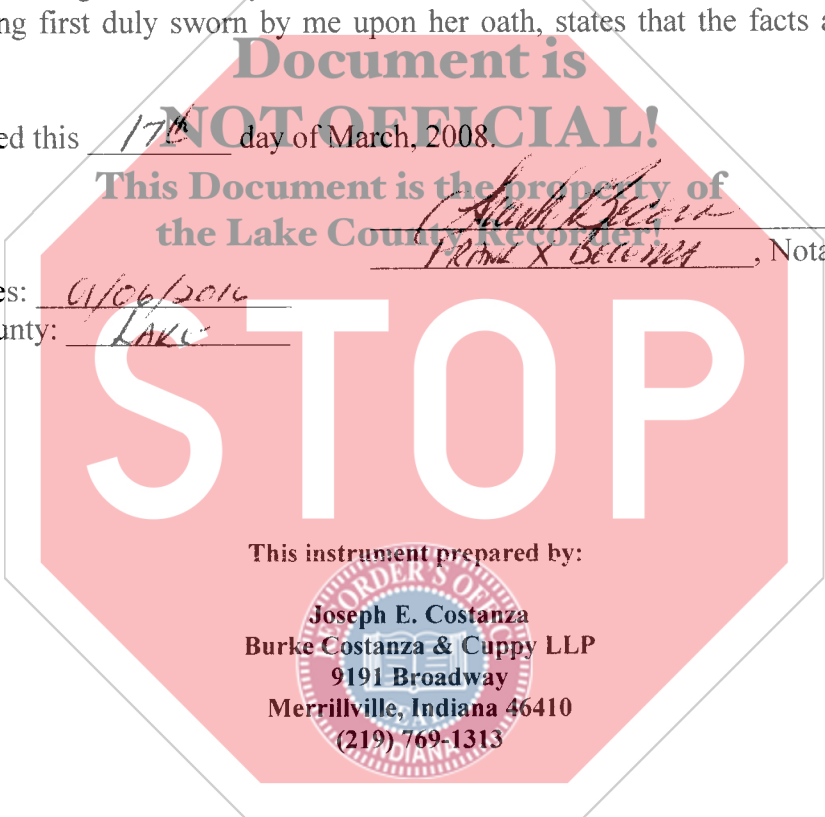
STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

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.

Lisa M. Mosen

Before me the undersigned, a Notary Public in and for said County and State, personally appeared Genva Williams, and she, being first duly sworn by me upon her oath, states that the facts alleged in the foregoing instrument are true.

Signed and sealed this 17<sup>th</sup> day of March, 2008.



Lisa M. Mosen  
Notary Public

My Commission Expires: 6/06/2016  
A Resident of Lake County: 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.

INDIANA STATE DEPARTMENT OF HEALTH

City Of East Chicago  
East Chicago, In 46312

CERTIFICATE OF DEATH

State No. ....

Local No. 298

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) John Robert Williams, Sr.		2 SEX Male	3a TIME OF DEATH 10:25A.M	3b DATE OF DEATH (Month, Day, Yr) November 23, 2007	
4 *SOCIAL SECURITY NUMBER -5151	5a AGE—Last Birthday (Years) 91	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) October 20, 1916	
7 BIRTHPLACE (City and State or Foreign Country) Grenada County, Mississippi	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				
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9b FACILITY NAME (If not institution, give street and number) St. Catherine Hospital	9c CITY, TOWN OR LOCATION OF DEATH East Chicago	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Geneva Elizabeth Reese	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) (ret.) Funeral Director/Embalmer	12b KIND OF BUSINESS/INDUSTRY Funeral Home		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION East Chicago	13d STREET AND NUMBER 4859 Alexander Avenue		
13e ZIP CODE 46312	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	17 DECEDENT'S EDUCATION (Specify only highest grade completed) 12th				
18 FATHER'S NAME (First, Middle, Last) Tillmon Williams		19 MOTHER'S NAME (First, Middle, Maiden Surname) Vidie Parker			
20a INFORMANT'S NAME (Type/Print) Geneva Elizabeth Williams		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4859 Alexander Ave. East Chicago, IN 46312		20c Relationship Wife	
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) December 1, 2007 Fern Oaks Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Tracy Cheri Williams		22b EMBALMER'S LICENSE NO. FD08600238		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b LICENSE NUMBER (of Licensee) FD08600238		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Hinton & Williams Funeral Home, Inc. 4859 Alexander Avenue East Chicago, IN 46312 FH83001520	
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. <i>Cardiovascular collapse</i> DUE TO (OR AS A CONSEQUENCE OF)					
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last 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					
<i>Carcinoma Lung Chronic Obstructive Lung Disease Pneumonia</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) 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. 01035700		29d DATE SIGNED (Month, Day, Year) 11-29-07	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 364 RIDGE RD HIGHTCARD, IN 46322 MANSUETO SILVERMAN					
31 HEALTH OFFICER'S SIGNATURE <i>Quia Bonnie Aboumou MD</i>				32 DATE FILED (Month, Day, Year) 12/20/07	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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.			

IVRA-20

(7/05) SDH06-004 State Form 10110 (R5/1-99)

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT