STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

2009 060326

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2009 SEP -1 AM 10:08
MICHAEL A. BROWN
RECORDER

5

AFFIDAVIT OF HEIRSHIP

Comes now, James McKinnie Lowe, being duly sworn upon his oath, and states as follow:

1. That Faith McKinney and Flora McKinney held title, as tenants in common, to the following described real estate in Lake County, Indiana, to-wit:

Lot 23, Block 5, in a subdivision of part of the Northwest Quarter (NW1/4), Section 33, Township 37 North, Range 9, West of the 2nd P.M., in the City of East Chicago, Lake County, Indiana.

Parcel No. 45-03-33-130-037.000-024

Commonly known as 610 E. 151st Street, East Chicago, Indiana

2. That Flora McKinney died intestate, a resident of Lake County, Indiana, on February 14, 1994, a copy of the Death Certificate is attached hereto and made a part hereof, and left surviving her the following heirs at law: Faith McKinney, adult sister of decedent, entitled to a 50% interest in her estate and David McKinney, adult brother of decedent, entitled to a 50% interest in her estate. No estate administration was commenced.

3. That Faith McKinney died intestate, a resident of Lake County, Indiana, on April 13, 1998, a copy of the Death Certificate is attached hereto and made a part hereof, and left the sole surviving the following heir at law: David McKinney, adult brother of decedent, entitled to a 100% interest in her estate. No estate administration was commenced.

FILED
AUG 31 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

2009
105077
RM

016132

been opened in the Lake Superior Court with Estate No.: 45D04-0711-ES-00060.

5. That by reason of this Affidavit, the entire interest in the Real Estate vests in the Estate of David McKinney.

6. That the statements in this Affidavit are true and complete insofar as the Affiant knows and are made for the purpose of establishing the ownership of the real estate described hereinabove.

FURTHER YOUR AFFIANT SAYETH NOT.

James McKinnie Lowe

James McKinnie Lowe

State of Nevada)
) SS:
County of Clark)

Before me, the undersigned, a Notary Public in and for said County and State, on this date personally appeared before me James McKinnie Lowe, known to me to be the person whose name is subscribed to the foregoing Affidavit of Heirship and acknowledged to me that he executed it for the purposes therein specified.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, this 20th day of March, 2009

Jannette A. Stewart

Notary Public
Resident of Clark County
My Commission Expires: April 16, 2011

RECORDER'S OFFICE SEAL INDIANA

NOTARY PUBLIC
STATE OF NEVADA
County of Clark
JANNETTE A. STEWART
No: 07-[illegible]
My Appt Expires Apr. 16, 2011

This instrument prepared by:
James L. Clement, Jr.
LUCAS, HOLCOMB & MEDREA, LLP
300 E. 90th Drive
Merrillville, IN 46410
(219) 769-3561

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.

Mark S. Lucas

* **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.

City Of East Chicago
East Chicago, In 46312

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 91 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): FAITH McKINNEY
2. SEX: FEMALE
3a. TIME OF DEATH: 3:32 aM
3b. DATE OF DEATH (Month, Day, Yr.): APRIL 13,1998
4. *SOCIAL SECURITY NUMBER: 306-34-5664
5a. AGE—Last Birthday (Years): 64
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo, Day, Yr): APRIL 7,1934
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO, INDIANA
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): SAINT CATHERINE HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: EAST CHICAGO
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): NEVER MARRIED
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): VOICE OVER ARTIST
12b. KIND OF BUSINESS/INDUSTRY: RADIO
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: EAST CHICAGO
13d. STREET AND NUMBER: 610 E. 151st. STREET
13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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 (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): ALFRED McKINNEY
19. MOTHER'S NAME (First, Middle, Maiden Surname): CHERRY HILL

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DAVID McKINNEY
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 610 EAST 151st.EAST CHICAGO, IN 46312
20c. Relationship: BROTHER

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 17,1998 OAKWOODS CEMETERY
21c. LOCATION—City or Town, State: WAUKEGAN, ILLINOIS
22a. EMBALMER'S NAME: AVIS ROBINSON
22b. EMBALMER'S LICENSE NO.: FD29700012
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Avis Robinson
24b. LICENSE NUMBER (of Licensee): FD29700012
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: GENESIS FUNERAL HOME FH19600010 421 W. 5th. AVE. GARY, INDIANA

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. Intracranial Bleeding

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF): Septicemia
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death

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)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a. CERTIFIER (Check only one):
☐ 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: Dr.
29c. MEDICAL LICENSE NO.: 01042348
29d. DATE SIGNED (Month, Day, Year): 04/15/98

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Satish Patel 5500 Hohman Ave. Hammond In
31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Rautouch
32. DATE FILED (Month, Day, Year): 4-15-98

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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)

94-010467

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0421-94 State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT—NAME (First, Middle, Last): FLORA MCKINNEY
2. SEX: FEMALE
3a. TIME OF DEATH: 5:45 P.M.
3b. DATE OF DEATH: FEBRUARY 14, 1994
4. SOCIAL SECURITY NUMBER: 311-28-2184
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR (Months / Days)
5c. UNDER 1 DAY (Hours / Minutes)
6. DATE OF BIRTH: Aug.30.1925
7. BIRTHPLACE: Milwaukee, Wisconsin
8a. WAS DECEDENT EVER IN U.S. ARMED FORCES?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES
9. PLACE OF DEATH: HOSPITAL — Inpatient; OTHER — Nursing Home, Other, Residence
9a. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9b. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9c. COUNTY OF DEATH: LAKE
10. MARITAL STATUS: Never Married
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION: Secretary
12b. KIND OF BUSINESS/INDUSTRY: Real Estate
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 610 East 151st Street
13e. ZIP CODE: 46312
13f. INSIDE CITY LIMITS?: Yes
14. CITIZEN OF WHAT COUNTRY: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: No
16. RACE—American Indian, Black, White, etc.: Black Amer.
17. DECEDENT'S EDUCATION: Elementary/Secondary (0-12): 12th. Grade; College (1-4 or 5+):
13g. ON A FARM?: No

PARENTS

18. FATHER'S NAME (First, Middle, Last): Alfred McKinney
19. MOTHER'S NAME (First, Middle, Maiden Surname): Cherry Hill

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Faith McKinney
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 610 East 151 St., East Chicago, Ind.
20c. Relationship: Sister

DISPOSITION

21a. METHOD OF DISPOSITION: Burial; Cremation; Removal from State; Donation; Other (Specify)
21b. DATE AND PLACE OF DISPOSITION: Feb. 17.1994 Cremation Ser. Northwest Indiana
21c. LOCATION—City or Town, State: Crown Point, Indiana
22a. EMBALMER'S NAME: Celeste P. Kaufman
22b. EMBALMER'S LICENSE NO: FDE:1033626
23. WAS DEATH REPORTED TO CORONER?: No
24a. SIGNATURE OF FUNERAL DIRECTOR: Celeste P. Kaufman
24b. LICENSE NUMBER (or Licensure): FDH:3002411
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FDH:3002411 Kaufman Funeral Home 421 W. 5th. Ave., Gary, Indiana

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter mode of dying, 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. Congestive heart failure
Due to (or as a consequence of): b. Pneumonia
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.
Conditions if any which gave rise to the immediate cause stating the underlying cause last.
Approximate Interval Between Onset and Death:
PART II. Other significant conditions. Conditions contributing to death but not resulting in the underlying cause given in PART I: Chronic Lymphocytic Leukemia
27. WAS DECEDENT PREGNANT IN LAST 90 DAYS?: No
28. WAS AN AUTOPSY PERFORMED?: No
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?: N/A

CERTIFIER

30. CERTIFIER: Physician (Per NCHS); Medical Examiner; Coroner
31. SIGNATURE AND TITLE OF CERTIFIER:
32. MEDICAL LICENSE NO: 27970
33. DATE SIGNED: FEBRUARY 16, 1994

HEALTH OFFICER

34. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If other than Certifier): SALMAN GAILANI, M.D. 9114 COLUMBIA AVENUE MUNSTER, IN 46321
35. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
36. DATE FILED: February 17, 1994

37. MANNER OF DEATH: Natural; Pending Investigation; Accident; Suicide; Could not be Determined; Homicide
38a. DATE OF INJURY
38b. TIME OF INJURY
38c. INJURY AT WORK?
38d. DESCRIBE HOW INJURY occurred
38e. PLACE OF INJURY—At home, farm, street, factory, office
38f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
38g. DATE PRONOUNCED DEAD
38h. MOTOR VEHICLE ACCIDENT?

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD

SEAL OF THE STATE OF INDIANA 1816

THE ABOVE IS A TRUE COPY OF THE RECORD ON FILE WITH THE INDIANA STATE DEPARTMENT OF HEALTH

JUL 16 2008

STATE REGISTRAR

CERTIFICATE
State Form 26217 (R/2-92)

125678

Not valid unless machine signed with multi-colored ribbon.
It is unlawful to reproduce this record.

OFFICE OF THE LAKE COUNTY RECORDER

LAKE COUNTY GOVERNMENT CENTER
2293 NORTH MAIN STREET
CROWN POINT, INDIANA 46307

MICHAEL A. BROWN
Recorder

PHONE (219) 755-3730
FAX (219) 755-3257

MEMORANDUM

DISCLAIMER

This document has been recorded as presented.
It may not meet with State of Indiana Recordation requirements.

1. **STAINED DOCUMENT AT TIME OF RECORDING** ✓
2. **RIPPED OR TORN DOCUMENT AT TIME OF RECORDING** ____
3. **PAGE (S) MISSING AT TIME OF RECORDING** ____
4. **ATTACHEMENTS MISSING AT TIME OF RECORDING** ____
5. **DOCUMENT TOO LIGHT AT TIME OF RECORDING** ____
6. **DOCUMENT NOT LEGIBLE AT TIME OF RECORDING** ____
7. **DOCUMENT TORN DURING PROCESS OF RECORDING** ____
8. **DOCUMENT STAINED DURING PROCESS OF RECORDING** ____
9. **CUSTOMER INSISTING DOCUMENT TO BE RECORDED** ____
10. **DOCUMENT RECORDED AS IS, MAY NOT MEET STATE REQUIREMENTS.** ____

CUSTOMER INITIALS MAL **DATE:** 12/27/09

EMPLOYEE INITIALS RM **DATE:** 12/27/09