

STATE OF INDIANA )  
 ) SS: IN RE: JESSIE M. WEATHERSBY, DECEDENT  
COUNTY OF LAKE )

**AFFIDAVIT FOR TRANSFER OF REAL PROPERTY**

1. That the above-named decedent died intestate on September 5, 2007, while domiciled in Lake County, Indiana.

2. That forty-five (45) days have elapsed since the death of the decedent.

3. That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction, or is contemplated to be filed.

4. That the following named persons are the only heirs of the decedent:

William Weathersby, 2380 McKinley Street, Gary, Indiana 46404  
Laverne Weathersby, 8320 S. Justine Street, Chicago, IL 60620

5. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of Fifty Thousand Dollars (\$50,000), as provided under IC §29-1-8-3, the costs of expenses of administration and reasonable funeral expenses.

6. That among the decedent's probate assets is a parcel of real estate which was owned by the decedent located in Lake County, Indiana, more particularly described as follows:

Koepkes Sub. L. 21 BL.2 L.22 BL.2 in the Office of the Recorder of Lake County, Indiana.  
Commonly known as: 2380 McKinley Street, Gary, Indiana 46404  
Key No: 45-08-17-253-022.000-004

7. That the following list of persons, firms, or corporations are the only creditors of the estate and the amount set opposite each name is the sum due said creditor, so far as the same is known to the affiant: NONE

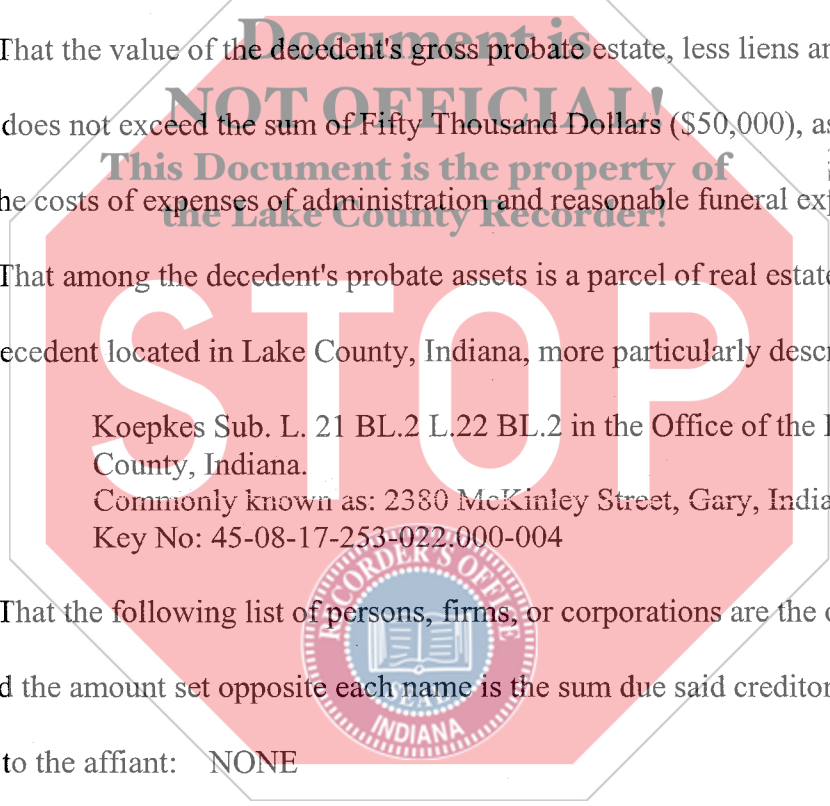
8. That the individuals entitled to the real estate as a result of the decedent's death are William Weathersby, 2380 McKinley Street, Gary, Indiana 46404, son of decedent

2010011321

MICHELLE B. JIMM  
RECORDER

2010 MAR -2 AM 9:19

STATE OF INDIANA  
LAKE COUNTY  
OFFICE FOR RECORDER



**FILED**  
MAR 01 2010

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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Laverne Weathersby, 8320 S. Justine Street, Chicago, IL 60620 , daughter of decedent,

9. That by reason of the above-stated matters, the affiant requests that the above-list real estate of Jessie M. Weathersby, be transferred to them pursuant to the laws of intestate distribution , in accordance with the provisions of IC §29-1-8-1, §29-1-8-2, and §29-1-8-3.

William Weathersby  
William Weathersby, Affiant

I swear or affirm that the foregoing is true and accurate to the best of my knowledge and belief.

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

William Weathersby  
William Weathersby, Affiant

Robert Lewis  
Affiant

Robert L. Lewis, 10070-45  
ROBERT L. LEWIS & ASSOCIATES  
Attorneys at Law  
2148 West 11<sup>th</sup> Avenue  
Gary, Indiana 46404  
219) 944-2755-phone



\* 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. 07-0473.....

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)<br>Jessie M. Weathersby   |  |  |  | 2. SEX<br>Male   |  | 3a. TIME OF DEATH<br>1:30 A <sub>M</sub>   |  | 3b. DATE OF DEATH (Month, Day, Year)<br>September 5, 2007                    |  |   |  |  |  |   |  |
| 4. *SOCIAL SECURITY NUMBER<br>345-28-2801  |  | 5a. AGE - Last Birthday (Years)<br>95  |  | 5b. UNDER 1 YEAR<br>Months Days  |  | 5c. UNDER 1 DAY<br>Hours Minutes   |  | 6. DATE OF BIRTH (Mo, Day, Yr)<br>Jan. 6, 1912                               |  | 7. BIRTHPLACE (City and State or Foreign Cou)<br>Liberty, MS  |  |  |  |   |  |
| 8a. WAS DECEDENT A U.S. VETERAN?<br>No   |  | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?<br>N/A  |  | 9a. PLACE OF DEATH (Check only one. See instructions.)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)<br><input checked="" type="checkbox"/> Residence |  |  |  |  |  |   |  |  |  |   |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br>2380 McKinley St.  |  |  |  | 9c. CITY, TOWN, OR LOCATION OF DEATH<br>Gary   |  |  |  | 9d. COUNTY OF DEATH<br>Lake  |  |   |  |  |  |   |  |
| 10. MARITAL STATUS (Specify)<br>Widowed  |  | 11. SURVIVING SPOUSE (If wife, give maiden name)<br>N/A  |  | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br>Homemaker   |  |  |  | 12b. KIND OF BUSINESS/INDUSTRY<br>Domestic                                   |  |   |  |  |  |   |  |
| 13a. RESIDENCE - STATE<br>IN   |  | 13b. COUNTY<br>Lake  |  | 13c. CITY, TOWN, OR LOCATION<br>Gary   |  |  |  | 13d. STREET AND NUMBER<br>2380 McKinley St.                                  |  |   |  |  |  |   |  |
| 13e. ZIP CODE<br>46404   |  | 13f. INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes |  | 14. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 15. WAS DECEDENT OF HISPANIC ORIGIN?<br><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)<br>Black            |  | 17. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or more) |  |  |  |   |  |
| 18. FATHER'S NAME (First, Middle, Last)<br>George Knox   |  |  |  |  |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Dora (Unknown)  |  |  |  |   |  |  |  |   |  |
| 20a. INFORMANT'S NAME (Type/Print)<br>Andrew Leak  |  |  |  | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code)<br>7838 S. Cottage Grove Chicago, IL 60619   |  |  |  | 20c. Relationship<br>Records   |  |   |  |  |  |   |  |
| 21a. METHOD OF DISPOSITION<br><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)<br>September 12, 2007<br>Burr Oak Cemetery  |  |  |  | 21c. LOCATION - City or Town, State<br>Alsip, IL                             |  |   |  |  |  |   |  |
| 22a. EMBALMER'S NAME:<br>Brian T. Burns  |  |  |  | 22b. EMBALMER'S LICENSE NO.<br>8601763   |  | 23. WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  |  |  |  |   |  |  |  |   |  |
| 24a. SIGNATURE OF FUNERAL DIRECTOR<br><i>Sally A. Burns</i>  |  |  |  | 24b. LICENSE NUMBER (of Licensee)<br>20700071  |  | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br>Burns-Kish FH #3002819 5840 Hohman Hammond, IN 46320 (for Leak and Sc Chicago, IL 60619 signature only) |  |  |  |   |  |  |  |   |  |
| 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)<br>a. <u>Sepsis</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |  |  | days  |  |  |  |   |  |
| b. <u>Abdominal Abscess</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |  |  | days  |  |  |  |   |  |
| c. <u>INFECTED Pancreas</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |  |  | days  |  |  |  |   |  |
| d.   |  |  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.<br><u>presumed maternal injury to gall bladder and pancreas, UTI, NIDDM, pulmonary congestion, dementia, abnormality of gall</u>   |  |  |  |  |  |  |  |  |  | 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No)<br>No  |  | 28a. WAS AN AUTOPSY PERFORMED? (Yes or No)<br>NO |  | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) |  |
| 29a. CERTIFIER (Check only one)<br><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.<br><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.<br><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<br><i>[Signature]</i>  |  |  |  |  |  | 29c. MEDICAL LICENSE NO.<br>x 01036724   |  | 29d. DATE SIGNED (Month, Day, Year)<br>x Sept 21, 2                          |  |   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br>Dr. A. Johns 3300 W 15th Ave. Gary, IN 46404   |  |  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 31. HEALTH OFFICER'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |  |  |  |  |  |  | 32. DATE FILED (Month, Day, Year)<br>SEP 27 2007  |  |  |  |   |  |
| 33. MANNER OF DEATH<br><input type="checkbox"/> Natural Death<br><input type="checkbox"/> Accident<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide<br><input type="checkbox"/> Could Not Be Determined  |  |  |  | 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.   |  |  |  |  |  |   |  |  |  |   |  |

45-08-17-253-022-000-004

