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SMALL ESTATE AFFIDAVIT OF SURVIVORSHIP

State of Indiana  
County of Lake

2011 042324

I, Bernetta Murray, upon duly sworn, state on my oath that:

1. My address is: 2521 W. 12<sup>th</sup> Ave. Gary, In 46404
2. My residence is: 2521 W. 12<sup>th</sup> Ave. Gary, In 46404
3. I am a successor to the decedent or a claimant entitled to the property of the named decedent. *Bernetta Murray is the only heir*

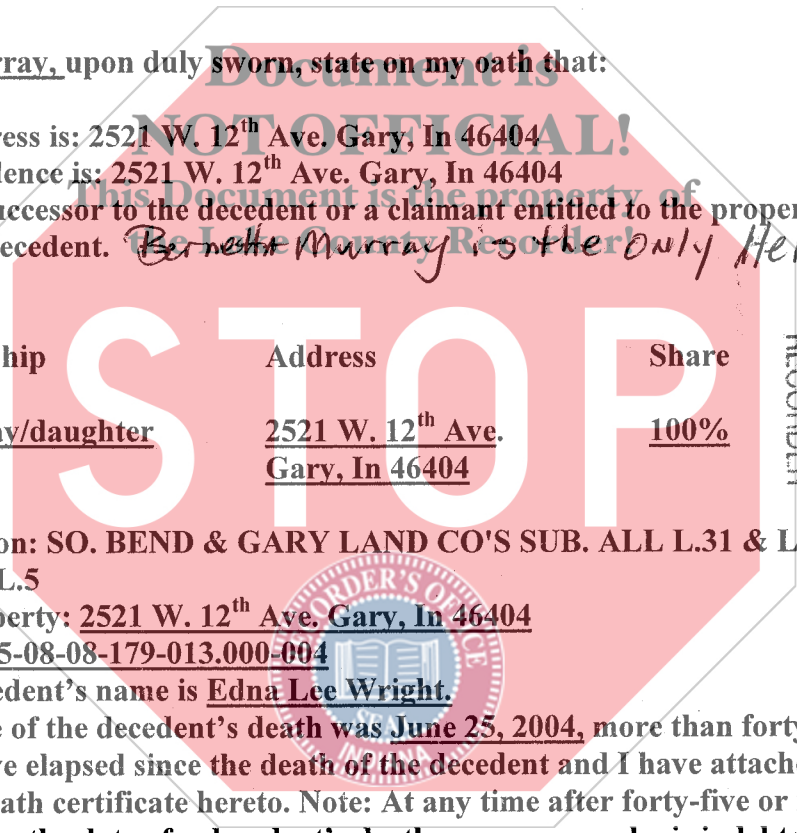
Name/Relationship	Address	Share
<u>Bernetta Murray/daughter</u>	<u>2521 W. 12<sup>th</sup> Ave. Gary, In 46404</u>	<u>100%</u>

Legal Description: SO. BEND & GARY LAND CO'S SUB. ALL L.31 & L.32 BL. E.15FT. L.30 BL.5

Address of property: 2521 W. 12<sup>th</sup> Ave. Gary, In 46404

Key Number: 45-08-08-179-013.000-004

4. The decedent's name is Edna Lee Wright.
5. The date of the decedent's death was June 25, 2004, more than forty-five (45) days have elapsed since the death of the decedent and I have attached a copy of the death certificate hereto. Note: At any time after forty-five or more days from the date of a decedent's death, any person who is indebted to or who has possession of any property or an instrument evidencing a debt, obligation, stock chose in action, or stock brand belonging to the decedent, shall pay such indebtedness or deliver such personal property, or so much of either as is claimed to a person claiming to be a successor of the decedent or entitled to payment or deliver of the property belonging to the decedent upon being presented an affidavit made by said person.
6. That the value of the gross probate estate, wherever located, less lien and encumbrances does not exceed fifty thousand dollars (\$50,000.00).
7. That at least forty-five (45) days has elapsed since the death of decedent.
8. That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction.



MICHELLE PALMARI  
RECORDER

2011 AUG -5 PM 1:04

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

**FILED**

AUG 05 2011

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

#16  
CS  
028140  
CS  
NON  
CONF

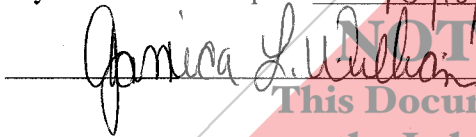
**THE FOREGOING STATEMENT IS MADE UNDER THE PENALTIES OF PERJURY**

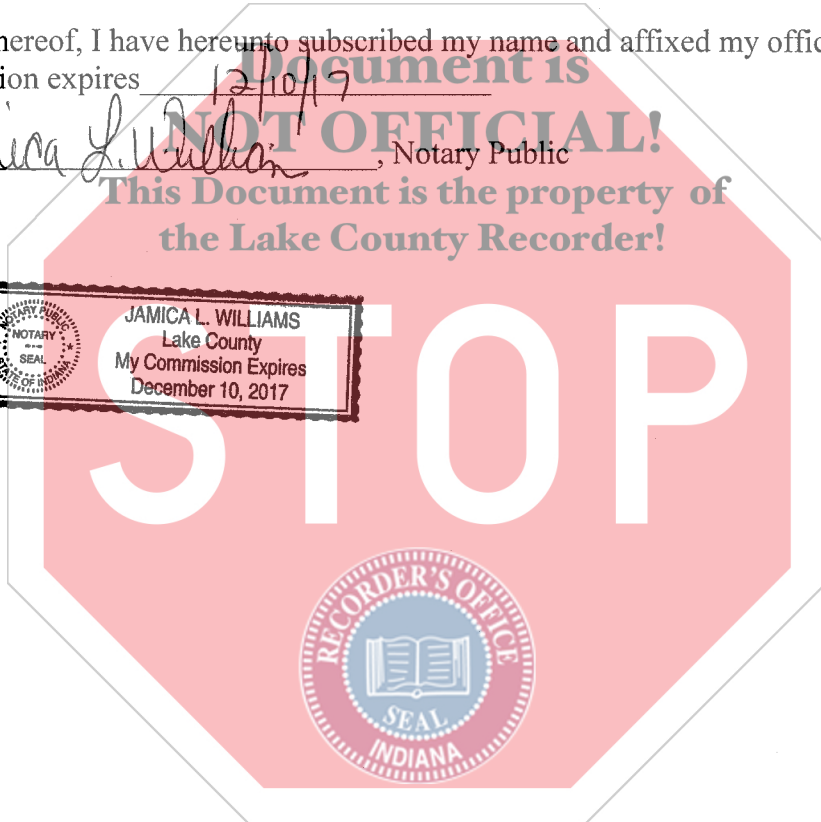
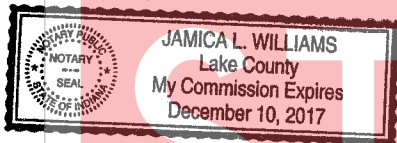
**STATE OF INDIANA  
COUNTY OF LAKE**

Before me, the undersigned, a Notary Public in and for said County and State, this 18th day of June, 2011.

 personally appeared.

In witness whereof, I have hereunto subscribed my name and affixed my official seal.  
My commission expires 12/10/17

, Notary Public



ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.\*

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No. 04 0397

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT IN PERMANENT BLACK INK	1. DECEASED - NAME (First, Middle, Last) <b>Edna Wright</b>		2. SEX <b>Female</b>		3a. TIME OF DEATH <b>12:30a.m</b>	3b. DATE OF DEATH(Month, Day, Yr.) <b>June 25, 2004</b>	
	4. *SOCIAL SECURITY NUMBER <b>306-34-0467</b>		5a. AGE - Last Birthday (Years) <b>70</b>	5b. UNDER 1 YEAR Months Days Hours Minutes	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH(Mo., Day, Yr.) <b>September 1, 1933</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Gary Indiana</b>
DECEDENT	8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		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 type="checkbox"/> Residence		
	9b. FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital Northlake</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>GARY</b>		9d. COUNTY OF DEATH <b>Lake</b>	
	10. MARITAL STATUS (Specify) <b>Widowed</b>		11. SURVIVING SPOUSE (If wife, give maiden name)		12. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Assembly line worker</b>		12b. KIND OF BUSINESS/INDUSTRY <b>King Foundry</b>
PARENTS	13a. RESIDENCE - STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN OR LOCATION <b>Gary</b>		13d. STREET AND NUMBER <b>2521 West 12th Avenue</b>
	13e. ZIP CODE <b>46404</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		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) <b>Black</b>		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>		18. FATHER'S NAME (First, Middle, Last) <b>Charles Jennings</b>		
INFORMANT	20a. INFORMANT'S NAME (Type/Print) <b>Bernetta Murry</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3941 Lincoln Street, Gary, IN 46408</b>		20c. Relationship <b>Daughter</b>	
	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) <b>July 2, 2004</b> <b>EVERGREEN MEMORIAL PARK</b>		21c. LOCATION - City or Town, State <b>HOBART, Indiana</b>		
DISPOSITION	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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
	24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee)		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Smith Bizzell &amp; Warner FH19600034</b> <b>4209 Grant Street, Gary, Indiana 46407-</b>		
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. <b>a. Congestive Heart Failure &amp; Renal failure acute</b> <b>b. Coronary Artery Disease; Hypertension</b> <b>c. Chronic Hypertension</b> <b>d. Multiple dependent Diabetes Mellitus</b>					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) <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) <b>NO</b>
CERTIFIER	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> <b>H. F. Badar</b>	
						29c. MEDICAL LICENSE NO. <b>01026783</b>	29d. DATE SIGNED (Month, Day, Year) <b>7-8-04</b>
HEALTH OFFICER	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26f) (Type/Print) <b>DR GF BADAR 5490 BROADWAY MERRILLVILLE IN 46410</b>						
	31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32. DATE FILED (Month, Day, Year) <b>JUL 19 2004</b>	
	33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <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.				