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MICHAEL D. FAJMAN
RECORDER

STATE OF INDIANA)
) SS: RE: MELANIE D. CHAMBERS PARROTT
COUNTY OF LAKE) a/k/a MELANIE D. PARROTT, Deceased

AFFIDAVIT OF HEIRSHIP
FOR TRANSFER OF REAL ESTATE

Comes now Monroe Parrott, III, before the undersigned Authority, duly authorized to take oaths, and being duly sworn, states as follows:

1. That he is the surviving spouse of Melanie D. Parrott and makes this Affidavit based upon personal knowledge.

2. Melanie D. Parrott ("Decedent") is the owner of the following described real estate located in Lake County, Indiana:

Part of Lot 2 and 3, in Block 26, as marked and laid down on the recorded plat of Gary Land Company's Fourth Subdivision, more particularly described as: Commencing at a point on the Southwesterly line of said Lot 2, which said point is 26.195 feet Southeasterly measured along the Southwesterly line of Lot 2, from the Southwesterly corner of said Lot 2; thence Northwesterly 65.465 feet along the Southwesterly lines of said Lots 2 and 3 to a point which is 13.1 feet Southeasterly measured along the Southwesterly line of Lot 3 from the Southwesterly corner of said Lot 3; thence Northeasterly 125 feet to a point in the Northeasterly line of said Lot 3 which said point is 6.946 feet Southeasterly measured along the Northeasterly line of said Lot 3 from the Northwesterly corner of said Lot 3; thence Southeasterly 34.73 feet along the Northwesterly lines of said Lots 3 and 2 to a point which is 13.892 feet Southeasterly measured along the Northeasterly line of said Lot 2 from the Northwesterly corner of said Lot 2; thence Southwesterly 125 feet to the point of beginning, in the City of Gary, in Lake County, Indiana, as shown in Plat Book 14, page 15 in the Lake County, Indiana.

Commonly Known As: 443 Cleveland Street, Gary, Indiana 46404

Parcel Number: 45-08-05-281-007.000-004

FILED

SEP 05 2012

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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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3. The Decedent died intestate on the 8th day of December, 2002, while domiciled in Lake County, Indiana. (A true and accurate copy of the death certificate of the Decedent is attached hereto, and incorporated herein by reference, as Exhibit "A.")

4. No Probate proceedings were ever commenced for or on behalf of the Decedent in Lake County, Indiana, or elsewhere.

5. No Indiana Inheritance taxes, inheritance taxes from other states, federal estate taxes, or other death taxes were due by reason of the death of the Decedent.

6. No claims were made against the Decedent by reason of her death, and any and all debts, charges, and liabilities of the Decedent have been paid in full or otherwise discharged by expiration of time.

7. The Decedent was survived by the following as her sole heirs at law: Monroe Parrott III (surviving spouse) and Angelique L. J. Parrott (adult daughter).

8. The Decedent left no child or children, or descendants of any predeceased child or children, other than those listed above.

9. Pursuant to I.C. § 29-1-7-23, said property devolved to Monroe Parrot III and Angelique L. J. Parrott upon the Decedent's death, whereby they are entitled to delivery of the above-stated property as the Decedent's heirs at law under the Indiana laws of intestacy.

10. The Affiant requests that the transfer agent of the Lake County Auditor's Office transfer the above parcel to Monroe Parrot III and Angelique L. J. Parrott, each as to an undivided one-half (1/2) interest, as tenants in common.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

* 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.

Local No. 02 0754

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) Melanie Diane Chambers Parrott				2. SEX Female	3a. TIME OF DEATH 5:05 A M	3b. DATE OF DEATH (Month, Day, Yr.) December 8, 2002
4. SOCIAL SECURITY NUMBER 316-56-6846		5a. AGE—Last Birthday (Years) 50	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) January 3, 1952	7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana
8a. WAS DECEASED 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: <input type="checkbox"/> Inpatient <input checked="" 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) Methodist Hospital Northlake				9c. CITY, TOWN, OR LOCATION OF DEATH Gary	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS Married	11. SURVIVING SPOUSE (Specify if wife, give maiden name) Monroe Parrott III		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Supervisor		12b. KIND OF BUSINESS/INDUSTRY Methodist Hospitals	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 443 Cleveland Street		
13e. ZIP CODE 46404	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U S A	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) Black	17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years	
18. FATHER'S NAME (First, Middle, Last) Henry L. Chambers				19. MOTHER'S NAME (First, Middle, Maiden Surname) Johnnie Mae Ewing		
20a. INFORMANT'S NAME (Type/Print) Monroe Parrott III			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 443 Cleveland Street Gary, Indiana 46404		20c. Relationship Husband	
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 14, 2002 Evergreen Cemetery		21c. LOCATION—City or Town, State Hobart, Indiana	
22a. EMBALMER'S NAME Roosevelt Allen Jr.			22b. EMBALMER'S LICENSE NO. #01051701		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Carmelita Perry</i>			24b. LICENSE NUMBER (of Licensee) #29700070		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404	
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. Vascular collapse b. Due to arteriosclerotic heart and vascular disease c. d. Unknown						
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.						
27. WAS DECEASED 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)	
29a. CERTIFIER <input 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. Chief Deputy <input checked="" 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. N/A		29d. DATE SIGNED (Month, Day, Year) December 16, 2002
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Jeffrey R. Wells, Chief Deputy 2900 West 93rd Avenue, Crown Point, Indiana 46307						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32. DATE FILED (Month, Day, Year) DEC 20 2002	
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"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF	34c. INJURY AT WORK?	34d. DESCRIBE HOW INJURY OCCURRED	
		34e. PLACE OF INJURY—At building, etc. (Specify)		LOCATION (Street and Number or Rural Route Number, City or Town, State)		
34g. DATE PRONOUNCED DEAD (Month, Day, Year) December 8, 2002			34h. MOTOR VEHICLE (Type of vehicle, e.g., driver, passenger, pedestrian, etc.)			

