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STATE OF INDIANA)
COUNTY OF LAKE)

SS: 2013 001767

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 JAN 9 AM 10:30

LAKE COUNTY RECORDER

MIKE BROWN

**AFFIDAVIT OF HEIRSHIP
FOR TRANSFER OF REAL PROPERTY**

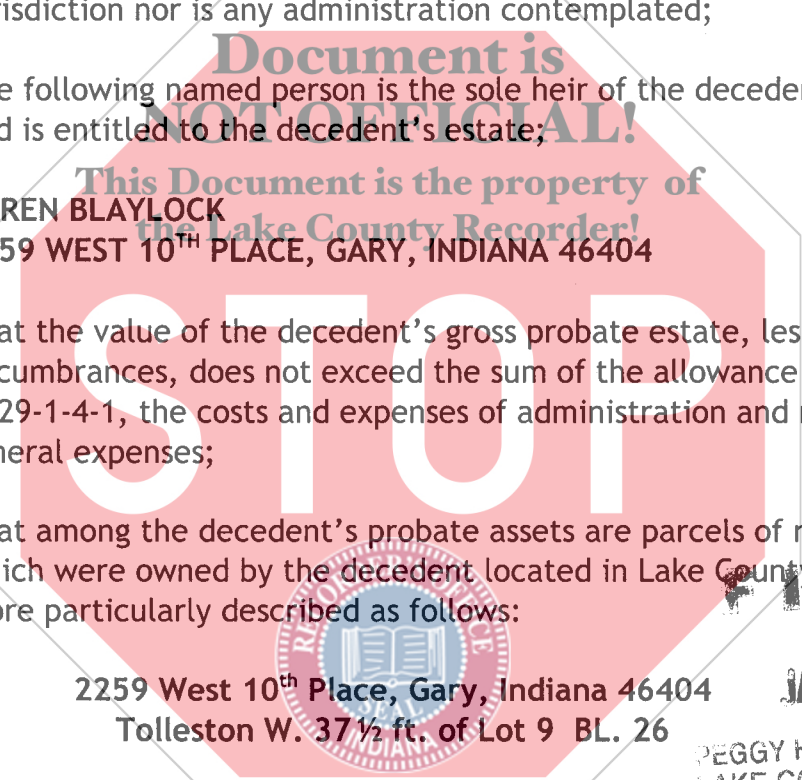
KAREN BLAYLOCK, having been first duly sworn upon her oath states:

1. That Carnella Black, decedent, died intestate on March 3, 2004, 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 of said decedent is pending or has been granted in any jurisdiction nor is any administration contemplated;
4. The following named person is the sole heir of the decedent's estate and is entitled to the decedent's estate;

KAREN BLAYLOCK
 2259 WEST 10TH PLACE, GARY, INDIANA 46404



5. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of the allowance provided by IC 29-1-4-1, the costs and expenses of administration and reasonable funeral expenses;
6. That among the decedent's probate assets are parcels of real estate which were owned by the decedent located in Lake County, Indiana more particularly described as follows:
 2259 West 10th Place, Gary, Indiana 46404
 Tolleston W. 37 1/2 ft. of Lot 9 BL. 26
7. That there are no known creditors of the estate and no claims have been made against the decedent's estate;
8. That the individual entitled to the real estate as a result of the decedent's death is the decedent's heir at law as provided under the



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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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laws of intestate succession as follows:


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- 9. That the gross value of the estate of the decedent, Carnella Black, as determined for the purposes of Federal Estate Taxes, was less than the value required for the filing of a Federal Estate Tax Return. As a consequence therefore, the decedent's estates was not subject to Federal Estate Tax;
- 10. That the decedent's estate was not subject to Indiana Inheritance Tax.


KAREN BLAYLOCK, AFFIANT

Under the penalties of perjury, the following representations have been subscribed and sworn to before me, a Notary Public, in the State of Indiana, County of Lake, this 9th day of January, 2012.




NOTARY, Resident of Lake County, Indiana

Renae A. Long
Printed Name of Notary

My Commission expires:
6/30/2017



TENNESSEE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

E/PRINT IN WARENTE FOR INK FOR INSTRUCTIONS AND BOOK

| | | | | | | | | |
|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Carnella Black | | | | 2. SEX Female | | 3. DATE OF DEATH (Month, Day, Year) Mar. 2, 2005 | | |
| 4. SOCIAL SECURITY NUMBER (of Decedent) 414-38-0574 | | 5a. AGE-LAST BIRTHDAY (years) 76 | 5b. UNDER 1 YEAR MOS. DAYS | 5c. UNDER 1 DAY HOURS MIN. | 6. DATE OF BIRTH (Month, Day, Year) Aug. 23, 1928 | | 7. BIRTHPLACE (City and State or Foreign Country) Francis, MS | |
| 8. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 9a. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 9b. FACILITY NAME (If not institution, give street and number) Methodist Hospital-Central | | | 9c. CITY, TOWN, OR LOCATION OF DEATH Memphis | | | 9d. COUNTY OF DEATH Shelby | | |
| 10. MARITAL STATUS-Married, Never Married, Widowed, Divorced (Specify) Divorced | | 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.) Owner/Operator | | 12b. KIND OF BUSINESS/INDUSTRY Black's Cafe | | |
| 13a. RESIDENCE-STATE IN | | 13b. COUNTY Lake | | 13c. CITY, TOWN OR LOCATION Gary | | 13d. STREET AND NUMBER OR RURAL LOCATION 2259 West 10th Place | | |
| 13e. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 13f. ZIP CODE 46404 | | 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify, if yes: | | 15. RACE-American Indian, Black, White, etc. (Specify) Black | | |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 17. FATHER'S NAME (First, Middle, Last) Samuel L. Black | | | | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Jordan | | | | | | 19a. INFORMANT'S NAME (Type/Print) Sabrina Jackson | | |
| 19b. RELATIONSHIP TO DECEASED Daughter | | | | 19c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 East Barton Avenue West Memphis, AR 72301 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Evergreen Cemetery | | | 20c. LOCATION-City or Town, State Hobart, IN | | | |
| 21a. SIGNATURE OF FUNERAL DIRECTOR <i>J. Dale Kelly</i> | | 21b. LICENSE NUMBER OF FUNERAL DIRECTOR 4383 | | 21c. SIGNATURE OF EMBALMER <i>J. Dale Kelly</i> | | 21d. LICENSE NUMBER OF EMBALMER 4327 | | |
| 22a. NAME AND ADDRESS OF FUNERAL HOME Mid-South Mortuary & Removal Service, Inc. P. O. Box 22966, Memphis, TN 38122 | | | | | | 22b. LICENSE NUMBER OF FUNERAL HOME 715 | | |
| 23. REGISTRAR'S SIGNATURE <i>Cynn H. Williams</i> Deputy | | | | 24. DATE FILED (Month, Day, Year) MAR 18 2005 | | | | |
| 25a. PHYSICIAN - To the best of my knowledge, death occurred at the date and place, and due to the cause(s) and manner as stated. 1 <input checked="" type="checkbox"/> SIGNATURE AND TITLE OF PHYSICIAN <i>Bennett L. Rodas</i> | | 25b. LICENSE NUMBER 0000024796 | | 25c. DATE SIGNED (Month, Day, Year) 3/16/05 | | | | |
| 26a. MEDICAL EXAMINER - On the basis of examination and/or investigation, in my opinion, death occurred at the date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> SIGNATURE AND TITLE OF MEDICAL EXAMINER | | 26b. LICENSE NUMBER | | 26c. DATE SIGNED (Month, Day, Year) | | | | |
| 27. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR MEDICAL EXAMINER) (Type/Print) Dr. Bennett L. Rodas, 295 S. Bellevue St., Memphis, TN 38104 | | | | | | | | |
| 28. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the 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) → Chronic Lung Disease | | | | | | Approximate interval between Onset and Death years | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cor pulmonale | | | | | | 29a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 30. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 31a. DATE OF INJURY (Month, Day, Year) | 31b. TIME OF INJURY M | 31c. INJURY AT WORK? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 31d. DESCRIBE HOW INJURY OCCURRED | | | |
| 31e. PLACE OF INJURY-At home, farm, street, factory, office building, etc. (Specify) | | | 31f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |

Use only physician or physician assistant

DECEDENT

PARENTS

INFORMANT

DISPOSITION

REGISTRAR

CERTIFIER

PHYSICIAN OR MEDICAL EXAMINER EXECUTING MUST HAVE STATE LICENSE AND SIGNATURE CERTIFICATION 148 HOURS.

INSTRUCTIONS OTHER SIDE

CAUSE OF DEATH