

Commonly known as: 1971 Central Drive, Gary, IN 46407

6. That more than 45 days have passed and no formal estate has been open nor is it anticipated that an estate will be opened.

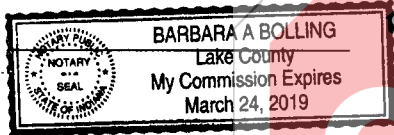
7. That there are no known creditors.

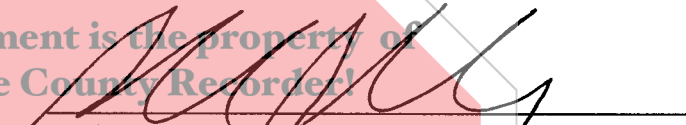
WHEREFORE, the decedent, EARNESTINE COPELAND'S, interest in the above stated property should be transferred to her children: EVA L. PRINCE AND ROBERT A. KELLY as joint tenants with rights of survivorship. They each have an undivided 1/2 interest in the property.

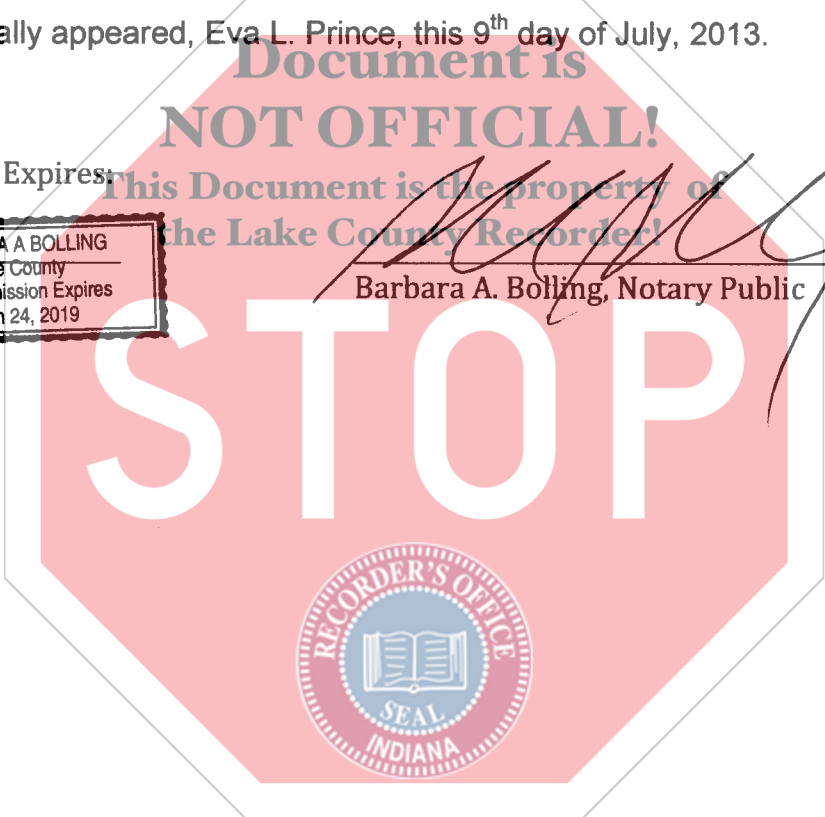

Eva L. Prince, affiant

Subscribed to and sworn before me Notary Public for the above State and County, personally appeared, Eva L. Prince, this 9th day of July, 2013.

My Commission Expires:




Barbara A. Bolling, Notary Public





INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 000595

EDR No 000000245088

State No 008628

Form containing fields for decedent information (Jacob Copeland), birth details (10/23/1916), death date (02/13/2012), cause of death (Septic Shock), and certifier information (Susan W. Best).

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH - RESUBMIT

1033796



Local No 000251

EDR No 000000326714

State No 026048

| | | | | | | | | | |
|---|----------------------------|---|--------------------------------------|---|--|---|--|--|--|
| 1. Decedent's Legal Name (First, Middle, Last) ERNESTINE COPELAND | | | | 1a. Maiden Name (If female) PRINCE | | 2. Sex FEMALE | 3. Time Of Death 03:09 PM | 4. Date Of Death (Month/Day/Year) 05/28/2013 | |
| 5. Social Security Number 409-50-7062 | 6a. Age - Yrs 84 | 6b. Under 1 Year Months | 6c. Under 1 Month Days | 6d. Under 1 Day Hours | 6e. Under 1 Hour Minutes | 7. Date of Birth (Month/Day/Year) 06/09/1928 | | 8. Birthplace (City and State or Foreign Country) TALLAHASSEE COUNTY, MS | |
| 9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival | | | 10a. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify) | | | | |
| 11. Facility Name (If Not Institution, Give Street and Number) METHODIST HOSPITALS INC. | | | | | | | | | |
| 12. City Or Town, State, And Zip Code GARY, IN, 46402 | | | | 13. County Of Death LAKE | | | 14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown | | |
| 15. Surviving Spouse's Name | | | 15a. (If Wife) Give Maiden Last Name | | | 16. Decedent's Usual Occupation HOMEMAKER | | 17. Kind Of Business/Industry OWN HOME | |
| 18. Residence - State INDIANA | | 18a. County LAKE | | 18b. City Or Town GARY | | | | | |
| 18c. Street And Number 1971 CENTRAL AVENUE | | | | | | 18d. Apt. No. | 18e. Zip Code 46407 | 18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 19. Decedent's Education 9TH - 12TH GRADE; NO DIPLOMA | | 20. Decedent Of Hispanic Origin NOT HISPANIC | | | 21. Decedent's Race Black or African American | | | | |
| 22. Father's Name (First, Middle, Last) ARTHUR PRINCE | | | | 23. Mother's Name (First, Middle, Last) MALINDA PRINCE | | | 23a. Mother's Maiden Last Name FROST | | |
| 24. Informant's Name EVA PRINCE | | 24a. Relationship To Decedent DAUGHTER | | 24b. Mailing Address (Street And Number, City, State, Zip Code) 1985 CENTRAL AVENUE, GARY, IN 46407 | | | | | |
| 25. Place Of Disposition | | | | | | | | | |
| 25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify): | | 25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) EVERGREEN CEMETERY | | | 25c. Location - City, Town, And State HOBART, IN | | | | |
| 26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 27. Name And Complete Address Of Funeral Facility RIDGELAWN FUNERAL HOME, INC., 4201 W. RIDGE ROAD, GARY, IN 46408 | | | | | 27a. Funeral Home License Number: FH10200007 | | |
| 27b. Signature Of Indiana Funeral Service Licensee: SHELIA C KIRBY-NUSS, BY ELECTRONIC SIGNATURE | | | | | | 27c. License Number (Of Licensee): FD29500088 | | | |
| 28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. | | | | | | | | | |
| Immediate Cause (Final Disease Or Condition Resulting In Death) | | | | A. <u>CARDIOPULMONARY ARREST</u> | | Due to (Or As A Consequence Of): | | Approximate Interval. Onset To Death MINS | |
| Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last | | | | B. <u>VENTRICULAR ARRHYTHMIA</u> | | Due to (Or As A Consequence Of): | | HR | |
| | | | | C. | | Due to (Or As A Consequence Of): | | | |
| | | | | D. | | Due to (Or As A Consequence Of): | | | |
| Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I DEMENTIA, HYPERTENSION, CARCINOMA OF BREAST | | | | | | 29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year | | | | 33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined | | | |
| 34. Date Of Injury (Month/Day/Year) | | 35. Time Of Injury | | 36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area) | | | 37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 38. Location Of Injury - State | | 38a. City Or Town | | 38b. Street & Number | | 38c. Apt. No. | | 38d. Zip Code | |
| 39. Describe How Injury Occurred | | | | | | 40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) | | | |
| 41. Signature, Of Person Certifying Cause Of Death: BIKASH AGARWAL, BY ELECTRONIC SIGNATURE | | | | | | 42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer | | | |
| 43. Name, Address And Zip Code Of Person Certifying Cause Of Death: BIKASH AGARWAL, 1507 WABASH STREET, SUITE 500B, MICHIGAN CITY, IN 46360 | | | | | | 44. License Number 01048288A | | 45. Date Certified 06/03/2013 | |
| 46. Additional Funeral Service Provider: | | | | | | 47. *Akas: | | | |
| 48. Signature of Local Health Officer: ROLAND H WALKER, VIA ELECTRONIC SIGNATURE | | | | | | 49. For Registrar Only - Date Filed (Month/Day/Year): JUN 17 2013 | | | |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) | | | | | | | | | |
| 49: 06/04/2013 5: 309-50-7062 | | | | | | | | | |

State Form 5409A-2011 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal. (7/05)

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT