

“There is no surviving spouse or children under the age of eighteen (18) years of age so IC 29-1-4-1 does not apply to this estate.

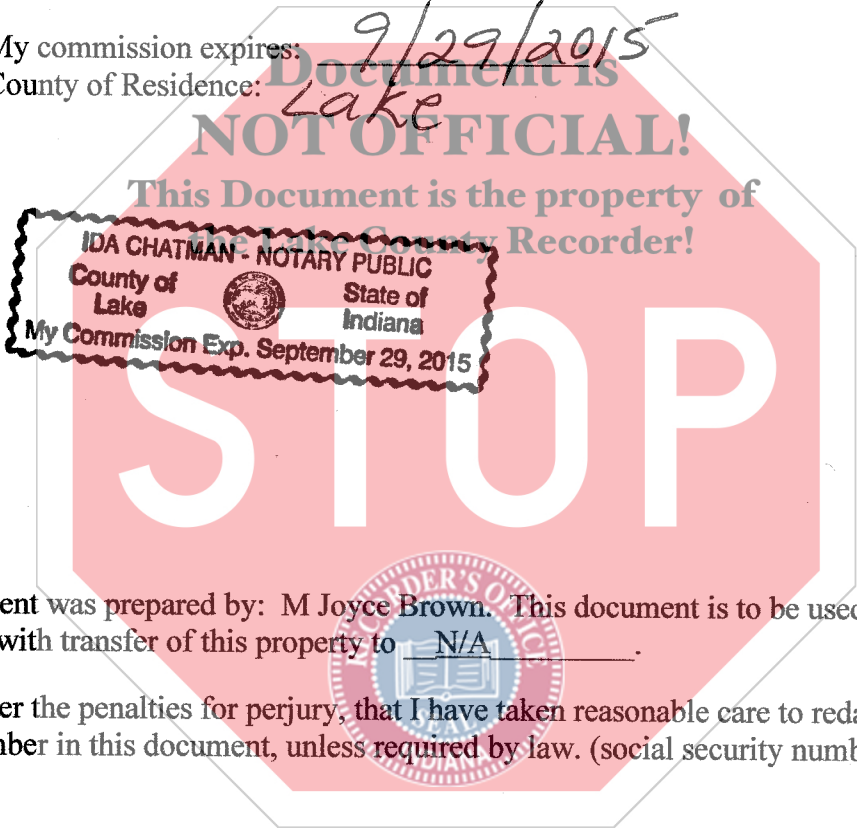
“The individuals entitled to the estate, including real estate, as a result of the decedent’s death is KENNAN BROWN, HELENA SCOTT, AND DEMETRIUS BROWN, the only children of BERNARD A BROWN, by way of intestate succession.

Florence W. Sadler
FLORENCE SADLER

Subscribed and sworn before me, a Notary Public, this 21st day of September, 2013.

Ida Chatman
NOTARY PUBLIC

My commission expires: 9/29/2015
County of Residence: Lake



This instrument was prepared by: M Joyce Brown. This document is to be used only in conjunction with transfer of this property to N/A.

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law. (social security number not included)

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



Local No. #09-276

State No.

1. Decedent's Legal Name (First, Middle, Last) Bernard Ames Brown				1a. Maiden Last Name (If Female) N/A		2. Sex Male	3. Time Of Death 11:46 AM	4. Date Of Death (Month/Day/Year) June 5, 2009			
5. Social Security Number [REDACTED]		6a. Age - Yrs 52	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) May 15, 1957		8. Birthplace (City And State Or Foreign Country) Gary, Indiana		
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 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 checked="" 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) 6600 Ash Place											
12. City Or Town, State, And Zip Code Gary, Indiana					13. County Of Death Lake		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
15. Surviving Spouse's Name NO			15a. (If Wife) Give Maiden Last Name N/A		16. Decedent's Usual Occupation Teacher		17. Kind Of Business/Industry 21st Century Charter School/ at Gary				
18. Residence - State Indiana			18a. County Lake		18b. City Or Town Gary			18c. Street And Number 6600 Ash Place	18d. Apt. No.	18e. Zip Code 46403	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education 5 Years of College			20. Decedent Of Hispanic Origin NO		21. Decedent's Race Black						
22. Father's Name (First, Middle, Last) Bernard Brown				23. Mother's Name (First, Middle, Last) Rosa Brown			23a. Mother's Maiden Last Name Sadler				
24. Informant's Name Janice Armour			24a. Relationship To Decedent Sister		24b. Mailing Address (Street And Number, City, State, Zip Code) 6600 Ash Place Gary, Indiana 46403						
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) June 13, 2009 Evergreen Cemetery			25c. Location - City, Town, And State Hobart, Indiana						
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404					27a. Funeral Home License Number: 83007704				
27b. Signature Of Indiana Funeral Service Licensee: 						27c. License Number (Of Licensee): #08700298					
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. Cause Of Death (See Instructions And Examples) Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Pancreatic Cancer</u> Approximate Interval: Onset To Death month B. <u>DM</u> year C. <u>asthma</u> year D. _____ 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 Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I											
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No						30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" 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: 						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: FADI ALZEIDAN, M.D. 311 E. 89TH AVE., MERRILLVILLE, IN 46410						44. License Number 01053003A	45. Date Certified 6/9/09				
46. Additional Funeral Service Provider:						47. *Akas:					
48. Signature of Local Health Officer: 						49. For Registrar Only - Date Filed (Month/Day/Year): JUN 15 2009					

State Form 10114 (07/07) 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. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

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