

SMALL ESTATE AFFIDAVIT

STATE OF INDIANA

COUNTY OF LAKE

I, Lawrence E. Moran, upon oath state:

- a. My mailing address is: 2907 Cleveand Street, Hammond, Indiana, 46323.
- b. My residential address is: 2907 Cleveand Street, Hammond, Indiana, 46323.
- c. My telephone number is: _____
- d. I am a successor of the Decedent's estate and am at or over the age of majority and am legally competent in all respects to make this affidavit.
- e. I am an heir.

DECEDENT'S INFORMATION:

- a. The Decedent's full name is: Imogene O. Moran
- b. The date of the Decedent's death was October 29, 1997.
- c. The Decedent's place of death was: Hammond, Indiana.
 - 1. I have attached a certified copy of the death certificate.
- d. At least 30 days have elapsed since the death of the Decedent.
- e. The Decedent's place of residence immediately before her death was: 7620 Beech St, Hammond, Indiana, 46323.
- f. No letters of office are now outstanding on the Decedent's estate, and no petition for the appointment of a personal representative has been granted or is pending in Indiana or in any other State to my knowledge.
- g. This court has jurisdiction in this matter, because the Decedent resided in this State prior to death

DECEDENT'S ESTATE VALUE:

The gross value of the Decedent's entire estate including real property, wherever located, and including contents of a safe deposit box but excluding liens and encumbrances, does not exceed \$46,000.00.

DECEDENT'S FUNERAL EXPENSES:

All of the Decedent's funeral expenses have been paid.

MEDICAID ESTATE RECOVERY ACT:

All money owed, if any, to the Department of Health and Human Services as a result of payment for benefits for Medicaid have been paid or provided for.

DECEDENT'S CREDITOR CLAIMS:

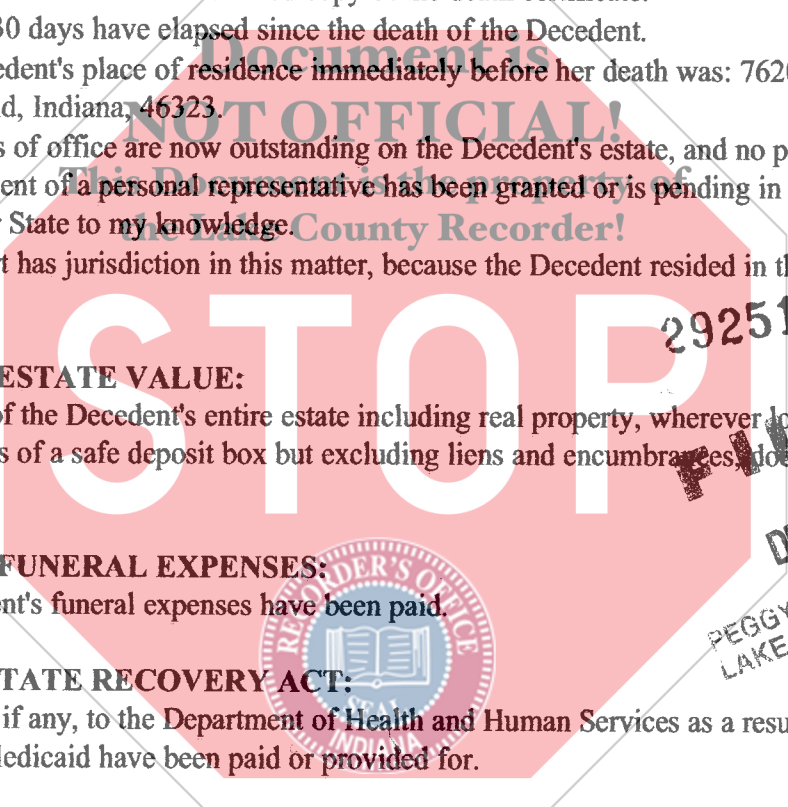
There is no known unpaid claimant or contested claim against the Decedent, except as stated in the section entitled "Decedent's Funeral Expenses."

2014 083809

2014 DEC 30 PM 2:27

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

MICHAEL J. STONEMAN
RECORDER



29251

FILED

DEC 30 2014

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

NON-COM
\$18.00
M-E
CASH

DECEDENT DIED:

The Decedent died without a will (intestate).

The names and places of residence of any surviving spouse, living minor child(ren), and living adult child(ren) of the Decedent are as follows:

John C Moran son
3662 N Hashknife Circle Tucson, Arizona, 85749
Portion of Estate: 0%

Richard J Moran son
3311 S. County Line Road Westville, Indiana, 46391
Portion of Estate: 0%

Lawrence E Moran son
2907 Cleveland Street Hammond, Indiana, 46323
Portion of Estate: Property at 7629 Beech St. Hammond, In 46323 Legal Description:
EVERGREEN PARK L.45 BL.4

LIST OF ASSETS IN THE DECEDENT'S ESTATE

1. DECEDENT'S PERSONAL PROPERTY TO BE DISTRIBUTED:

No other person has a superior right to the interest of the decedent in the described property. The affiant or declarant requests that the described property be paid, delivered, or transferred to those persons named below.

<u>Property Description</u>	<u>Fair Market Value</u>
Nothing	\$0.00
Recipient Name: _____	
Total Fair Market Value of Decedent's Personal Property:	\$0.00

2. DECEDENT'S REAL PROPERTY TO BE DISTRIBUTED:

<u>Real Property Description</u>	<u>Fair Market Value</u>
EVERGREEN PARK L.45 BL.4 #45-07-18-276-044.000-023, 7620 Beech St Hammond, Indiana, 46324	\$46,000.00
Recipient Name: Lawrence E Moran	
Total Fair Market Value of Decedent's Real Property:	\$46,000.00

3. DECEDENT'S MOTOR VEHICLES:

None

\$0.00

DECLARATIONS OF AFFIANT:

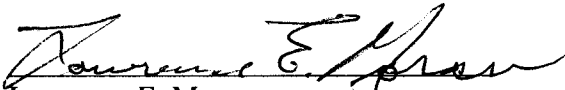
I have given written notice, by personal service or by certified mail, identifying my claim and describing the property claimed, to every person whose right to succeed to the Decedent's property is equal or superior to mine, and at least 14 days have elapsed since the notice was served or mailed.

I further acknowledge and understand that filing a false affidavit may constitute a felony in this state.

I declare under penalty of perjury under the laws of the State of Indiana that the foregoing document is true and correct to the best of my knowledge, information, and belief.

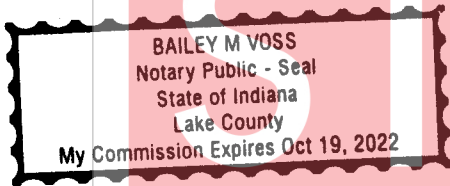
EXECUTED this 29th day of December, 2014.

SIGNATURE OF AFFIANT


Lawrence E. Moran

STATE OF INDIANA, COUNTY OF LAKE, ss:

This Affidavit was acknowledged before me on this 29th day of December, 2014 by Lawrence E. Moran, who, being first duly sworn on oath according to law, deposes and says that he/she has read the foregoing Affidavit subscribed by him/her, and that the matters stated herein are true to the best of his/her information, knowledge and belief.



Bailey m voss
Notary Public
Title (and Rank)



My commission expires Oct 19, 2022

* 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.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE A COMPLETE COPY OF DEATH ON FILE WITH : HAMMOND HEALTH DEPARTMENT.

G. Jano, M.D.
Hammond Health Commissioner

Local No. **834**

Oct. 30, 1997
Date Issued

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) IMOGENE O. MORAN				2. SEX FEMALE		3a. TIME OF DEATH 9:00 AM		3b. DATE OF DEATH (Month, Day, Year) OCTOBER 29, 1997			
4. *SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) 94		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) SEPT. 14, 1903		7. BIRTHPLACE (City and State or Foreign Country) Willow Hill, Illinois	
8a. WAS DECEDENT A U.S. VETERAN? no		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? no		9a. 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 checked="" type="checkbox"/> Residence							
9b. FACILITY NAME (If not institution, give street and number) Residence: 7620 Beech				9c. CITY, TOWN, OR LOCATION OF DEATH Hammond				9d. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) none		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker				12b. KIND OF BUSINESS/INDUSTRY Own Home			
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hammond				13d. STREET AND NUMBER 7620 Beech			
13e. ZIP CODE 46324		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		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) white		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 	
18. FATHER'S NAME (First, Middle, Last) Richard Hawes						19. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth (unavailable)					
20a. INFORMANT'S NAME (Type/Print) Mr. Lawrence Moran				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2907 Cleveland Hammond, IN 46323				20c. Relationship Son			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) November 1, 1997 Chapel Lawn Memorial Gardens				21c. LOCATION—City or Town, State Schererville, Indiana			
22a. EMBALMER'S NAME John G. Ault				22b. EMBALMER'S LICENSE NO. FD01013507				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) FD01013507				25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323			
26. PART I Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Melanotic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF) a. _____ b. _____ c. _____ d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last										Approximate Interval Between Onset and Death 5 years	
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) 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) no	
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>								29c. MEDICAL LICENSE NO. 01040756		29d. DATE SIGNED (Month, Day, Year) Oct. 30, 1997	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) G. Jano, M.D. 7905 Calumet Avenue Munster, IN 46321											
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>										32. DATE FILED (Month, Day, Year) October 30, 1997	
33. MANNER OF DEATH <input 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 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.							