

Corrected

AFFIDAVIT OF SURVIVORSHIP

2

STATE OF Indiana COUNTY OF Lake 415-68-09-333-687-000-004

I, Warren G. Smith, residing at 1764 Polk Street, in the county of Lake in the state of Indiana and being duly sworn, do hereby depose and attest that:

1. The Decedent, M. Lumentha Smith, is named in the attached death certificate.
2. The Decedent died on February 11, 2001 and {was/was not} legally married at the time.
3. The names of the Decedent's survivors are Warren G. Smith

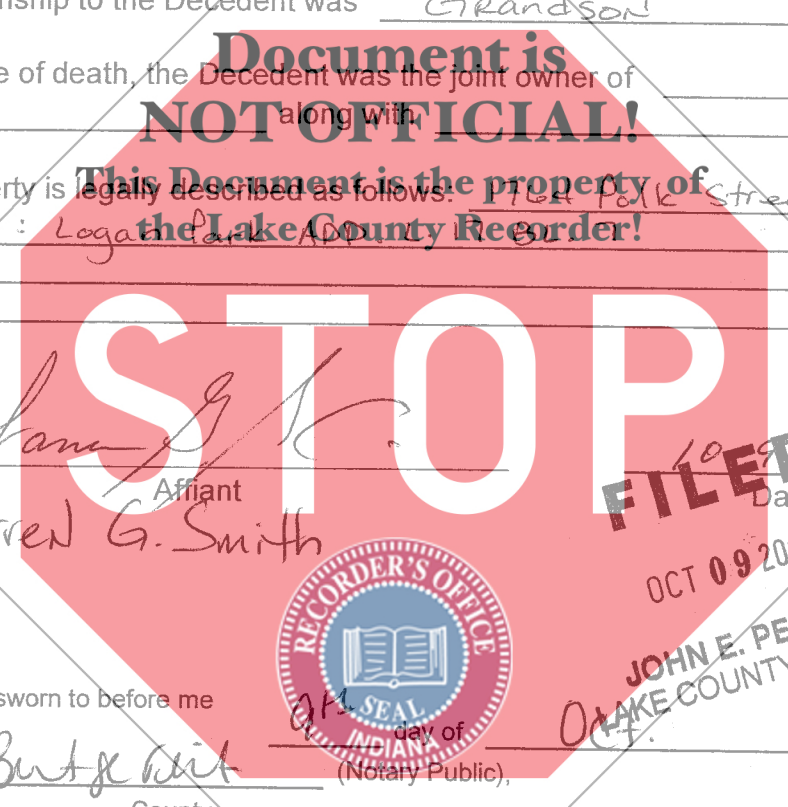
4. My relationship to the Decedent was Grandson

5. At the time of death, the Decedent was the joint owner of _____ along with _____

6. The property is legally described as follows: 1764 Polk Street
46407 - Logan Park Addition

2015069432

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
MICHAEL BERDMAN
RECORDER
2015 OCT -9 PM 2:11



Warren G. Smith
Affiant
Warren G. Smith

FILED
10 9 2015
OCT 09 2015

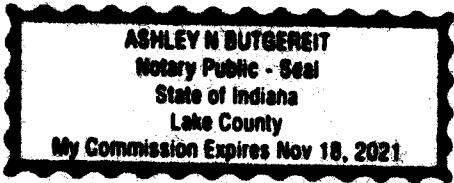
22275

JOHN E. PETALAS
LAKE COUNTY AUDITOR

Subscribed and sworn to before me this _____ day of _____, 2015

Ashley Butgereit
Lake County.

My commission expires NOV. 19 20 21



14
CAST
BY
NOT. COX

10CC

*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

Local No. 01 0107

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

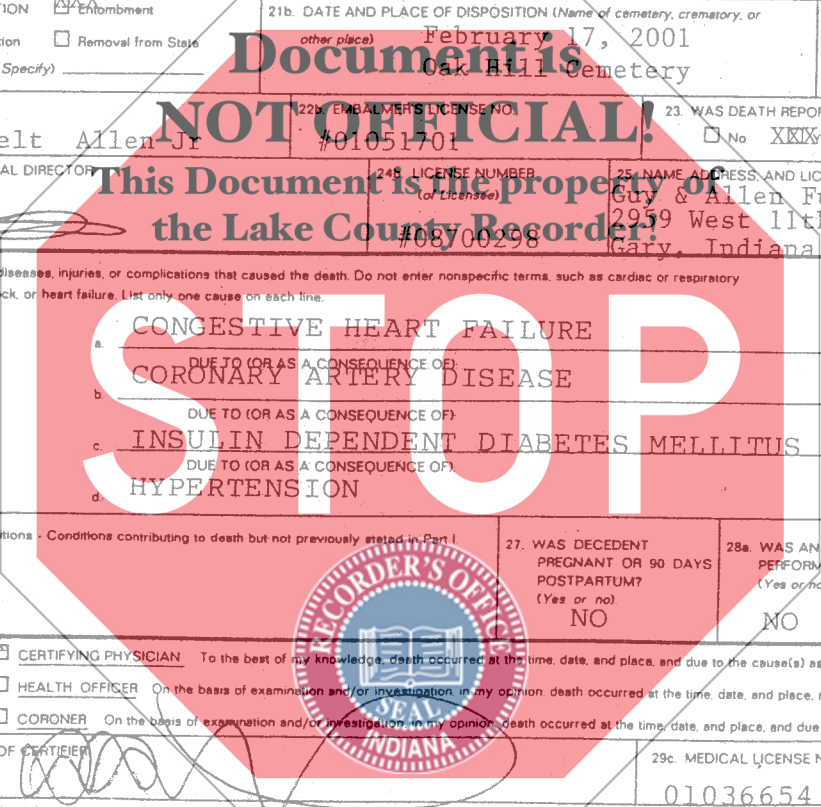
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Lumentha M. Smith		2. SEX Female	3a. TIME OF DEATH 12:35 P.M.	3b. DATE OF DEATH (Month, Day, Yr.) February 11, 2001	
4. SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE—Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) December 17, 1919	
7. BIRTHPLACE (City and State or Foreign Country) Magnolia, Mississippi	8a. WAS DECEDENT 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 type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) 1764 Polk Street		9c. CITY, TOWN, OR LOCATION OF DEATH Gary	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS Widowed	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) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Home	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 1764 Polk Street		
13e. ZIP CODE 46407	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) Black	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 Years		18. FATHER'S NAME (First, Middle, Last) Murray W. Richards Sr.			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary M. Varnado			20a. INFORMANT'S NAME (Type/Print) Emma Smith		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1764 Polk Street Gary, Indiana 46407		20c. Relationship Daughter			
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) February 17, 2001 Oak Hill Cemetery		21c. LOCATION—City or Town, State Gary, Indiana	
22a. EMBALMER'S NAME Roosevelt Allen Jr.		22b. EMBALMER'S LICENSE NO. #01051701	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) #0800298	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704		
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF) b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF) c. INSULIN DEPENDENT DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF) d. HYPERTENSION		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 			
29c. MEDICAL LICENSE NO. 01036654		29d. DATE SIGNED (Month, Day, Year) 02 19 2001			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ADOLPHUS A. ANEKWE, M.D. 3195 Broadway Gary, IN 46409					
31. HEALTH OFFICER'S SIGNATURE 				32. DATE FILED (Month, Day, Year) FEB 22 2001	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" 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)			



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