SMALL ESTATE AFFIDAVIT OF SURVIVORSHIP

2017 011695

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2017 JUL -7 PM 3:2
JOHN E. PETALAS
RECORDER

State of Indiana
County of Lake

I, Jacqueline P. Cheairs, upon duly sworn, state on their oath that:

1. **My address & residence is 2248 Arthur St. Gary In 46404**
2. **I am the only successor to the decedents or a claimant entitled to the property of the named decedents.**

Name/Relationship	Address	Share
Jacqueline P. Cheairs	2248 Arthur St.	100%

Legal Description: Gary Park 4th Addition Lot 13 Block 3 All Lot 14 Block 3
Address of property: 2248 Arthur St . Gary, IN 46404

Key Number: 45-08-17-229-028.000-004

3. **The decedent's names are Willie Allen Chearis & Pauline Larue Chearis, husband and wife.**
4. **The date of the decedents' deaths for Willie Allen Chearis was Nov. 5, 2001, in Gary, IN & for Pauline Larue Chearis was Sept. 6, 2006, in Gary, IN. more than forty-five (45) days have elapsed since the death of the decedent and I have attached a copy of the death certificate hereto. Note: At any time after forty-five or more days from the date of a decedent's death, any person who is indebted to or who has possession of any property or an instrument evidencing a debt, obligation, stock chose in action, or stock brand belonging to the decedent, shall pay such indebtedness or deliver such personal property, or so much of either as is claimed to a person claiming to be a successor of the decedent or entitled to payment or deliver of the property belonging to the decedent upon being presented an affidavit made by said person.**
5. **That the value of the gross probate estate, wherever located, less lien and encumbrances does not exceed twenty five thousand dollars ($25,000.00).**
6. **That at least forty-five (45) days has elapsed since the death of decedent.**
7. **That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction.**

THE FOREGOING STATEMENT IS MADE UNDER THE PENALTIES OF PERJURY

STATE OF INDIANA
COUNTY OF LAKE

Before me, the undersigned, a Notary Public in and for said County and State, this 7 day of July, 2017.

Jacqueline P Cheairs
Signature

Jacqueline P. Cheairs
Printed Name

In witness whereof, I have hereunto subscribed my name and affixed my officials seal.

My commission expires 2/9/22

Notary Public

DOUGLAS H. ACHTERHOF
Lake County
My Commission Expires
February 9, 2022

FILED
JUL 07 2017
JOHN E. PETALAS
LAKE COUNTY AUDITOR

003910

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.
PREPARED BY:

25. CASH

CERTIFICATE OF DEATH

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

Local No. 01 0703 CERTIFICATE OF DEATH State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED--NAME (First, Middle, Last): Willie Allen Cheairs
2. SEX: Male
3a. TIME OF DEATH: 11:25-P M
3b. DATE OF DEATH (Month, Day, Yr.): November 05, 2001
4. *SOCIAL SECURITY NUMBER: [redacted]
5a. AGE--Last Birthday (Years): 86
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr): December 22, 1914
7. BIRTHPLACE (City and State or Foreign Country): Hickory Valley, Tennessee
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: Inpatient / ER/Outpatient / DOA OTHER: [X] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Timberview Rehab Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Pauline Coleman
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Animal Control Officer
12b. KIND OF BUSINESS/INDUSTRY: City of Gary
13a. RESIDENCE--STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2248 Arthur Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] 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): 3 / College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Morgan Cheairs
19. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Woods

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Pauline Cheairs
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2248 Arthur Street Gary, IN 46404
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 10, 2001 Evergreen Memorial Park
21c. LOCATION--City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD 01016254
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Yolanda Landon-Smith
24b. LICENSE NUMBER (of Licensee): FD20000361
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home, FH19600034, 4209 Grant St, Gary, IN, 46408

CAUSE OF DEATH

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. Cerebral Vascular Accident — Approximate Interval Between Onset and Death:
DUE TO (OR AS A CONSEQUENCE OF):
b. Hypertensive Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Cirrhosis of Liver
DUE TO (OR AS A CONSEQUENCE OF):
d. Alzheimers Disease

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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): NC
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

CERTIFIER

29a. CERTIFIER (Check only one)
[ ] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] 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.
[ ] 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: Idah Cannon MD
29c. MEDICAL LICENSE NO.: 01037499
29d. DATE SIGNED (Month, Day, Year): 11/7/01

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Idah M. Cannon MD 1619 W 5th Ave Gary IN 46404
31. HEALTH OFFICER'S SIGNATURE: Idah Cannon M.D. mfh
32. DATE FILED (Month, Day, Year): NOV 14 2001

33. MANNER OF DEATH: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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.

SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1

STATE OF INDIANA

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. 06 0483 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Pauline Larue Cheairs
2. SEX: Female
3a. TIME OF DEATH: 7:00 pm M
3b. DATE OF DEATH (Month, Day, Yr): September 6, 2006
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 82
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): October 9, 1923
7. BIRTHPLACE (City and State or Foreign Country): Somersville Tennessee
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Timberview Rehabilitation Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name):
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: Gary
13d. STREET AND NUMBER: 2248 Arthur Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 9; College (1-4 or 5 +): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): Egbert Haywood Coleman
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lennie Mae Waller

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Clarence Lamar Cheairs
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 267 Grant, Gary, IN 46402
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 14, 2006 EVERGREEN MEMORIAL PARK
21c. LOCATION—City or Town, State: HOBART, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD01016254
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of Licensee): FD01016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner FH10500021, 4209 Grant Street, Gary, Indiana

CAUSE OF DEATH

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Multiple Myeloma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Kidney Failure, s/p chemotherapy.

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

CERTIFIER

29a. CERTIFIER (Check only one):
☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: MD
29c. MEDICAL LICENSE NO:
29d. DATE SIGNED (Month, Day, Year): 9/20/06

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. Jyotsna P. Sanghvi 8127 Merrillville Road Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): SEP 26 2006

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

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.