2

AFFIDAVIT OF SURVIVORSHIP

2017 045046

2017-045046

STATE OF INDIANA
COUNTY OF LAKE

I, Marnita Garland, residing at 1327 Wright Street, in the county of LAKE in the state of INDIANA and being duly sworn, do hereby depose and attest that:

1. The Decedent, Leo Brown, is named in the attached death certificate.

2. The Decedent died on July 27, 2004 and (was/was not) legally married at the time.

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STOP
RECORDER'S OFFICE SEAL

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2017 JUL 20 PM 12:39
MICHAEL B. BROWN
RECORDER

3. The names of the Decedent's survivors are Connie Brown

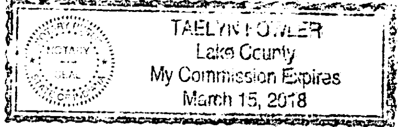
4. My relationship to the Decedent was Daughter

5. At the time of death, the Decedent was the joint owner of 1136 Burr Street Gary, Indiana 46406 along with Connie Brown

6. The property is legally described as follows:
W. G. Wright 2nd Addition All Lots 13 & 14 BL. 1

Marnita Garland — Marnita Garland
Affiant

July 19, 2017
Date


TAELYN FOWLER
Lake County
My Commission Expires
March 15, 2018

"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: Marnita Garland

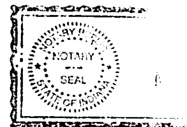
Subscribed and sworn to before me this 20 day of July 20 17
Taelyn Fowler (Notary Public),
Lake County.

My commission expires March 15 20 18

$25.00
cash
JAB

FILED
031171
JUL 20 2017
JOHN E. PETALAS
LAKE COUNTY AUDITOR

TAELYN FOWLER
Lake County
My Commission Expires
March 15, 2018



www.BusinessFormTemplate.com

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.

Local No. 04 0456

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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): LEO BROWN
2. SEX: MALE
3a. TIME OF DEATH: 9:20A.M
3b. DATE OF DEATH (Month, Day, Yr.): JULY 27,2004
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): FEBRUARY 22 1929
7. BIRTHPLACE (City and State or Foreign Country): PERRYVILL,ARKANSAS
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: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): NORTHLAKE METHODIST HOSPITAL
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): CONNIE BANNER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired):
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE—STATE: IN
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: GARY
13d. STREET AND NUMBER: 1136 BURR ST.
13e. ZIP CODE: 46406
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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): ALPHONSO BROWN
19. MOTHER'S NAME (First, Middle, Maiden Surname): EULIA HOLMES

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CONNIE BROWN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1136 BURR ST.GARY,IN.46406
20c. Relationship: WIFE

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): AUGUST 2,2004 EVERGREEN MEMORIAL PARK
21c. LOCATION—City or Town, State: HOBART, IN
22a. EMBALMER'S NAME: LEON COLEMAN JR.
22b. EMBALMER'S LICENSE NO.: 4523
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 104-5231
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: POWELL-COLEMAN FUNERAL HOME 1901 WASHINGTON ST.GARY,IN 88602434

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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. CARDIOGENIC SHOCK and
DUE TO (OR AS A CONSEQUENCE OF):
b. SEPTIC SHOCK
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death

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): N.A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: [signature]
29c. MEDICAL LICENSE NO: 01052867A
29d. DATE SIGNED (Month, Day, Year): 7/30/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): ABRAR KHAN, 5454 BROADWAY GARY- IN 46409

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): AUG 02 2004

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.

VOID IF ALTERED OR ERASED

WARNING: ORIGINAL DOCUMENT HAS A MULTICOLORED BACKGROUND ON SPECIAL WHITE SECURITY PAPER AND THE GREAT SEAL OF THE STATE OF INDIANA ON BACK THAT TURNS FROM ORANGE TO YELLOW WHEN RUBBED. ORIGINAL DOCUMENT HAS A HIDDEN VOID ON FRONT THAT APPEARS WHEN PHOTOCOPIED.

STATE OF INDIANA