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Mail Tax Bills to:  
3412 W. 77<sup>th</sup> Ave.  
Merrillville, IN 46410

2017 048122

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2017 AUG -2 PH 4: 07

MICHAEL B. BROWL  
RECORDER

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

**FILED**

IN RE THE ESTATE OF: )  
CLYDE O. HAWKINS SR., )  
Deceased. )

AUG 2 2017

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

AFFIDAVIT OF SURVIVORSHIP

Comes now VANESSA ROBINSON, daughter of the Decedent, first being duly sworn upon her oath deposes and says:

**Document is NOT OFFICIAL!**

**This Document is the property of the Lake County Recorder!**

**STOP**

1. That the above named Decedent, CLYDE O. HAWKINS SR. aka CLYDE HAWKINS SR. aka CLYDE O. HAWKINS, died intestate on November 24, 1996. His death certificate is attached to this affidavit. Reasonable care has been taken to redact the social security number from the document.
2. Decedent, CLYDE O. HAWKINS SR., was survived by his wife, Olavelt Hawkins.
3. That the Decedent, CLYDE O. HAWKINS SR., and his wife, Olavelt Hawkins, jointly owned a fee simple interest in the property listed below, as husband and wife:

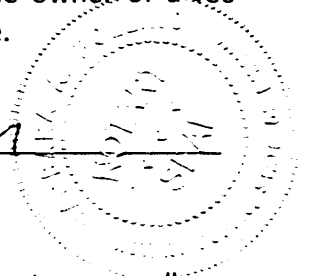
Tax ID# 45-08-10-183-016-000-004

Lot 12 and the South half of Lot 13, Block 10, Gary Land Company's Ninth Subdivision, in the City of Gary, as shown in Plat Book 13, Page 15, in Lake County, Indiana.

Commonly known as: 1340 Carolina Street, Gary, IN

4. That as a result of the Decedent's death she now vested as sole owner of a fee simple interest in the real property described in Paragraph 3 above.

*Vanessa Robinson*  
Vanessa Robinson, Affiant



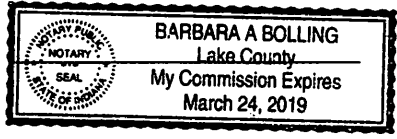
Subscribed to and sworn before me Notary Public for the above State and County, personally

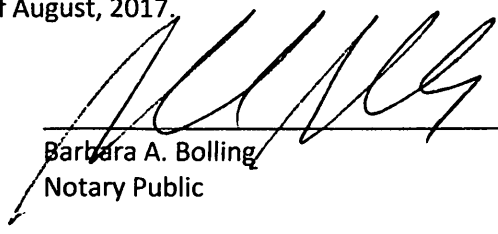
041038

JAS  
1  
✓ #1191 \$25.00

appeared Vanessa Robinson this 2<sup>nd</sup> day of August, 2017.

My Commission Expires:



  
\_\_\_\_\_  
Barbara A. Bolling  
Notary Public



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.

1CC + 3 Free VETS  
INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

96-0803

Local 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) **Clyde Hawkins Sr.**

2. SEX **Male**

3a. TIME OF DEATH **11:01 A**

3b. DATE OF DEATH (Month, Day, Yr.) **November 24, 1996**

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) **November 19, 1921**

7. BIRTHPLACE (City and State or Foreign Country) **Arkansas**

8a. WAS DECEDENT A U.S. VETERAN? **YES**

8b. YEAR LAST SERVED IN U.S. ARMED FORCES? **1945**

9. PLACE OF DEATH (Check only one. See instructions.)  
 HOSPITAL **XXX**  Patient  
 ER/Outpatient  DOA  
 OTHER  Nursing Home  Other (Specify)  
 Residence

9b. FACILITY NAME (If not institution, give street and number) **Methodist Hospital Northlake**

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) **Olavelt Adkins**

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Foreman**

12b. KIND OF BUSINESS/INDUSTRY **Gary Window Cleaning**

13a. RESIDENCE—STATE **Indiana**

13b. COUNTY **Lake**

13c. CITY, TOWN, OR LOCATION **Gary**

13d. STREET AND NUMBER **1340 Carolina Street**

13e. ZIP CODE **46407**

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) **11th** College (1-4 or 5+)

18. FATHER'S NAME (First, Middle, Last) **John Hawkins**

19. MOTHER'S NAME (First, Middle, Maiden Surname) **Ora Payne**

20a. INFORMANT'S NAME (Type/Print) **Olavelt Hawkins**

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1340 Carolina Street, Gary, Indiana 46407**

20c. Relationship **Wife**

21a. METHOD OF DISPOSITION  Burial  Entombment  Cremation  Removal from State  Donation  Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **November 30, 1996 Evergreen Cemetery**

21c. LOCATION—City or Town, State **Hobart, Indiana**

22a. EMBALMER'S NAME **Roosevelt Allen Sr.**

22b. EMBALMER'S LICENSE NO. **#01051696**

23. WAS DEATH REPORTED TO CORONER?  Yes  No

24a. SIGNATURE OF FUNERAL DIRECTOR *[Signature]*

24b. LICENSE NUMBER (of Licensee) **#01051701**

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **Guy & Allen Funeral Directors, Inc. 007704  
2959 West 11th Avenue Gary, Indiana 46404**

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. **Cardiorespiratory Arrest**  
 DUE TO (OR AS A CONSEQUENCE OF)  
 b. **metastatic carcinoma of the lung**  
 DUE TO (OR AS A CONSEQUENCE OF)  
 c. \_\_\_\_\_  
 DUE TO (OR AS A CONSEQUENCE OF)  
 d. \_\_\_\_\_

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) \_\_\_\_\_

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) **12/2/96**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **Dr. Idah Cannon MD 1619 West 5th Avenue Gary, Indiana 46402**

31. HEALTH OFFICER'S SIGNATURE *[Signature]*

32. DATE FILED (Month, Day, Year) **DEC 05 1996**

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

34a. DATE OF INJURY (Month, Day, Year)

34b. TIME OF INJURY

34c. INJURY AT WORK? (Yes or no)

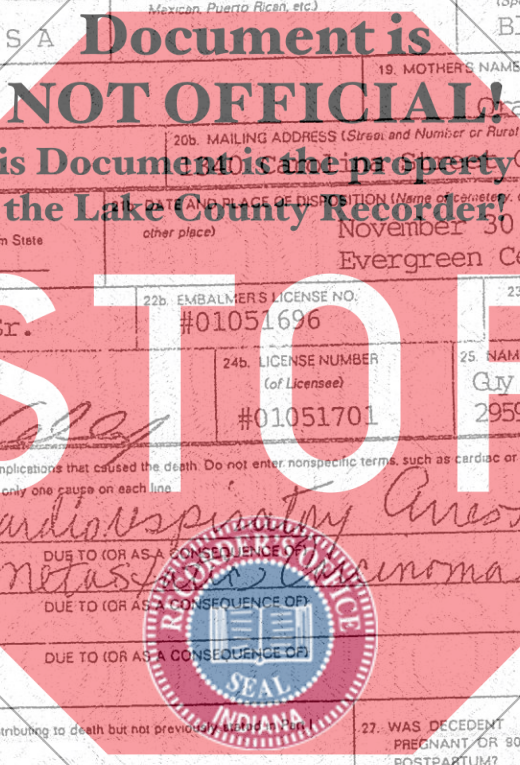
34d. DESCRIBE HOW INJURY OCCURRED

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.)



VOID IF ALTERED OR ERASED

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