

STATE OF INDIANA )  
                                  ) SS: IN RE: HATTIE ISHMON, Deceased  
COUNTY OF LAKE ) And ~~4140~~ 4240 W. 21<sup>st</sup> Place, Gary, IN

*CPV* DAN L. ISHMON AND (Deceased)  
*4240*

**AFFIDAVIT FOR TRANSFER OF REAL PROPERTY  
WITHOUT THE NEED TO OPEN AN ESTATE**

2019 0229829

The undersigned, upon personal knowledge and belief, makes these statements under the requirements of I.C. 29-1-8, et seq.:

1. Hattie Ishmon died intestate Dec. 22, 2003 while domiciled in Lake County, Indiana.

2. She had been preceded in death by her husband, Dan Leon Ishmon, who died intestate on Nov. 7, 2000, while domiciled in Lake County, Indiana.

3. Together they had owned, as tenants in the entirety, property at 4240 W. 21<sup>st</sup> Place in Gary, IN.

4. The value of Hattie Ishmon's gross probate estate, did not exceed \$50,000.00 as provided under I.C. 29-1-8-3, allowing for the costs and encumbrances of administration and reasonable funeral expenses.

5. More than 45 days have passed since Decedent's death. (Certificate attached).

*This Document is being  
rec-recorded to correct names.  
CPV*

*CPV aka DAN L. ISHMON*

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2019 JUN 12 AM 11:58

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2019 JUN 12 AM 11:58

**FILED**  
MAY 20 2019

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

**FILED**

JUN 12 2019

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

Page 1 of 4

25229

001868

\$ 25.00  
*[Signature]*

6. No petition for the appointment of personal representative for the Decedent has been granted and none is contemplated.

7. That among Decedent's probate assets is a parcel of real estate which was owned by the Decedent, located in Gary, Indiana, and more particularly described as Parcel Key# 45-08-18-126-018.000-004, with a legal description of :

Lot 18, Block 2, as marked and laid down on the recorded plat of Tarrytown Second Subdivision in the City of Gary, Lake County, IN as the same appears of record in Plat Book 30, page 86 in the Lake County Recorder's Office.

Commonly known as 4240 W. 21<sup>st</sup> Place, Gary, IN, in Lake County, IN.

8. That the undersigned has notified the other heirs of Dan and Hattie Ishmon of his intention to present this affidavit under I.C. 29-1-8, et. seq.

*AKA DAN L. ISHMON AND HATTIE ISHMON* *CPV*

9. That the claimant is entitled to delivery or payment of the property on behalf of each person identified in the affidavit.

10. The name and address of each heir that is entitled to a share of the property is as follows:

A. Daniel Ishmon, a son, 1029 Ames St., Hammond, IN 46320.  
**Entitled to an undivided one-fifth (1/5).**

B. Constance Rayburn, a daughter, 2539 Gilpin St., Denver, CO. 80205, **Entitled to an undivided one-fifth (1/5).**

C. Ruben Ishmon, a son, 16608 Flopilla Way, Woodbridge, VA. 32191, **Entitled to an undivided one-fifth (1/5).**

D. Dwight Ishmon, a son, 876 South <sup>Chambers</sup> Cambers Road, Apt. #207, Aurora, CO., 80017, **Entitled to an undivided one-fifth (1/5).**

E. James Ishmon, a son, 47 Rand Ave., Buffalo, NY 14216, **Entitled to an undivided one-fifth (1/5).**

**F. Tax bill shall be mailed to: Dan Ishmon, 1029 Ames St., Hammond, IN 46320.**

11. The claimants are all of and the only legal heirs of Hattie Ishmon and are entitled to payment or delivery of the following property:

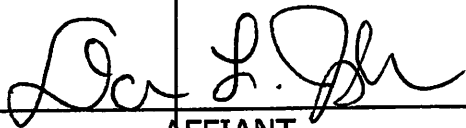
Lot 18, Block 2, as marked and laid down on the recorded plat of Tarrytown Second Subdivision in the City of Gary, Lake County, IN as the same appears of record in Plat Book 30, page 86 in the Lake County Recorder's Office,

Parcel key # 45-08-18-126-018.000-004, more commonly known as 4240 W. 21<sup>st</sup>

Place, Gary, IN.

That further, affiant sayeth Not.

5/16/19  
DATE



AFFIANT  
DAN ISHMON aka Dan L. Ishmon

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

Subscribed and sworn to me, a Notary Public, this 17<sup>th</sup> day

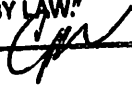
of May, 2019.

  
NOTARY PUBLIC

My Commission expires  
June 18, 2023

Resident of Lake County, Indiana

**CURTIS P. VOSTI**  
NOTARY'S PRINTED SIGNATURE

"I AFFIRM, UNDER THE PENALTIES FOR  
PERJURY THAT I HAVE TAKEN REASON-  
ABLE CARE TO REDACT EACH SOCIAL  
SECURITY NUMBER IN THIS DOCUMENT,  
UNLESS REQUIRED BY LAW."  
PREPARED BY: 

**CURTIS P VOSTI**  
Notary Public - Seal  
State of Indiana  
Lake County  
My Commission Expires Jun 18, 2023

\* 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. ....00...0825.....

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) <b>DAN LEON ISHMON</b>		2. SEX <b>MALE</b>	3a. TIME OF DEATH <b>1:00 AM</b>	3b. DATE OF DEATH (Month, Day, Year) <b>November 7, 2000</b>
4. SOCIAL SECURITY NUMBER <b>[REDACTED]</b>	5a. AGE—Last Birthday (Years) <b>80</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month, Day, Year) <b>Dec. 18, 1919</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Mound Bayou, MS</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>YES</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>	9. PLACE OF DEATH (Check only one; See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DSA 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) <b>4240 West 21st Place</b>		9c. CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Hattie Idleburg</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Labor</b>		12b. KIND OF BUSINESS/INDUSTRY <b>US Steel-Gary Wor.</b>
13a. RESIDENCE—STATE <b>IN</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>Gary</b>		13d. STREET AND NUMBER <b>4240 W. 21st Place</b>
13e. ZIP CODE <b>46406</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>BLK</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		
18. FATHER'S NAME (First, Middle, Last) <b>Dan Ishmon</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie (unavailable) Ishmon</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Hattie Ishmon</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4240 W. 21st Pl., Gary, IN 46406</b>		20c. Relationship <b>Wife</b>
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) <b>Nov. 11, 2000—Ridgelawn Cem. Griffith, IN</b>		21c. LOCATION—City or Town, State
22a. EMBALMERS NAME <b>Paul Anthony Robinson</b>		22b. EMBALMERS LICENSE NO. <b>1017284</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Paul Anthony Robinson</i>		24b. LICENSE NUMBER (of Licensee) <b>1017284</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>HOUSE OF ROBINSON # 1950007 1900 W. 15th Ave., Gary, IN 46406</b>
25. 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. <b>CARDIOPULMONARY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>METASTATIC COLON CARCINOMA WITH</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>LIVER INVOLVEMENT</b> DUE TO (OR AS A CONSEQUENCE OF): d.				
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) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NA</b>
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>SERGE DAUPHIN M.D.</i>			29c. MEDICAL LICENSE NO. <b>01044748</b>	29d. DATE SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) <b>SERGE DAUPHIN M.D. 3229 BROADWAY STE 205 GARY, IN 46409</b>				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) <b>NOV 21 2000</b>
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.		

VOID IF ALTERED OR ERASED

WARNING: ORIGINAL DOCUMENT HAS A HIDDEN VOID ON BACK THAT APPEARS WHEN PHOTOCOPIED. ORIGINAL DOCUMENT HAS A HIDDEN VOID ON FRONT THAT APPEARS WHEN PHOTOCOPIED.

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assure its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 3099-03

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) <b>Hattie Ishmon</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>2:10P M</b>	3b DATE OF DEATH (Month, Day, Yr) <b>December 22, 2003</b>	
4 *SOCIAL SECURITY NUMBER <b>[REDACTED]</b>	5a AGE—Last Birthday (Years) <b>76</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <b>Aug. 20, 1927</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Mound Bayou, MS</b>	8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	9a PLACE OF DEATH (Check only one. See instructions) <b>HOSPITAL</b> <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <b>OTHER</b> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) <b>Munster Med Inn</b>		9c CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Widow</b>	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) <b>Homemaker</b>		12b KIND OF BUSINESS/INDUSTRY	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN, OR LOCATION <b>Gary</b>		13d STREET AND NUMBER <b>4240 West 21st Place</b>	
13e ZIP CODE <b>46404</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>BLK</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			
18 FATHER'S NAME (First, Middle, Last) <b>James Idleburg</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Isabell Moore Idleburg</b>			
20a INFORMANT'S NAME (Type/Print) <b>Dan Ishmon, Jr.</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1029 Ames St., Hammond, IN 46320</b>		20c Relationship <b>Son</b>	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) <b>December 29, 2003—Ridgeland</b>		21c LOCATION—City or Town, State <b>Gary, IN</b>	
22a EMBALMER'S NAME <b>Paul Anthony Robinson</b>		22b EMBALMER'S LICENSE NO. <b>1017284</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Paul Anthony Robinson</i>		24b LICENSE NUMBER (of Licensee) <b>1017284</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>HOUSE OF ROBINSON # 1950007 1900 W. 15th Ave., Gary, IN 4640</b>	
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)  Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last  a. <u>Cardiopulmonary collapse</u> DUE TO (OR AS A CONSEQUENCE OF) b. <u>Chronic obstructive pulmonary Disease</u> DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____		<p style="text-align: center;"><b>THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>JAN 14 2019</b></p> <p style="text-align: center;"><b>LAKE COUNTY HEALTH OFFICER</b></p>			
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <u>Hypertensive cardiovascular Disease</u>		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a. WERE DEATH RECORDS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> <b>CERTIFYING PHYSICIAN</b> 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"/> <b>HEALTH OFFICER</b> 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"/> <b>CORONER</b> 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>W. Whitehorn MD</i>		29c MEDICAL LICENSE NO. <b>010 20248</b>		29d DATE SIGNED (Month, Day, Year) <b>NOT VALID UNLESS</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>W WHITEHORN, MD. 7905 CALUMET AVE MUNSTER, IN</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Susan J But</i>					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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)	
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

RAISED SEAL AFFIXED