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2019-086517

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
MICHAEL B BROWN
RECORDER

STATE OF INDIANA)
COUNTY OF LAKE) SS:

2019 Dec 13 11:28 AM

AFFIDAVIT OF SURVIVORSHIP

Levon Hall, being first duly sworn upon her oath, deposes and says:

1. That she is the daughter of **Mary Reid**, that **James E. Reid and Mary Reid** were married on the date that they acquired title as husband and wife as tenants by the entireties to certain Real Estate in **Lake County, Indiana**, to-wit:

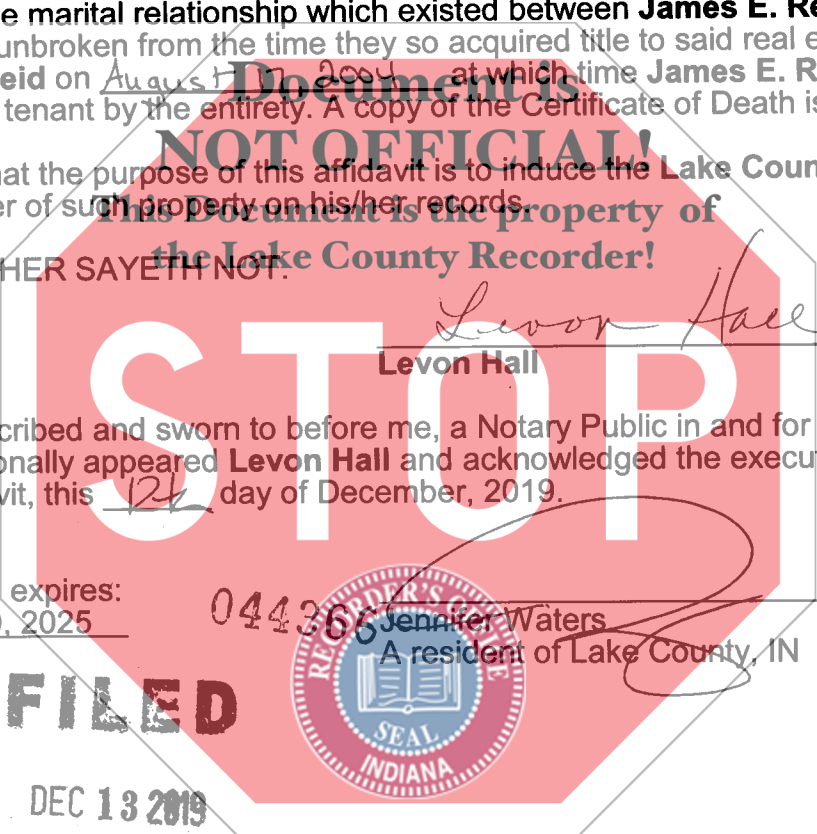
Lot Twenty-seven (27), Block Sixteen (16), Resubdivision of Gary Land Company's Sixth Subdivision, in the City of Gary, as shown in Plat Book 14, page 21, in Lake County, Indiana.

Commonly known as 350 Ellsworth Street, Gary, IN 46404

2. The marital relationship which existed between **James E. Reid and Mary Reid** continued unbroken from the time they so acquired title to said real estate until the death of **Mary Reid** on August 17, 2004 at which time **James E. Reid** acquired title as surviving tenant by the entirety. A copy of the Certificate of Death is attached.

3. That the purpose of this affidavit is to induce the **Lake County Auditor** to show the transfer of such property on his/her records.

AFFIANT FURTHER SAYETH NOT.



Levon Hall
Levon Hall

Subscribed and sworn to before me, a Notary Public in and for said County and State, personally appeared **Levon Hall** and acknowledged the execution of the foregoing affidavit, this 12 day of December, 2019.

My Commission expires:
September 20, 2025

044366 Jennifer Waters
A resident of Lake County, IN

FILED

DEC 13 2019

JOHN E. PETALAS
LAKE COUNTY AUDITOR

Mail Tax Bills To: **James E. Reid**
350 Ellsworth Street, Gary, IN 46404
TAX KEY NO (S): **45-08-05-177-026.000-004**

THIS INSTRUMENT PREPARED BY:
Douglas R. Kvachkoff
Attorney at Law
325 N. Main Street
Crown Point, IN 46307
219-662-8200
Our File: IN-19-62376-02

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.

Angela Anderson

INDIANA TITLE NETWORK COMPANY
325 NORTH MAIN
CROWN POINT, IN 46307

\$ 25.00

JPB

27478

**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 2113-04

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

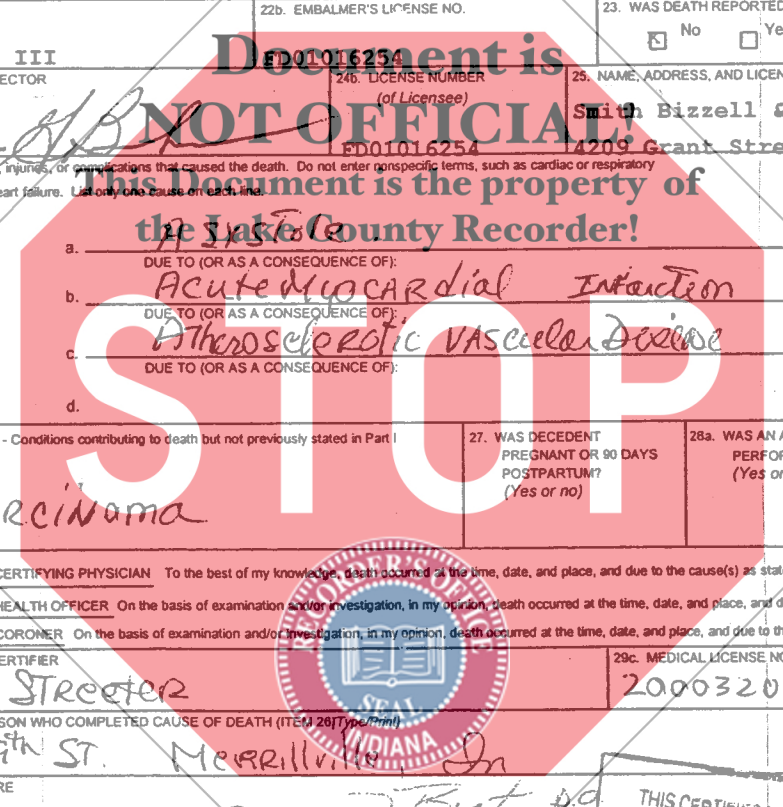
CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED - NAME (First, Middle, Last) Mary Reid		2. SEX Female	3a. TIME OF DEATH 7:17 PM	3b. DATE OF DEATH (Month, Day, Yr.) August 17, 2004
4. SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE - Last Birthday (Years) 76	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	8. DATE OF BIRTH (Mo., Day, Yr.) July 25, 1928
6a. WAS DECEDENT A U.S. VETERAN? No		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		7. BIRTHPLACE (City and State or Foreign Country) Madison Tennessee
9b. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Hobart		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) James Reid	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 350 Ellsworth Street	
13e. ZIP CODE 46404	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input 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) 9 College (1-4 or 5+) N/A		18. FATHER'S NAME (First, Middle, Last) Jim Gant		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Josie Boyd		20a. INFORMANT'S NAME (Type/Print) James Reid		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350 Ellsworth Street, Gary, IN 46404		20c. Relationship Husband		
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) August 24, 2004 Calumet Park Cemetery		21c. LOCATION - City or Town, State Merrillville, Indiana
22a. EMBALMER'S NAME Sherman G. Banks III		22b. EMBALMER'S LICENSE NO. FD01016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD01016254		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner FH19600034 4209 Grant Street, Gary, Indiana 46407-
26. PART I Enter the disease, 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. Acute Myocardial Infarction Atherosclerotic Vascular Disease				Approximate Interval Between Onset and Death
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Colon Carcinoma				27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)				28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
29a. CERTIFIER (Check only one) <input 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 Dennis Streeter			29c. MEDICAL LICENSE NO. 2000320	29d. DATE SIGNED (Month, Day, Year) 8-24-04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)(Type/print) 119 E 89th St. Merrillville, IN				32. DATE FILED (Month, Day, Year) August 31, 2004
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) August 31, 2004
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)
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34f. LOCATION (Street and Number of Rural Route Number, City or Town, State)		
34g. DATE PRONOUNCED DEAD (Month, Day, Year) August 17, 2004		34h. MOTOR VEHICLE ACCIDENT?(Yes or No) If yes, specify driver, passenger, pedestrian, etc.		

SDH06-004



THIS CERTIFIES THE ABOVE IS A COMPLETE COPY OF THE ORIGINAL AS FILED WITH THE LAKE COUNTY HEALTH DEPT
AUG 21 2004