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STATE OF INDIANA)
) SS
COUNTY OF LAKE)

GINA PIMENTEL
RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2023-006434
4:00 PM 2023 Feb 28

AFFIDAVIT OF INHERITANCE

We, Debra Porter, of 7351 Montana Ave., Hammond, County of Lake, State of Indiana, and Vickie Sue Brown of 704 River Dr. , Munster, Indiana make this affidavit and state under penalties of perjury as follows:

1. The decedent, Cedric R Porter, is our father. He died on August 19, 2007, at the age of 71 years, in Munster, Indiana. A copy of the Death Certificate is attached hereto.

2. The decedent, Joan M Porter, is our mother. She died on September 9, 2012, at the age of 77 years, in Hammond, Indiana. A copy of the Death Certificate is attached hereto

3. That the decedents, Joan M. Porter and Cedric R. Porter were duly and legally married at the time they acquired title as husband and wife to the following described real estate.

4. They had two children born to them: Debra Porter and Vickie Sue Porter Brown. We are both adults and under no legal or physical disabilities. No children were adopted.

5. That the marital relationship which existed between Joan and Cedric at the time they acquired title to the real estate described below remained in effect and unbroken until the death of my Father, Cedric and my Mother, Joan never remarried.

6. It appears that the descedent's gross probate estate, less liens and encumbrances, does not exceed $50,000, the costs of administration, and reasonable funeral expenses.

7. Joan Porter left a will bequeathing 100% of all real property to her daughter, Debra Porter.

8. The legal description of the premises in question, 7351 Montana Ave. Hammond, IN, 46323, property tax index #: 45-07-15-128-021-000-023 is:
Lot 11, ORCHARD ACRES ADDITION, to the City of Hammond, Lake County Indiana, as per plot thereof, recorded in Lake County Recorders Office.

FILED
OCT 01 2012
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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9. No probate estate has been initiated in any jurisdiction.

10. Based on this information above, Debra Porter and Vickie Sue Brown are their heirs.

11. Based on the will, we both acknowledge that 100% of the real property located at 7351 Montana Ave. is bequeathed to Debra Porter.

12. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Debra Porter

Debra Porter, Affiant

Subscribed and Sworn to
Before me this day of
October 1, 2012.

Notary Public

My County of Residence is:

Lake.

My Commission Expires:

May 13, 2015.

"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: DP

JESSICA ZABALA
Lake County
My Commission Expires
May 13, 2015

Prepaid by Suepatino

Vickie Sue Brown

Vickie Sue Brown, Affiant

Subscribed and Sworn to
Before me this day of
October 1, 2012.

Notary Public

My County of Residence is:

Lake

My Commission Expires:

May 13, 2015

JESSICA ZABALA
Lake County
My Commission Expires
May 13, 2015

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 002813 | EDR No 000000278879 | State No

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (if female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
JOAN M PORTER	TOLSON	FEMALE	11:10 AM	09/09/2012

5. Social Security Number	6a. Age - Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date of Birth (Month/Day/Year)	8. Birthplace (City and State or Foreign Country)
[redacted]	77	Months	Days	Hours	Minutes	01/19/1935	WALNUT RIDGE, AR

9. Ever in U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street and Number)	12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death	15. Surviving Spouse's Name
7351 MONTANA	HAMMOND, IN, 46323	LAKE	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown	

15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
	CAFETERIA	HAMMOND PUBLIC SCHOOL

18. Residence - State	18a. County	18b. City Or Town	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
INDIANA	LAKE	HAMMOND		46323	☒ Yes ☐ No

18c. Street And Number: 7351 MONTANA

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
HIGH SCHOOL GRADUATE OR GED COMPLETED	NOT HISPANIC	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
RAYMOND TOLSON	HELEN TOLSON	CRAIG

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
DEBRA PORTER	DAUGHTER	7351 MONTANA, HAMMOND, IN 46323

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	CHAPEL LAWN MEMORIAL GARDENS	SCHERERVILLE, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number
☐ Yes ☒ No	WHITE FUNERAL HOME & CREMATION SERVICE, 921 WEST 45TH AVENUE, GRIFFITH, IN 46319	FH10600026

27b. Signature Of Indiana Funeral Services Licensee:	27c. License Number (Or Licensee):
RAYMOND E. WHITE JR, BY ELECTRONIC SIGNATURE	FD08700086

Cause Of Death (See Instructions And Examples)

28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.

			Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. ADVANCED LUNG CANCER	Due to, or As a Consequence Of:	LESS THAN 3 YEARS
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last	B.	Due to, or As a Consequence Of:	
	C.	Due to, or As a Consequence Of:	
	D.		

SEP 12 2012

IS A TRUE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE INDIANA STATE DEPARTMENT OF HEALTH

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I

29. Was An Autopsy Performed?	30. Were Autopsy Findings Available To Complete The Cause Of Death?
☐ Yes ☒ No	☐ Yes ☐ No

31. Did Tobacco Use Contribute To Death?	32. If Female:	33. Manner Of Death:
☐ Yes ☐ Probably ☐ No ☒ Unknown	☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 year Before Death ☐ Unknown If Pregnant Within The Past Year	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ No

38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code

39. Describe How Injury Occurred

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Or Person Certifying Cause Of Death:	42. Certifier (Check Only One)	43. Title Of Certifier
LYLE R MUNN , BY ELECTRONIC SIGNATURE	☒ Certifying Physician ☐ Coroner ☐ Health Officer	44. License Number: 01031582A

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	45. Date Certified
LYLE R MUNN , 1190 NORTH STATE ROAD 49, PORTER, IN 46304	09/11/2012

47. *Akas:

46. Additional Funeral Service Provider:	49. For Registrar Only - Date Filed (Month/Day/Year)
	SEP 12 2012

48. Signature of Local Health Officer:
SUSAN W. BEST, VIA ELECTRONIC SIGNATURE

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

ocal No. 01057-07 State No. ....

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

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ECEDENT

1. DECEASED—NAME (First, Middle, Last): Cedric R. Porter
2. SEX: Male
3a. TIME OF DEATH: 11:41a.m.
3b. DATE OF DEATH (Month, Day, Yr): August 19, 2007
4. *SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Nov. 3, 1935
7. BIRTHPLACE (City and State or Foreign Country): Flint, Michigan
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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Joan Tolson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Wrapper
12b. KIND OF BUSINESS/INDUSTRY: Manufacturing
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7351 Montana
13e. ZIP CODE: 46323
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

RENTS

18. FATHER'S NAME (First, Middle, Last): Ray Porter
19. MOTHER'S NAME (First, Middle, Maiden Surname):

ORMANT

20a. INFORMANT'S NAME (Type/Print): Joan Porter
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7351 Montana Hammond, IN. 46323
20c. Relationship: Wife

POSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 23, 2007 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, IN.
22a. EMBALMER'S NAME: Raymond White
22b. EMBALMER'S LICENSE NO.: FD08700086
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Raymond White
24b. LICENSE NUMBER (of Licensee): FD08700086
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH10600026 White FH&Cremation Service 921 W.45th Ave.Griffith, IN.4631

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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. Advanced stage (STAGE IV) lung (Adenocarcinoma)
DUE TO (OR AS A CONSEQUENCE OF)
b.
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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.

AUG 22 2007

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Coronary Artery disease, Chronic obstructive pulmonary disease
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): N/A

FIER

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.: 25781
29d. DATE SIGNED (Month, Day, Year): 8-21-07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MOHAMMED ALI M.D. 1630 45TH ST. MUNSTER, IN. 46321

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31. HEALTH OFFICER'S SIGNATURE: Susan L. Best D.O.
32. DATE FILED (Month, Day, Year): August 22, 2007

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

SDH06-004 State Form 10110 (R5/1-99)