

GINA PIMENTEL
RECORDER
STATE OF INDIANA
LAKE COUNTY
RECORDED AS PRESENTED
2024-005090
1:44 PM 2024 Feb 1

STATE OF INDIANA)
) ss
COUNTY OF MARION)

SURVIVORSHIP AFFIDAVIT

3 Reginald Atkins and Alphanza A. Atkins, Brothers and Co-Affient's
Being first duly sworn upon oath deposes and says:

1. That Charles H. Atkins, Brother
(the "Decedent") died on December 07, 2018
at Robley Rex VA Medical Center, Louisville, KY 40206
(Death Certificate Attached Hereto):
2. That the Decedent and Reginald Atkins and Alphanza A. Atkins
were duly and legally equal co-owners to the following described real estate:

Legal Description:

LOTS 12 TO 16, BOTH INCLUSIVE, BLOCK 8, EAST ENGLEWOOD ADDITION TO EAST CHICAGO, IN THE CITY OF GARY, AS SHOW IN PLAT BOOK 2, PAGE 26, IN LAKE COUNTY, INDIANA.

PARCEL NOS.: 45-08-07-430-018.000-004 AND 45-08-07-430-019.000-004

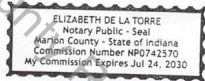
The address of such real estate is commonly known as: 1744-46 and 1754 Jennings Street, Gary, IN 46404

3. That they both request the respectful removal of Decedent Charles H. Atkins name from the above mentioned property.

Reginald Atkins
Signature of Co-Affient

Reginald Atkins

Type or Print Name



STATE OF INDIANA)
) ss
COUNTY OF MARION)

Before me, a Notary Public, in and for said County and State, personally appeared REGINALD ATKINS who acknowledged the execution of the forgoing Quit Claim Deed, and who, having been duly sworn, stated that any representation therein contained are true.

Witness my hand and Notarial Seal this 29th day of January, 2024.

My Commission Expires: Jul 24 2030

Notary Public

Elizabeth De la Torre
Printed

FILED

FEB 01 2024

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

25
CASH
D

"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: RA

PREPARED BY REGINALD ATKINS

SURVIVORSHIP AFFIDAVIT

Page 2

IN WITNESS WHERE OF, Co-Affiant Alphanza A. Atkins has executed this Survivorship Affidavit this 1st day of FEBRUARY, 2024.

Alphanza A. Atkins

Signature of Co-Affiant

Alphanza A. Atkins

Type or Print Name

STATE OF INDIANA)

) ss

COUNTY OF LAKE)

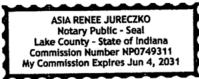
Before me, a Notary Public, in and for said County and State, personally appeared ALPHANZA A. ATKINS who acknowledged the execution of the forgoing Quit Claim Deed, and who, having been duly sworn, stated that any representation therein contained are true.

Witness my hand and Notarial Seal this 1st day of February, 2024.

My Commission Expires: Dec 04 2031

Asia Renee Jureczko
Notary Public

Asia Renee Jureczko
Printed



NOT AN OFFICIAL DOCUMENT

REGISTRAR OF VITAL STATISTICS

CERTIFIED COPY



5507303

116 201845776

Case #: E201812100085

KENTUCKY CERTIFICATE OF DEATH

14. DECEDENT'S LEGAL NAME (Print, Middle, Last) (Include AKA's if any) CHARLES H ATKINS				16. IF FEMALE, DECEDENT'S LAST NAME PRIOR TO FIRST MARRIAGE N/A		18. SEX MALE									
1. ACTUAL OR PRESUMED DATE OF DEATH (Month/Day/Year) (Print Month) December 07, 2018		4. SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE LAST BIRTHDAY (Years Months Days) 75		10. UNDER 1 DAY Hours: _____ Minutes: _____		6. DATE OF BIRTH (Month/Day/Year) 02/28/1943		7. COUNTY OF DEATH JEFFERSON					
11. PLACE OF DEATH (City and State) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> EPOC/Outpatient <input type="checkbox"/> Dead on Arrival OTHER: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input type="checkbox"/> Decedent's Residence <input type="checkbox"/> Other (Specify): _____				10. CITY OR TOWN, STATE AND ZIP CODE LOUISVILLE, KY 40206				13. SURVIVING SPOUSE (If wife, give name prior to first marriage) CLAUSTEN RICHMOND							
12. FACILITY NAME (If not institution, give street and number) ROBLEY REX VA MEDICAL CENTER				10. CITY OR TOWN, STATE AND ZIP CODE LOUISVILLE, KY 40206				13. SURVIVING SPOUSE (If wife, give name prior to first marriage) CLAUSTEN RICHMOND							
11. BIRTHPLACE (City and State or Foreign Country) BIRMINGHAM, ALABAMA				12. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married but Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown				13. SURVIVING SPOUSE (If wife, give name prior to first marriage) CLAUSTEN RICHMOND							
14. DECEDENT'S LEGAL OCCUPATION (Kind of work done during most of working life.) MAINTENANCE MECHANIC				15. KIND OF BUSINESS/INDUSTRY LEVER BROTHERS				16. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
17a. RESIDENCE - State INDIANA		17b. COUNTY LAKE		17c. CITY OR TOWN GARY		17d. STREET AND NUMBER 2399 HENDRICKS ST		17e. ZIP CODE 46404		17f. ANDEE CITY (LIMITED) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
18. DECEDENT'S EDUCATION (Check all that best describe the highest degree or level of school completed at the time of death.) <input type="checkbox"/> No Schooling <input type="checkbox"/> 8th - 12th Grade, No Diploma <input type="checkbox"/> High School Graduate (or GED Completed) <input type="checkbox"/> Some College/Graduate (No Degree) <input type="checkbox"/> Associates Degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's Degree (e.g., BA, BS, MA, MEd, MEd, MEd, MEd, MSW, MBA) <input type="checkbox"/> Masters (e.g., MEd, EdD) or Professional Degree (e.g., MD, DDS, DVM, LL.M., etc.)				19. DECEDENT OF HISPANIC OR LATINO DESCENT (Check one) (Do not check unless the decedent is of Spanish/Hispanic/Latino descent) <input type="checkbox"/> No (Do Not Specify Hispanic/Latino) <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify): _____				20. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean or Chamorro <input type="checkbox"/> Other (Specify): _____							
21. FATHER'S NAME (Print, Middle, Last) CHARLES ATKINS				25. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (Print, Middle, Last) MARY LEE RICHARDSON											
22. INFORMATANT NAME CLAUSTEN ATKINS				26. RELATIONSHIP TO DECEDENT SPOUSE				27a. MAILING ADDRESS (Street and Number, City, State, Zip Code) 2399 HENDRICKS STREET, GARY, IN 46404							
23. METHOD OF DISPOSITION (Check only one) <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Natural (See Note 1) <input type="checkbox"/> Other (Specify): _____				23. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) OAK HILL CREMATORY				23. LOCATION - City, Town, and State GARY, IN							
24. SIGNATURE OF FUNERAL SERVICE LICENSEE (Do not write in pencil) TIMOTHY R. BORDEN				DATE SIGNED (MM/DD/YYYY) 01/02/2019		25. KY LICENSE NUMBER (If known) 5364		26. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY T.E.S. 4810 PRODUCE RD LOUISVILLE, KY 40218							
28. DATE PROHIBITED DEAD (MM/DD/YYYY) 12/07/2018				29. ACTUAL OR PRESUMED TIME OF DEATH 1420		32. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
33. PART I. Enter the <u>cause</u> of death - disease, injuries, or complications - that caused death. DO NOT abbreviate. Enter only one cause on each line. Exclude without showing the etiology. DO NOT abbreviate. Enter only one cause on each line. ACUTE ON CHRONIC RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): a. EMPHATIC PULMONARY FIBROSIS (PPF) DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ e. _____ DUE TO (OR AS A CONSEQUENCE OF): f. _____				34. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined <input type="checkbox"/> Could not be Determined		35. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEK(S)									
36. PART II. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. None				37. HUSBAND OR WIFE PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				38. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown				39. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within past year			
40. DATE OF INJURY (Month/Day/Year) (Print Month) 12/07/2018				41. TIME OF INJURY 1420		42. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, school area) None		43. IF TRANSFERRED FROM OTHER FACILITY: <input type="checkbox"/> Transporter <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify): _____							
44. DESCRIBE HOW INJURY OCCURRED: None				45. LOCATION OF INJURY (Street and Number, City or Town, State, Zip Code) None											
46. TO BE COMPLETED BY CERTIFIER To the best of my knowledge, death occurred at the time, date, and place, and due to cause(s) and manner stated SIGNATURE JUAN GUARDIOLA, M.D. (Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to NRS 305.107 and NRS 306.118				47. DATE CERTIFIED (MM/DD/YYYY) 01/02/2019				48. TITLE OF CERTIFIER PHYSICIAN							
50. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (P01313) ROBLEY REX VA MEDICAL CENTER, 800 ZORN AVENUE, LOUISVILLE, KY 40206				51. REGISTRAR'S SIGNATURE Christina S. Stewart				52. DATE FILED (MM/DD/YYYY) 01/02/2019							

This is to certify that this is a true and correct copy of the certificate of birth, death, marriage or divorce of the person therein named, and that the original certificate is registered at the Kentucky Office of Vital Statistics under the file number shown.

DATE ISSUED 01/08/2019

Christina S. Stewart
State Registrar

FORM VS NO. 1-A
(REVISED 06/2015)



DOCUMENT CONTAINS A WATERMARK - HOLD UP TO LIGHT TO VIEW