

# NOT AN OFFICIAL DOCUMENT

GINA PIMENTEL  
RECORDER

2024-028843

STATE OF INDIANA  
LAKE COUNTY  
RECORDED AS PRESENTED

12:18 PM 2024 Sep 25

Mail Tax Bills To:

Return To:

Ralph E Thomas  
2124 E 20<sup>th</sup> Avenue  
Gary, IN 46407-1726

Ralph E Thomas  
2124 E 20<sup>th</sup> Avenue  
Gary, IN 46407-1726

## TRANSFER ON DEATH AFFIDAVIT

Ralph E Thomas, upon personal knowledge and belief, makes these statements:

1. **Maxine Thomas** died 12/09/2013, (a certified copy of the owner's death certificate is attached) owning an interest in the following described real estate in Lake County, Indiana:

### LEGAL DESCRIPTION:

Property Number: 45-08-14-205-021.000-004  
Marshalltown Terrace, Lot 3, Block 4, in Lake County Indiana  
Commonly known as: 2231 Wisconsin Street Gary, IN

2. On 02/27/2013, **Maxine Thomas** signed a Transfer on Death Deed transferring, on her death, her interest in the real estate described above which document was recorded on 02/28/2013 in the Office of the Recorder of Lake County, Indiana, as document number 2013 015467.
3. The designated beneficiary or beneficiaries in the Transfer on Death Deed and their addresses who did not survive Owner or were not in existence when Owner died are:

[N/A]

4. The designated beneficiary or beneficiaries in the Transfer on Death Deed and their addresses who survive the Owner or are in existence at Owner's death are:

[Ralph E Thomas 2124 E 20<sup>th</sup> Avenue Gary, IN 46407]

5. The purpose of this Affidavit is to comply with the requirements of IC 32-17-14-26(b)(20) to transfer on death Owner's interest in the real estate described above to the Transfer on Death Deed beneficiary.

In Witness Whereof, **Ralph E Thomas** has executed this instrument on

9-25-2024  
Date

Ralph E Thomas  
Signature  
Ralph E Thomas  
Printed Name

5/1  
CASH  
D

FILED

"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: [Signature]

SEP 25 2024



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INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tracing No. 413270

Local No 004295

EDR No 000001819587

State No 2013-060777

1. Decedent's Legal Name (First, Middle, Last) <b>MAXINE V THOMAS</b>		1a. Maiden Name (If Female) <b>HILLIARD</b>		2. Gender <b>Female</b>	3. Time Of Death <b>06:10 PM</b>	4. Date Of Death (Month/Day/Year) <b>12/09/2013</b>	
5. Social Security Number <b>[REDACTED]</b>	6a. Age - Yrs <b>91</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) <b>02/14/1922</b>	8. Birthplace (City and State or Foreign Country) <b>Eupora, Mississippi</b>
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In a Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival			10a. If Death Occurred Somewhere Other Than a Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)		
11. Facility Name (If Not Institution, Give Street and Number) <b>ST MARY MEDICAL CENTER INC</b>							
12. City or Town, State, and Zip Code <b>Hobart, Indiana 46342</b>				13. County Of Death <b>Lake</b>		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name			15a. Last Name Before First Marriage			16. Decedent's Usual Occupation <b>LIBRARIAN</b>	17. Kind Of Business/Industry <b>GARY COMMUNITY SCH</b>
18. Residence - State <b>IN</b>		18a. County <b>Lake</b>		18b. City Or Town <b>Gary</b>		18d. Apt. No.	18e. Zip Code <b>46407</b>
18c. Street And Number <b>2231 WISCONSIN Street</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
19. Decedent's Education <b>Bachelor's degree (e.g. BA, AB, BS)</b>				20. Decedent Of Hispanic Origin <b>Not Spanish/Hispanic/Latino</b>		21. Decedent's Race <b>Black or African American</b>	
22. Parent's Name (First, Middle, Last) <b>JAMES ITHICA HILLIARD</b>			23. Parent's Name (First, Middle, Last) <b>MATTIE HILLIARD</b>		23a. Parent's Last Name Before First Marriage <b>REDDING</b>		
24. Informant's Name <b>RALPH E THOMAS</b>		24a. Relationship To Decedent <b>Son</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>2124 E 20TH AVENUE, GARY, IN, 46407</b>			
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) <b>EVERGREEN MEMORIAL PARK</b>		25c. Location - City, Town, and State <b>Hobart, IN</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	27. Name And Complete Address Of Funeral Facility <b>GUY &amp; ALLEN FUNERAL DIRECTORS 2959 WEST 11TH AVENUE, GARY, INDIANA, 46404</b>			27a. Funeral Home License Number <b>FH83007704</b>			
27b. Signature Of Indiana Funeral Service Licensee <b>PATRICIA L OWENS</b>		Electronically Signed Cause of Death (See Instructions And Examples)		27c. License Number (Of Licensee) <b>FD06700298</b>		Approximate Interval: Onset To Death	
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.							
Immediate Cause (Final Disease Or Condition Resulting In Death)							
A. <b>RESPIRATORY ACIDOSIS</b>							
B. <b>RESPIRATORY FAILURE ETIOLOGY CHRONIC KIDNEY DISEASE STAGE I</b>							
C. <b>PLEURAL EFFUSION</b>							
D.							
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
31. Part II. Enter Other Significant Conditions Contributing To Death, But Not Resulting In The Underlying Cause Given In Part I							
<b>ANEMIA, CONGESTIVE HEART FAILURE, ATRIAL FIBRILLATION</b>							
32. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> No 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"/> Unknown If Pregnant Within The Past Year		33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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)		38c. Apt. No.	38d. Zip Code		
38. Location Of Injury - State	38a. City Or Town	38b. Street & Number					
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input checked="" type="checkbox"/> <b>NON-DRIVER UNLESS</b>	
41. Signature: Of Person Certifying Cause Of Death: <b>SHREYAS DESAI</b>				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		43. Date Certified <b>01/13/2014</b>	
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>SHREYAS DESAI 2640 HAMSTROM ROAD, FORT MONROE, IN 46306</b>				44. License Number <b>01027933A</b>		45. Date Certified <b>01/13/2014</b>	
46. Additional Funeral Service Provider:							
46. Signature of Local Health Officer: <b>JUSUK W. BESEY</b>				Electronically Signed		49. For Registrar Only: Date Filed (Month/Day/Year): <b>01/13/2014</b>	
<b>AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)</b>							

Property of State of Indiana

THIS IS A TRUE COPY Electronically Signed  
 THE RECORD ON FILE WITH THE  
 INDIANA STATE DEPARTMENT OF HEALTH  
 AUG 30 2024  
 LAKE COUNTY HEALTH OFFICER

RAISED SEAL AFFIXED

# NOT AN OFFICIAL DOCUMENT

## CERTIFICATE OF PROOF

WITNESS to the signature (s) on the foregoing instrument to which this Proof is attached.

[Signature]

Witness Signature

Caridad Colon

Witness Printed Name

PROOF:

STATE OF Indiana

COUNTY OF lake

Before me a Notary Public in and for said County and State, Dated on 09/25/24, personally appeared the above-named WITNESS to the foregoing instrument, who, being by me duly sworn, did depose and say that he/she knows WITNESS- Caridad Colon to be the individual(s) described in and who executed the foregoing instrument: that said WITNESS was present and saw said GRANTOR(S)- Ralph Thomas execute the same: and the said WITNESS at same time subscribed his/her name as a witness thereto

Brandie Flack

NOTARY PUBLIC SIGNATURE

Brandie Flack

NOTARY PRINTED NAME

Notary Name exactly as Commission

Notary Public- State of Indiana

Seal

My Commission Expires: August 18, 2027

Commission No: 0721842



**BRANDIE FLACK**  
Commission Number 0721842  
My Commission Expires  
August 18, 2027