

NOT AN OFFICIAL DOCUMENT

GINA PIMENTEL
RECORDER

2024-030708

STATE OF INDIANA
LAKE COUNTY
RECORDED AS PRESENTED

11:58 AM 2024 Oct 25

AFFIDAVIT OF SURVIVING SPOUSE

STATE OF INDIANA)
COUNTY OF Lake) SS:

Shirley A. Richardson

, being first duly sworn upon oath, deposes and says:

1. That John J. Richardson

^{S, P, R} died on MAY 12, 2010 at Gary, Indiana
A certified copy of the death certificate is attached

hereto as Exhibit A.

2. That John J. Richardson

and Shirley A. Richardson

were duly and legally married at the time they acquired title as husband and wife to the following described real estate, recorded on September 30, 1998 as Instrument # 2022-0325335, in the records of Lake

County, Indiana:

Tarrytown Second Subdivision, in the city of Gary - Block 9 - Lot 7
Plat Book 30, Page 86, Lake County Indiana

Property address: 2248 Williams St. Gary, Indiana 46404
Parcel ID: 45-08-18-105-018-000-004

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.

4. That Shirley A. Richardson

makes these representations to set forth the present ownership of title to the above real estate pursuant to IC 32-17-3-1(c).

Further affiant sayeth not.

Shirley A. Richardson
Affiant signature

Shirley A. Richardson
Print name

10-25-24
Date

FILED

OCT 25 2024

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Deeds.com

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1603582458
LK

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ACKNOWLEDGEMENT

STATE OF INDIANA)
COUNTY OF Lake) SS:

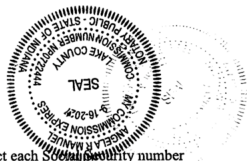
Before me, a notary public in and for said county and state, and a resident of Lake County, Indiana, personally appeared Shirley A. Richardson who acknowledged the execution of the foregoing instrument, and who, having been duly sworn, stated that any representations therein contained are true.

Witness my hand and notary seal this 25 day of October, 2024.

Notary signature: Angela R. Manuel

Print name: Angela R. Manuel

My commission expires: 9-16-2027



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. S. A. R.

This document was prepared and affirmation made by:

Coretta Duncan
Preparer's signature
Coretta Duncan
Print name

After recording, please return instrument to:

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INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No 001736

EDR No 00000187449

State No 2010-023263

1. Decedent's Legal Name (First, Middle, Last) JOHN J RICHARDSON				1a. Maiden Name (if female)		2. Gender Male		3. Time of Death 01:30 PM		4. Date of Death (Month/Day/Year) 05/12/2010		
5. Social Security Number [REDACTED]		7a. Age - Yrs 75		8a. Under 1 Year Months		8b. Under 1 Month Days		8c. Under 1 Day Hours		8d. Under 1 Hour Minutes		
7. Date of Birth (Month/Day/Year) 10/18/1934				8. Birthplace (City and State or Foreign Country) Arkansas								
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" 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 checked="" 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) ST ANTHONY HOSPICE-CROWN POINT												
12. City or Town, State, and Zip Code Crown Point, Indiana 46307						13. County of Death Lake			14. Marital Status At Time of Death <input checked="" 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 SHIRLEY RICHARDSON				15a. Last Name Before First Marriage COOKS				16. Decedent's Usual Occupation HOOKER		17. Kind of Business/Industry STEEL MILL		
18. Residence - State IN			18a. County Lake			18b. City or Town Gary			18c. Apt. No.		18d. Zip Code 46404	
18e. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			19c. Street and Number 2248 WILLIAMS Street			19d. Apt. No.			19e. Inside City Limits?			
19. Decedent's Education 8th grade or less				20. Decedent of Hispanic Origin Not Spanish/Hispanic/Latino				21. Decedent's Race Black or African American				
22. Parents' Names (First, Middle, Last) Unknown				23. Parents' Name (First, Middle, Last) WILLA MAE GRAHAM				23a. Parents' Last Name Before First Marriage RICHARDSON				
24. Informant's Name SHIRLEY RICHARDSON				24a. Relationship to Decedent Wife				24b. Mailing Address (Street and Number, City, State, Zip Code) 2248 WILLIAMS Street, Gary, IN, 46404				
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 Other (Specify)				25b. Place of Disposition (Name of Cemetery, Crematory, Other Place) OAKHILL CEMETERY				25c. Location - City, Town, and State Gary, IN				
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				27. Name And Complete Address Of Funeral Facility Powell-Coleman Funeral Home 3200 W. 15TH AVENUE, Gary, Indiana, 46404				27a. Funeral Home License Number FH10800011				
27b. Signature Of Indiana Funeral Service Licensee BOANNE E. TUGGLES				27c. License Number (Of Licensee) FD092400084				27d. License Number (Of Licensee)				
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. ESOPHAGEAL CANCER												
B. _____												
C. _____												
D. _____												
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input 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"/> Not Pregnant, But Pregnant Within 42 Days To Death <input type="checkbox"/> Pregnant, But Pregnant More Than 1 Year Before Death				33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				38. Location Of Injury - State				39a. City or Town				
39b. Street & Number				39c. Apt. No.				39d. Zip Code				
39. Describe How Injury Occurred												
40. If Transportation Injury, Specify: <input type="checkbox"/> Other Vehicle <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)												
41. Signature of Person Certifying Cause of Death KATHRYN Henkle MULLIGAN				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Medical Physician <input type="checkbox"/> NOT VALID UNLESS				43. Date Certified 05/19/2010				
43. Name, Address And Zip Code Of Person Certifying Cause of Death KATHRYN Henkle MULLIGAN 919 MAIN STREET, CROWN POINT, IN 46301				44. License Number				45. Date Certified				
44. Additional Funeral Service Provider				46. Signature of Local Health Officer SUSAN W. OREST				47. "Age" NOV 03 2011				
48. Signature of Local Health Officer				49. For Registrar Only - Date Filed (Month/Day/Year) 05/19/2010				50. For Registrar Only - Date Filed				

THIS IS A TRUE COPY Electronically Signed
 THE RECORD ON FILE WITH THE
 HEALTH DEPARTMENT
 NOV 03 2011
 LAKE COUNTY HEALTH OFFICER

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.

RAISED SEAL AFFIXED