

FILED

STATE OF INDIANA
COUNTY OF LAKE

OCT 14 1997

SS: SAM ORLICH
AUDITOR LAKE COUNTY

97069889

27-83-25

**AFFIDAVIT OF ESTABLISH SUCCESSOR TRUSTEE
OF SURUFKA TRUST**

Ann Surufka, being duly sworn upon her oath, deposes and says:

1. That she and her husband, Joseph F. Surufka, did on the 26th day of October 1993 as Grantors establish a Revocable Trust designated as the Surufka Trust with Joseph F. Surufka as Trustee.

2. Affiant further says that Paragraph 1.02 of Article I stated as follows:

1.02 Trustee - All reference in this Agreement to Trustee shall mean Joseph F. Surufka and/or Ann Surufka initially. Upon the death of the first, the Trustee shall thereafter mean the Survivor. Upon the death of the Survivor, the Trustee shall thereafter mean Michael James Senetar.

3. Affiant further says that affiant's husband, Joseph F. Surufka, died a resident of Lake County, Indiana, on the 15th day of May, 1994.

4. Affiant further says that pursuant to the terms of the Surufka Trust, affiant thereafter became the Successor Trustee of the Surufka Trust.

5. Affiant further says that the Revocable Trust Agreement was not revoked prior to the death of Joseph F. Surufka.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 OCT 17 AM 9:46
NOTES CENTER

212424

TICOR TITLE INSURANCE
Crown Point, Indiana

Return: C75,5311 Johnson Hand.

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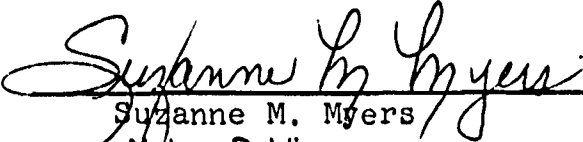
to
BLO
CP

Page 2 - Affidavit to Establish Successor Trustee
of Surufka Trust

Further affiant saith not.

✓ 
Ann Surufka

Subscribed and sworn to before me, a Notary Public, this 8th day of October,
1997.


Suzanne M. Myers
Notary Public

My commission expires:

11-28-97

Resident of LAKE County, IN

Prepared by:
Charles W. Weaver
Attorney at Law
NICHOLS, WALLSMITH & WEAVER
54 E Washington St
Knox, IN 46534
(219)-772-2900

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH OCT 6

State No.

Local No. 1131-94.....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) JOSEPH F. SURUFKA		2 SEX MALE	3a TIME OF DEATH 8:30 A	3b DATE OF DEATH (Month Day Yr) MAY 15, 1994	
4 SOCIAL SECURITY NUMBER 309-14-9994	5a AGE—Last Birthday (Years) 72	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Aug. 19, 1921	
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	8a WAS DECEDENT A U.S. VETERAN? YES				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		9a PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution give street and number) THE 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) Ann Senetar	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Shift Superintendent		12b KIND OF BUSINESS/INDUSTRY Oil Co.	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Highland	13d STREET AND NUMBER 3337 Highway		
13e ZIP CODE 46322	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify) U.S.A.	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12 College (1-4 or 5 +)
18 FATHER'S NAME (First Middle Last) Frank Surufka		19 MOTHER'S NAME (First Middle Maiden Surname) Agatha Synos			
20a INFORMANT'S NAME (Type/Print) Ann Surufka		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 3337 Highway Ave Highland, Indiana		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) May 18, 1994 Calumet Park Cemetery		21c LOCATION—City or Town State Merrillville, Indiana	
22a EMBALMER'S NAME David Peterson		22b EMBALMER'S LICENSE NO FDO 8601585		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500	
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					
IMMEDIATE CAUSE (First disease or condition resulting in death) Acute Myelogenous Leukemia DUE TO (OR AS A CONSEQUENCE OF)				Approximate interval Between Onset and Death	
Conditions if any which gave rise to the immediate cause stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
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)	
29a CERTIFIER <input checked="" 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 <i>[Signature]</i>			29c MEDICAL LICENSE NO 27970	29d DATE SIGNED (Month Day Year) MAY 17, 1994	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) SALMAN D. GAILANI, MD 9116 COLUMBIA AVENUE MUNSTER, IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams, MD</i>				32 DATE FILED (Month Day Year) May 17, 1994	
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)	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			

212424

PARENTS

INFORMANT

TIGOR TITLE INSURANCE
Crown Point, Indiana

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Return:
CFS
5311 Haven
Hnd.