MAIL TAXES TO
5076 OLD PLEASE ROAD
SOUTH FULTON, TN 38257

98075571

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

98 SEP 23 PM 1:05

MORRIS W. CARTER
RECORDER

THIS FORM HAS BEEN PREPARED FOR USE IN THE STATE OF INDIANA BY LAWYERS ONLY. THE SELECTION OF A FORM OF INSTRUMENT, FILLING IN BLANK SPACES, STRIKING OUT PROVISIONS, AND INSERTION OF SPECIAL CLAUSES, MAY CONSTITUTE THE PRACTICE OF LAW WHICH SHOULD ONLY BE DONE BY A LAWYER.

POWER OF ATTORNEY

FILED

SEP 23 1998

OF

VIRGINIA C. ROBINSON
PRINCIPAL

TO

DALE L. ROBINSON
ATTORNEY IN FACT

made under Indiana Code 30-5, as it may be amended, or replaced (the "Statute")

I, as principal, designate and name the person whose name appears above to be my attorney in fact.

A. **POWERS.** According to the Statute, an attorney in fact has a power granted under IC 30-5 if the power of attorney incorporates the power. Therefore, by referring to the language of the Statute describing powers, this Power of Attorney incorporates into it the powers here listed and confers general authority with respect to them:

real property transactions;	[IC 30-5-5-2]	fiduciary transactions;	[IC 30-5-5-10]
tangible personal property transactions;	[IC 30-5-5-3]	claims and litigation;	[IC 30-5-5-11]
bond, share, and commodity transactions;	[IC 30-5-5-4]	family maintenance;	[IC 30-5-5-12]
banking transactions;	[IC 30-5-5-5]	benefits from military service;	[IC 30-5-5-13]
business operating transactions;	[IC 30-5-5-6]	records, reports, and statements;	[IC 30-5-5-14]
insurance transacitons;	[IC 30-5-5-7]	estate transactions;	[IC 30-5-5-15]
beneficiary tarnsactions;	[IC 30-5-5-8]	all other matters.	[IC 30-5-5-19]
gift transactions;	[IC 30-5-5-9]		

[Note: Though the Statute grants powers with respect to health care [IC 30-5-5-16 and IC 30-5-5-17] and delegation [IC 30-5-5-18], this Power of Attorney does not include them. Health care can be provided in a separate power of attorney concerning health care.]

Any power I do not wish to incorporate into this Power of Attorney I have deleted by lining out and writing my initials opposite the deletion. Any power to be modified or added I have modified or added as follows: [and have verified by writing my initials in the space provided here in the margin].

_____ _____

_____ _____

IN FURTHERANCE OF THESE POWERS, I give my attorney in fact power to act on my behalf and to do for me and in my name those things which such attorney deems expedient to and necessary to effectuate the intent of this Power of Attorney, as fully as I could do for myself.

B. **RESERVATION OF POWER TO ACT AND TO REVOKE.** I reserve unto myself, however, the power to act on my own behalf and also to revoke or amend this Power of Attorney.

C. **CHAPTERS OF STATUTE ALSO APPLICABLE.** The following chapters of the Statute also apply to this Power of Attorney and acts performed under it:

Definitions [IC 30-5-2]
General Provisions [IC 30-5-3]
Duties [IC 30-5-6]
Reliance [IC 30-5-8]
Liabilities [IC 30-5-9]
Termination [IC 30-5-10]

D. **LIABILITY OF ATTORNEY IN FACT.** As permitted by IC 30-5-9-5, I, as principal, specifically provide that my attorney in fact is liable only if my attorney in fact acts in bad faith.

E. **RELIANCE ON POWER OF ATTORNEY.** In addition to provisions of the State regarding reliance, the holding institution(s) named in this Paragraph E and the banking institution named in Paragraph F may rely on this Power of Attorney being in effect unless I shall have executed a proper instrument revoking or changing it and delivered such instrument, or caused it to be delivered, to such person(s):

Holding Institution	Type of Account	Account Number

All other persons to whom this Power of Attorney may be delivered may rely on its being in effect unless I shall have executed a proper instrument revoking or changing it and recorded such instrument, or caused it to be recorded, in the Office of the Recorder of LAKE County, State of Indiana.

KEY NO. 27-18-235-19

00106

12.00
CS

F. SAFE DEPOSIT BOX. I have a safe deposit box, Number ____,

at ____.
(BANKING INSTITUTION) (BRANCH) (CITY)

I give my attorney in fact power to enter or have access to that box and to any other safe deposit box in my name either individually or jointly with any other person. I give the power also to remove property from such box or add property to it, and to relocate such box within the banking institution or at another. Powers here given are in addition to those incorporated into this Power of Attorney by reference.

G. DURATION OF POWER OF ATTORNEY. SELECT ONLY ONE OF THE FOLLOWING PROVISIONS BY STRIKING ALL INAPPLICABLE PROVISIONS: [in case of insufficient striking, provision a applies]:

a. This Power of Attorney is not terminated by my incapacity.

b. XXXXXXXXXXXXXXXXXXXXX ______________________ at ______________________
(DATE) (TIME)

c. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ______________________
(DATE)

X ______________, XXXXXXXXXXXX
(TIME)

H. REVOCATION OF PRIOR POWERS. I do/do not [strike one] revoke all powers of attorney I signed before the date of this Power of Attorney. Revocation does not affect the validity of an act performed under a prior power of attorney. In case of failure to strike, prior powers are revoked.

I. GUARDIANS. If protective proceedings for my person or for my estate, or for both, are commenced, I nominate Dale L. Robinson as guardian of my person, and Dale L. Robinson as guardian of my estate, to serve in each case without bond as may be permitted by law.

J. SUCCESSOR ATTORNEY IN FACT. As a successor to my attorney in fact I designate and name Shirley S. McClure Such succesor shall become my attorney in fact when the person(s) first designated and named has/have failed or ceased to serve as specified in the Statute, or has/have declined to serve.

By giving me written notice while I am not incapacitated, my attorney in fact may resign or decline to serve. During a period of my incapacity, my attorney in fact shall continue to serve until a successor attorney in fact is authorized to act under this Power of Attorney, whether designated and named in this Power of Attorney as such successor or selected by a court of competent jurisdiction to be such successor.

K. BINDING EFFECT. Any act or thing performed by my attorney in fact under this Power of Attorney binds me and my successors in interest, as the Statute provides.

Signed this 30th day of April, 1997, in 1 counterparts, each of which shall be considered an original.

Counterpart No. 1

Virginia C. Robinson
PRINCIPALS'S SIGNATURE

308-18-7492
PRINCIPAL'S SOCIAL SECURITY NUMBER

1027 W. 41st Place
PRINCIPAL'S STREET OR OTHER ADDRESS

Hobart, Indiana 46342
PRINCIPAL'S CITY, STATE AND ZIP CODE

STATE OF INDIANA, COUNTY OF LAKE SS:

Before me, the undersigned, a Notary Public in and for said County and State, this 30th day of April, 1997, personally appeared the principal named above, signed this Power of Attorney, and acknowledged the execution of it, as the voluntary act and deed of the principal, for the uses and purposes therein stated.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal the day and year last above written.

Ervin C. Carstensen
NOTARY PUBLIC'S SIGNATURE

ERVIN C. CARSTENSEN
NOTARY PUBLIC'S NAME, PRINTED OR TYPED

My Commission Expires: 6-29-97 Resident of Lake County.

This Instrument prepared by ERVIN C. CARSTENSEN, I.D.#3141-45, Attorney at Law.
503 Main Street, Hobart, Indiana 46342

MAIL TO:

State of Tennessee, Obion County
This instrument was filed July 8, 1998
Time 3:00 PM, and recorded in Misc Book 55-W
Page 438-439. State Tax paid $ — fee —
Rec. Fee $ 8.00 Total $ 10.00
Pre Fee 2.00
Register [signature] Receipt No. 7728
notebook 44 pg 172

Shirley McClure 5296 Old Pierce Rd. So Fulton TN 38257

7cc'a

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

Local No. 1792-98

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): DALE LEWIS ROBINSON
2. SEX: Male
3a. TIME OF DEATH: 4:30PM
3b. DATE OF DEATH (Month Day Yr): May 20, 1998
4. SOCIAL SECURITY NUMBER: 306-10-4194
5a. AGE - Last Birthday (Years): 82
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo Day Yr): January 22, 1916
7. BIRTHPLACE (City and State or Foreign Country): Wheeler, Indiana
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): St. Mary Medical Center
9c. CITY TOWN OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Virginia C. Frye
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Switchman
12b. KIND OF BUSINESS INDUSTRY: Railroad
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 1027 W. 41st Avenue
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Millard Robinson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Baker

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Virginia C. Robinson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1027 W. 41st Avenue, Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 23, 1998 McCool Cemetery
21c. LOCATION - City or Town State: Portage, Indiana
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

CAUSE OF DEATH

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. Ventricular tachycardia
DUE TO (OR AS A CONSEQUENCE OF)
b. Bleeding ulcer
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

SEP 23 1998

SAM ORLICH
LAKE COUNTY RECORDER

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): No

CERTIFIER

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: M. Gasparis
29c. MEDICAL LICENSE NO: 01037515
29d. DATE SIGNED (Month Day Year): 22 May 98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Milton Gasparis MD, 1400 S. Lake Park Avenue, Suite 301, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month Day Year): May 22, 1998

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

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

MAY 22 1998

001557

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER