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2000 003071

STATE OF INDIANA
LAKE COUNTY
FILED

2000 JAN 14 AM 11:14

RECORDED

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

ALICE M. RINKENBERGER, being duly sworn upon her oath, says that she is a resident of Lake County, Indiana; that she is the surviving spouse of Raymond F. Rinkenberger, who died on the 26th day of August, 1999, a resident of Lake County, Indiana; and

That affiant and said decedent were the sole Grantors, the Trustees, and the Beneficiaries of The Raymond F. Rinkenberger and Alice M. Rinkenberger Revocable Living Trust executed on the 10th day of May, 1993; and pursuant to said Raymond F. Rinkenberger and Alice M. Rinkenberger Trust, said Trust is now to be known as the "Survivor's Trust" and the affiant, Alice M. Rinkenberger, is the sole Trustee thereof; and

That included in said Raymond F. Rinkenberger and Alice M. Rinkenberger Revocable Living Trust, now Survivor's Trust, is certain real estate which the affiant, as said sole Trustee, intends to sell to Leon S. Tokarz, Jr. and Dawn L. Tokarz, husband and wife; which real estate, situated in Lake County, Indiana, is described as follows, to-wit:

Part of the East Half (E-1/2), West Half (W-1/2) Section Twelve (12), Township Thirty-Three (33) North, Range Eight (8) West of the Second Principal Meridian, described as follows: Commencing at the Southwest (SW) corner of the Northeast

FILED

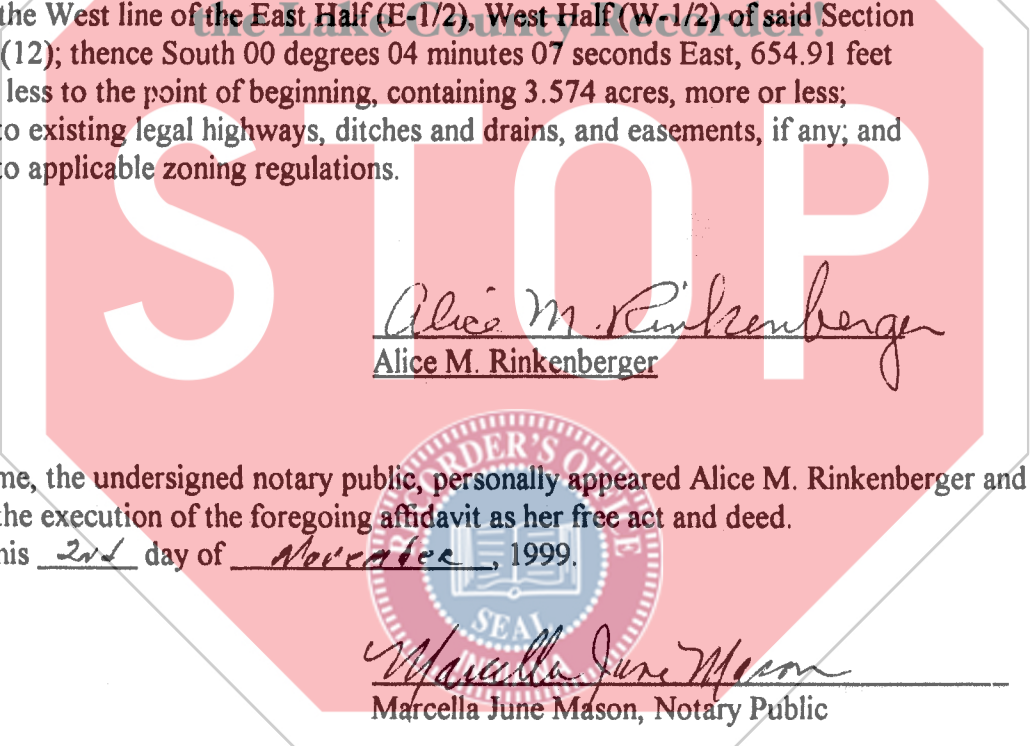
JAN 13 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

20V
1300
4008

25 x 17

Quarter (NE-1/4), Southwest Quarter (SW-1/4) of said Section Twelve (12);
thence North 00 degrees 04 minutes 07 seconds West along the West line of the
East Half (E-1/2), West Half (W-1/2) of said Section Twelve (12) a distance of
1623.07 feet; thence South 89 degrees 24 minutes 50 seconds East, 454.69 feet to
the point of beginning of this described parcel; thence continuing South 89 degrees
24 minutes 50 seconds East, 287.82 feet more or less to a line 45 rods East of the
West line of the East Half (E-1/2), West Half (W-1/2) of said Section Twelve (12);
thence North 00 degrees 04 minutes 07 seconds West, 426.88 feet more or less to
the center line of South Grove Road; thence North 50 degrees 24 minutes 39
seconds West along said center line, 369.39 feet more or less to a line 454.69 feet
East of the West line of the East Half (E-1/2), West Half (W-1/2) of said Section
Twelve (12); thence South 00 degrees 04 minutes 07 seconds East, 654.91 feet
more or less to the point of beginning, containing 3.574 acres, more or less;
subject to existing legal highways, ditches and drains, and easements, if any; and
subject to applicable zoning regulations.


Alice M. Rinkenberger
Alice M. Rinkenberger

Before me, the undersigned notary public, personally appeared Alice M. Rinkenberger and
acknowledged the execution of the foregoing affidavit as her free act and deed.

Dated this 2nd day of November, 1999.


Marcella June Mason
Marcella June Mason, Notary Public

My Commission Expires:
January 18, 2001.

Resident County: Porter.

This Instrument Prepared By: THEODORE A. FITZGERALD, Atty. No. 6903-64
Hebron, IN 46341

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* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

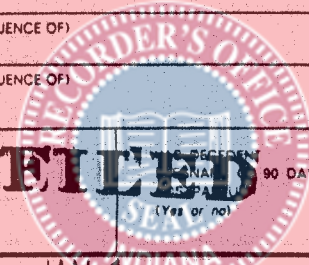
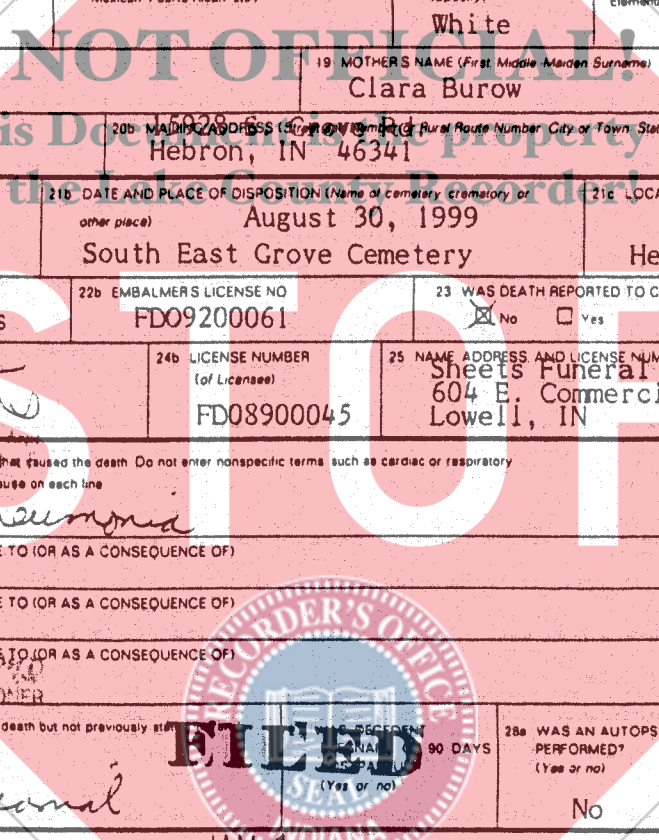
State No.

Local No. 2000-99

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Raymond F. Rinkenberger		2 SEX Male	3a TIME OF DEATH 01:45P	3b DATE OF DEATH (Month, Day, Yr) August 26, 1999
4 SOCIAL SECURITY NUMBER 304-34-3928	5a AGE—Last Birthday (Year) 78	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Apr 5, 1921
7 BIRTHPLACE (City and State or Foreign Country) Hebron, IN		8a WAS DECEDENT A U.S. VETERAN? Yes		
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		9a PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <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) St. Marys Medical Center		9c CITY, TOWN OR LOCATION OF DEATH Hobart	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife give maiden name) Alice Becker	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired). Farmer	12b KIND OF BUSINESS/INDUSTRY Farming	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hebron	13d STREET AND NUMBER 15928 S. Grove Rd.	
13e ZIP CODE 46341	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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) 12 College (14 or 8+)		18 FATHER'S NAME (First, Middle, Last) William Rinkenberger		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Clara Burow		20a INFORMANT'S NAME (Type/Print) Alice Rinkenberger		
20b MAILING ADDRESS (City, State, Zip Code) Hebron, IN 46341		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) August 30, 1999 South East Grove Cemetery		21c LOCATION—City or Town, State Hebron, IN
22a EMBALMER'S NAME Molly E. Tucker Hawkins		22b EMBALMER'S LICENSE NO. FDO9200061	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) FD08900045	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN	
26 PART I: Enter the disease, 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. HEALTH DEPT. Pneumonia IMMEDIATE CAUSE (Final disease or condition resulting in death) SEP 02 1999 DUE TO (OR AS A CONSEQUENCE OF) Conditions if any which gave rise to the immediate cause stating the underlying cause last Alexander & Wilkins, M.D. DUE TO (OR AS A CONSEQUENCE OF) ALEXANDER & WILKINS, M.D. LAKE COUNTY HEALTH COMMISSIONER				
PART II: Other significant conditions. Conditions contributing to death but not previously stated. Intra cerebral bleed. Aneurysm - intracranial				
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 (Check only one) <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> PETER BENJAMIN LAKE COUNTY AUDITOR		29c MEDICAL LICENSE NO. 1031652	29d DATE SIGNED (Month, Day, Year) 8/31/99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Dr. Charles Rebesco, 1400 S. Lake Park Ave., Suite 405, Hobart, IN 46342				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> Alexander & Wilkins, M.D.				32 DATE FILED (Month, Day, Year) September 2 1999
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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. (0)775		



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

25x10