

FILED

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD **MAR 22 2000**

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PETER BENJAMIN
LAKE COUNTY AUDITOR

MORRIS W. CAMBER
RECORDER

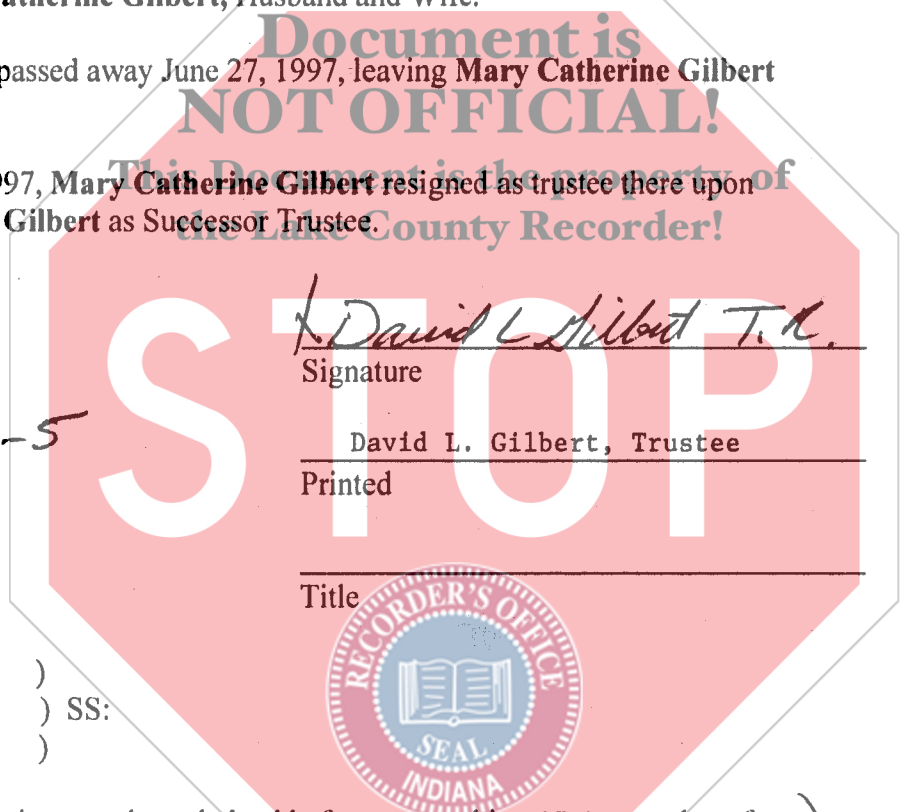
AFFIDAVIT

I, **David L. Gilbert**, hereby certify the following to be true and correct.

The Gilbert Living Trust was created July 2, 1992 naming Co-trustees as **Sanford L. Gilbert** and **Mary Catherine Gilbert**, Husband and Wife.

Sanford L. Gilbert passed away June 27, 1997, leaving **Mary Catherine Gilbert** trustee.

On September 16, 1997, **Mary Catherine Gilbert** resigned as trustee there upon appointing **David L. Gilbert** as Successor Trustee.



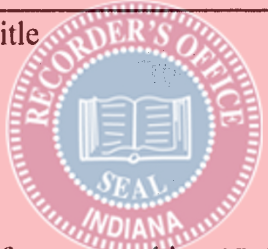
David L. Gilbert T.R.
Signature

David L. Gilbert, Trustee
Printed

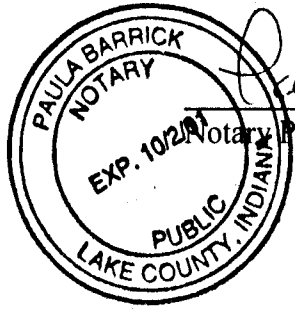
Title

Key # 11-160-5

State of INDIANA)
) SS:
County of LAKE)



The foregoing Affidavit was acknowledged before me on this 17th day of March, 2000 by David L. Gilbert



Paula Barrick
Notary Public Paula Barrick

My Commission Expires:
10-2-01

County of Residence:
Lake

01457 11.00
 E.P.
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This document was prepared by: **David L. Gilbert**

Ticor M.O. 920000869 **Gilbert**

C. UETS

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

File No. 1374-97

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

REPRINT IN PERMANENT INK

DECEDENT

INFORMANTS

FORMANT

POSITION

USE OF HEALTH

CERTIFIER

HEALTH OFFICER

Key # 11-160-5

1 DECEASED—NAME (First, Middle, Last) Sanford L. Gilbert		2 SEX Male	3a TIME OF DEATH 11:20 P M	3b DATE OF DEATH (Month, Day, Yr) June 27, 1997	
4 SOCIAL SECURITY NUMBER 262-36-4941	5a AGE—Last Birthday (Years) 66	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Dec 30, 1930	
7 BIRTHPLACE (City and State or Foreign Country) Florida	8a WAS DECEDENT A U.S. VETERAN? Yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1953		
9a FACILITY NAME (If not institution, give street and number) 8810 Patterson Street		9b CITY, TOWN, OR LOCATION OF DEATH St. John		9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Mary Catherine Parker	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Salesman		12b KIND OF BUSINESS/INDUSTRY Sales	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION St. John	13d STREET AND NUMBER 8399 Patterson		
13e ZIP CODE 46373	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) White	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) Sanford Gilbert			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Buelah Cranger		20a INFORMANT'S NAME (Type/Print) Mary Catherine Gilbert			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8399 Patterson St. John, IN 46373		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) July 3, 1997 Lowell Memorial Cemetery		21c LOCATION—City or Town, State Lowell, IN	
22a EMBALMER'S NAME Kenneth P. Sheets		22b EMBALMER'S LICENSE NO. FD08900045	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ken Sheets</i>		24b LICENSE NUMBER (of Licenses) 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 diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as "aspirator" or "apoplexy". List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Extensive blunt force trauma				Approximate Interval Between Onset and Death Unknown	
Conditions if any which gave rise to the immediate cause, stating the underlying cause last					
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) Yes		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes	
29a CERTIFIER (Check only one) Deputy <input 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 checked="" 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 MEDICAL LICENSE NO. N/A		29c DATE SIGNED (Month, Day, Year) July 1, 1997	
29a SIGNATURE AND TITLE OF CERTIFIER <i>Charles L. ...</i>					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>					
THIS CERTIFIES THAT ABOVE IS A COMPLETE COPY OF THE ORIGINAL CERTIFICATE OF DEATH.					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" 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) June 27, 1997	34b TIME OF INJURY Unknown	34c INJURY AT WORK? (Yes or no) No	34d DESCRIBE HOW INJURY OCCURRED Vehicle accident. Lost control passing a car, struck utility pole, ejected from auto.
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) Street		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 8810 Patterson Street St. John, Indiana			
34g DATE PRONOUNCED DEAD (Month, Day, Year) June 27, 1997		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. Yes 01488 Driver		LAKE COUNTY HEALTH COMMISSIONER <i>Alexander S. Williams, M.D.</i>	