

2

CERTIFICATION

Delia Dworak AND -FILED- after being first duly sworn upon their oath, state and certify as follows:

- 2000 052773
1. That ~~they are~~ <sup>she is</sup> the duly appointed ~~and acting~~ <sup>Trustee</sup> to the Adolph Dworak dated \_\_\_\_\_;
  2. That the \_\_\_\_\_ Trust is in existence and is in full force and effect;
  3. That there have been ~~no~~ <sup>3 (5/2/95, 9/20/95 & 12/28/99)</sup> amendments made to the Trust since its creation; and the entire trust has been amended & restated as of \_\_\_\_\_ of \_\_\_\_\_
  4. That as of the date hereof, ~~they have~~ <sup>she has</sup> not received any written notices or directions of any amendment, rescission or revocation of the trust; <sup>6/13/00</sup>
  5. That ~~they~~ <sup>she</sup> make this Certification for the purpose of showing the current status of the Adolph Dworak and Delia Dworak dated 4/28/93; and they have the right to act for and on behalf of the Trust. <sup>she</sup>
  6. SEE BELOW
- IN WITNESS WHEREOF, We have executed this Certification this 21st day of July, ~~19~~ <sup>2000</sup>

6. Pursuant to the direction of the beneficiary/beneficiary of the above captioned trust, you are hereby authorized & directed to pay all proceeds to: Delia Dworak  
Delia Dworak

LEGAL: Lot 5 in Block F in Meadowland Manor Unit 2 as per plat thereof recorded in Plat Book 31, page 97 in the Office of the Recorder of Lake County, Indiana

STATE OF INDIANA )  
 ) SS:  
 COUNTY OF LAKE )

PETER BENJAMIN  
 LAKE COUNTY AUDITOR

Before me, a Notary Public in and for said County and State, this 21st day of July, ~~19~~ <sup>2000</sup>; personally appeared Delia Dworak and \_\_\_\_\_ who acknowledged the execution of the foregoing instruments as their free and voluntary act.

Given under my hand and notarial seal this 21st day of July, ~~19~~ <sup>2000</sup>.

My Commission Expires:  
11/11/01

Jennifer Arcus  
 A Resident of LAKE County, IN  
 NOTARY PUBLIC

This instrument was prepared by: Delia Dworak

01517

*R<sup>00</sup>/<sub>Ac</sub>*

HOLD FOR FIRST AMERICAN TITLE

①

F32335

25 X 17

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2595-93

CERTIFICATE OF DEATH

State No. ....

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) <b>ADOLF DWORAK</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>10:10 AM</b>	3b DATE OF DEATH (Month Day Yr) <b>November 6, 1993</b>	
4 SOCIAL SECURITY NUMBER <b>313-34-2954</b>	5a AGE—Last Birthday (Years) <b>77</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>April 16, 1916</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Godno, Poland</b>	8a WAS DECEDENT A US VETERAN? <b>No</b>				
8b YEAR LAST SERVED IN US ARMED FORCES? <b>--</b>		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) <b>Methodist Hospital - Southlake Campus</b>		9c CITY TOWN OR LOCATION OF DEATH <b>Merrillville</b>	9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>Delia Peters</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Crane Operator</b>	12b KIND OF BUSINESS/INDUSTRY <b>U.S. Steel</b>		
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Merrillville</b>	13d STREET AND NUMBER <b>5345 Delaware Street</b>		
13e ZIP CODE <b>46410</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
18 FATHER'S NAME (First Middle Last) <b>unknown</b>		19 MOTHER'S NAME (First Middle Maiden Surname) <b>Valerie Dworak</b>			
20a INFORMANT'S NAME (Type/Print) <b>Delia Dworak</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) <b>5345 Delaware St., Merrillville, IN 46410</b>	20c Relationship <b>Wife</b>		
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) <b>November 9, 1993 Calumet Park Cemetery</b>		21c LOCATION—City or Town State <b>Merrillville, Indiana</b>	
22a EMBALMER'S NAME <b>Charles W. Wells</b>		22b EMBALMER'S LICENSE NO <b>1042372</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Pruzin</i>		24b LICENSE NUMBER (of Licensee) <b>1009893</b>	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>PRUZIN BROS. FUNERAL SERVICE #300245 6360 Broadway, Merrillville, IN 4641</b>		
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. <b>Serious</b> a DUE TO (OR AS A CONSEQUENCE OF) <b>Aspirin overdose pneumonia</b> b DUE TO (OR AS A CONSEQUENCE OF) <b>Stroke</b> c DUE TO (OR AS A CONSEQUENCE OF) <b>Serious end stage Rheumatoid arthritis</b> d					
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) <b>No</b>		28a WERE AUTOPSY FINDINGS PERFORMED? (Yes or no) <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
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>Don H. Kim MD</i> <b>LAKE COUNTY AUDITOR</b>			
29c MEDICAL LICENSE NO <b>01036861</b>		29d DATE SIGNED (Month Day, Year) <b>11/8/93</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>John H. Kim, M.D., 6111 Harrison #208, Merrillville, IN 46410 (219) 887-7325</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i> <b>LAKE COUNTY HEALTH COMMISSIONER</b>					
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 <b>JUL 21 2000 1518</b>
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) <i>Alexander S. Williams MD</i> <b>LAKE COUNTY HEALTH COMMISSIONER</b>			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc <b>F32335 HOLD FOR FIRST AMERICAN TITLE</b>			

DECEDENT

PARENTS

INFORMANT

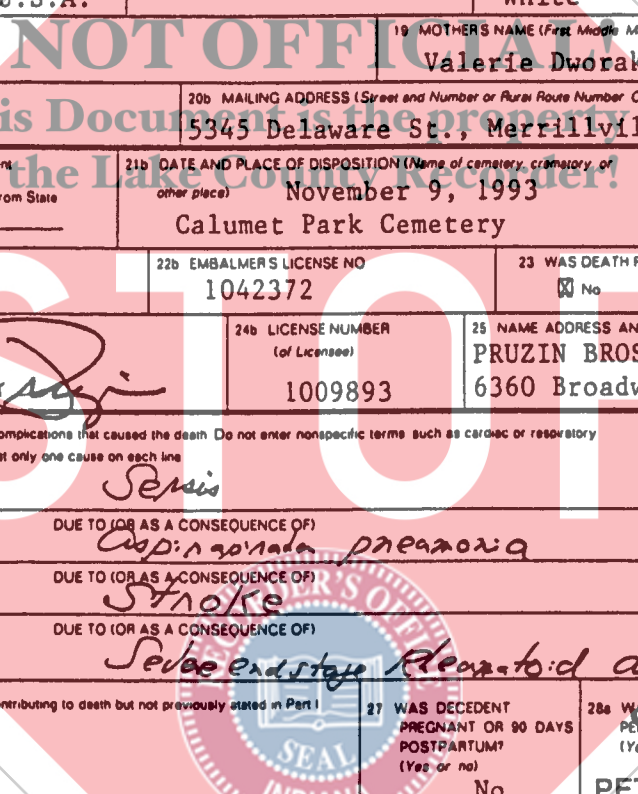
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



FILED

JUL 26 2000