AFFIDAVIT

STATE OF INDIANA) 2002 060112
) SS:
COUNTY OF LAKE)

2002 JUL -5 AM 9:41

MORRIS J. CARTER
RECORDER

JENI L. CARLEY, being first duly sworn upon her oath, deposes and says:

1. That JAMES R. CARLEY died on MARCH 28, 2002, a resident of Lake county, State of Indiana. A certified copy of his death certificate is attached hereto as "Exhibit A"

2. That at the time of his death, JAMES R. CARLEY was the Trustee of the James R. Carley, Living Trust as Restated November 29, 1988..

3. That said TRUST is the owner of the following described real estate:

THE SOUTH 5 FEET OF LOT 9 AND THE NORTH 35 FEET OF LOT 10, BLOCK 2, WISTERIA A REDIVISION OF QUINTON TERRACE IN HAMMOND AS SHOWN IN PLAT BOOK 29, PAGE 4 IN LAKE COUNTY INDIANA.
Commonly known as : 7539 Oakdale, Hammond, IN 46323

4. That the undersigned became the Successor Trustee of the said James R. Carley Living Trust as Restated November 29, 1988, upon the death of JAMES R. CARLEY on March 28, 2002, and accepted the appointment as Successor Trustee of said Trust.

Jeni Carley
JENI L. CARLEY

FILED
JUL 5 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

Subscribed and Sworn to before, me a Notary Public, on this 16 day of April, 2002.

Patricia A. Giancola
Notary Public
My Commission Expires:

"OFFICIAL SEAL"
PATRICIA A. GIANCOLA
NOTARY PUBLIC, STATE OF INDIANA
MY COMMISSION EXPIRES JULY 31, 2009

Resident of Lake County.

MAIL TO
Thomas L. Kirsch
Atty. at Law
131 Ridge Road
Munster, In. 46321

11.50
17016

"EXHIBIT A"

* **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

Local No. 89 ..... CERTIFICATE OF DEATH ..... State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
JAMES R. CARLEY	Male	07:10 AM M	March 28, 2002

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
314-01-2896	82			May 26, 1919	HAMMOND, INDIANA

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
YES	1946	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. CATHERINE HOSPITAL	East Chicago	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	JENI SHERER	FORMER CO-OWNER	Carley's Best Movers

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	HAMMOND	6431 New Hampshire Avenue

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46323	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	WHITE	Elementary/Secondary (0-12): 12	College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
L. GRANT CARLEY	PEARL O'NEIL

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
JENI CARLEY	6431 New Hampshire Avenue, HAMMOND, IN 46323	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Apr 1, 2002 ELMWOOD CEMETERY	HAMMOND IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
C. WILLIAM MCCOY	FDO1013612	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FDO1013507	BOCKEN FUNERAL HOME, INC. FH83002801 7042 KENEDY AVENUE, HAMMOND, IN

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. descending colon cancer	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): cardiac dysrhythmia	
	c. DUE TO (OR AS A CONSEQUENCE OF): CHF	
	d. DUE TO (OR AS A CONSEQUENCE OF): COPD	

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
[signature]	01032460A	4-2-02

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
SAMI AHMADZAI, M.D. 6924 INDIANAPOLIS AVENUE, HAMMOND, IN 46324-

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Dr. Timothy Bayhorick	4/2/02

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

SDH06-004 State Form 10110 (R5/1-99)