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AFFIDAVIT

The below signed person, MARIAN SAVAGE, affirms or swears the following:

- 1. She was named successor trustee of the LUCILLE J. WASIL REVOCABLE LIVING TRUST DATED JUNE 23, 1999;
- 2. The grantor, LUCILLE J. WASIL, retained a life estate in real estate transferred to the trust, which real estate is described as:

Lot 6 and the East 2 feet of Lot 5, Block 4, Fairview Heights, in the City of Crown Point, as shown in Plat Book 30, page 81 in Lake County, Indiana

- 3. The grantor, LUCILLE J. WASIL, deceased July 25, 2002;
- 4. There is no longer a life estate remaining in the above described property;
- 5. MARIAN SAVAGE is the designated successor trustee, and she is now serving as the trustee;
- 6. As trustee, MARIAN SAVAGE has full authority and power to dispose of any and all assets of the trust as so authorized in the trust.

I SO SWEAR OR AFFIRM UNDER THE PENALTIES OF LAW FOR PERJURY OF THE STATE OF INDIANA.

DATE: 11/1/02 Marian Savage
MARIAN SAVAGE

WITNESSES

[Signature]
[Signature]

STATE OF INDIANA)
COUNTY OF LAKE)

This Document is the property of the Lake County Recorder!

Before me the undersigned notary public for the state and county above stated, appeared MARIAN SAVAGE, who signed this document of her own free will and intent and for the purposes purported therein, all done on the date below signed by me.

DATE: 11/1/02 Cristine A Keller NOV 21 2002

PRINT: CRISTINE A KELLER
NOTARY PUBLIC

PETER BENJAMIN
LAKE COUNTY AUDITOR
RESIDENT OF THE COUNTY OF LA PORTE
COUNTY

MY COMMISSION EXPIRES: 07/15/10



001633

Document prepared by: Dan R. Hill, Attorney, 7517-45, 218 W. Washington, #430, South Bend, IN 46601 574/246-9999

2002 107254

2002 NOV 22 AM 9:09

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDER

MORRIS W. CARTER
RECORDER



9-238-6 (23)

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920025481

12.00
XP

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

(12)

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 122702
416126

State No.....

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

9-238-6 (23)

1. DECEASED - NAME (First, Middle, Last) Lucille Wasil		2. SEX Female	3a. TIME OF DEATH 11:10 AM	3b. DATE OF DEATH (Month, Day, Yr.) July 25, 2002
4. SOCIAL SECURITY NUMBER 317-09-5839		5a. AGE - Last Birthday (Years) 85	5b. UNDER 1 YEAR Months: Days: 0 0	5c. UNDER 1 DAY Hours: Minutes: 0 0
6. DATE OF BIRTH (Mo., Day, Yr.) November 26, 1916		7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana		
8a. WAS DECEASED A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) 436 Fairview Ave.		9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) N/A	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Crown Point	13d. STREET AND NUMBER 436 Fairview Ave.	
13e. ZIP CODE 46307	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEASED 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. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		18. FATHER'S NAME (First, Middle, Last) Matthew Macko		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Walko		20a. INFORMANT'S NAME (Type/Print) Marian Savage		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12839 Woodbury Dr., Plymouth, IN 46563		20c. Relationship Daughter		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) 7/27/02 Calvary Cemetery		21c. LOCATION - City or Town, State Portage, Indiana
22a. EMBALMER'S NAME Not Applicable		22b. EMBALMER'S LICENSE NO. Not Applicable		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry Sever</i>		24b. LICENSE NUMBER (of Licensee) FDO9000013		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home FH19900060 109 N. East St., Crown Point, Indiana
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary artery disease</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Conditions, if any, which gave rise to the immediate cause stating the underlying cause last		Approximate Interval Between Onset and Death NOV 21 2002		
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I		27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	28b. WERE AUTOPSY FINDINGS COMPLETE? (Yes or no) 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>Joseph C. Samyn M.D.</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Joseph C. Samyn M.D. 1205 S. Main St., Crown Point, IN 46307		29c. MEDICAL LICENSE NO. 31090278		29d. DATE SIGNED (Month, Day, Year) 7/25/02
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. East</i>		32. DATE FILED (Month, Day, Year) July 26, 2002		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34d. DESCRIBE HOW INJURY OCCURRED <i>0016</i>		
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.				



FILED

NOV 21 2002

PETER BENJAMIN LAKE COUNTY AUDITOR