

PERSONAL REPRESENTATIVE'S DEED

THIS INDENTURE WITNESSETH that Patricia A. Kulavic, as personal representative of the Supervised Estate of Carol R. Galster, deceased, who was not married at the time of her death, under Cause No. 45D01-0403-ES-00037, for good and sufficient consideration, conveys to Gregory M. Adams and Sara B. Adams, husband and wife, the following real estate:

2004050400000000

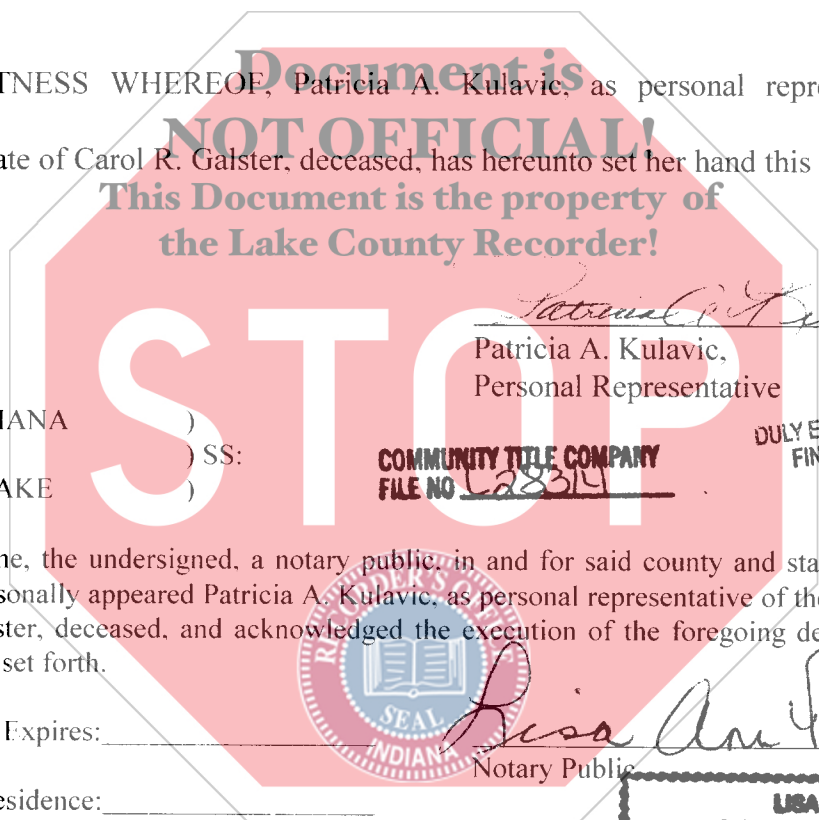
Commonly known as 8636 Hohman Avenue, Munster, Indiana 46321.
Key No. 18-28-0189-0023.

The South Ten (10) Feet of Lot Twenty-Three (23), the North Fifty-Five (55) Feet of Lot Twenty-Two (22), Block Three (3), Knickerbocker Manor Sixth Addition to the Town of Munster, Lake County, Indiana, as shown in Plat Book 31, Page 101 in Lake County, Indiana.

Subject to unpaid taxes, building lines, highways, streets, alleys, easements, covenants, liens, conditions and restrictions of record.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

IN WITNESS WHEREOF, Patricia A. Kulavic, as personal representative of the Supervised Estate of Carol R. Galster, deceased, has hereunto set her hand this 23rd day of April, 2004.



Patricia A. Kulavic
Patricia A. Kulavic,
Personal Representative

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

COMMUNITY TITLE COMPANY
FILE NO. L28314

DULY ENTERED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER
MAY 4 2004

Before me, the undersigned, a notary public, in and for said county and state of Indiana, on the 23rd day of April, 2004, personally appeared Patricia A. Kulavic, as personal representative of the Supervised Estate of Carol R. Galster, deceased, and acknowledged the execution of the foregoing deed for the use and purposes therein set forth.

STEPHEN RISTIGLICH
LAKE COUNTY AUDITOR
000152

My Commission Expires: _____
My County of Residence: _____

Lisa Ann Ross
Notary Public

LISA ANN ROSS
NOTARY PUBLIC - INDIANA
My Commission Expires 10/28/11

Printed Name _____

This document prepared by: Gilbert F. Blackmun, Blackmun, Bomberger, Moran & Tyler, 9006 Indianapolis Boulevard, Highland, Indiana 46322.

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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

Local No. 043-01
33028

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

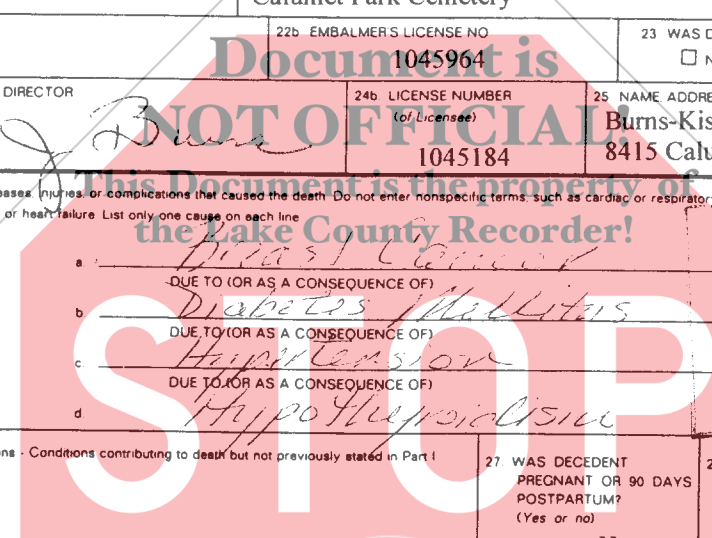
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Carol R. Galster		2 SEX Female	3a TIME OF DEATH 8:45P	3b DATE OF DEATH (Month, Day, Yr.) January 23, 2004
4. *SOCIAL SECURITY NUMBER 310-36-5637	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) January 23, 1936
7 BIRTHPLACE (City and State or Foreign Country) Gary, IN	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a 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"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence	
9b FACILITY NAME (If not institution, give street and number) 8636 Hohman Ave.		9c CITY, TOWN OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Never Married	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) Personnel Manager	12b KIND OF BUSINESS/INDUSTRY Prudential	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Munster	13d STREET AND NUMBER 8636 Hohman Ave.	
13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input 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) Ernest Galster		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Freida Beister		20a INFORMANT'S NAME (Type/Print) Patricia L. Ashmore		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Henry Ct., Hobart, IN 46342		20c Relationship Niece		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) January 28, 2004 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, IN
22a EMBALMER'S NAME James Porras		22b EMBALMER'S LICENSE NO. 1045964		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of licensee) 1045184		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home Lic # 3004968 8415 Calumet Ave, Munster, IN 46321-2521
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a Heart Failure b Diabetes Mellitus c Hypertension d Hypothyroidism 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) 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>			29c MEDICAL LICENSE NO. X01041301	29d DATE SIGNED (Month, Day, Year) 1/27/04
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Cheryl Morgan-Irby, M.D. 1630 45th Munster, IN 46321				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) January 28, 2004
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.		



Document is NOT OFFICIAL

STOP

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH AS FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT ON JAN 28 2004