

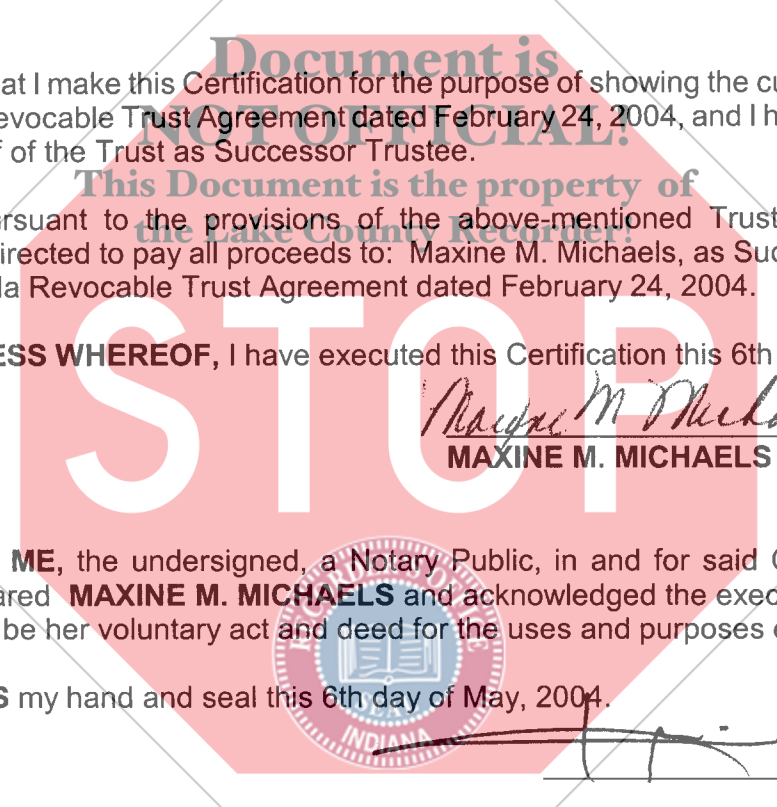
TRUST CERTIFICATION

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

2004
050776

MAXINE M. MICHAELS, after being duly sworn upon her oath, states and certifies as follows:

1. That she is the duly appointed and acting Successor Trustee to the Jean F. Chirila Revocable Trust Agreement dated February 24, 2004.
2. That the Jean F. Chirila Revocable Trust Agreement dated February 24, 2004 is in existence and is in full force and effect.
3. That there have been no amendments made to the Trust since its creation.
4. That as of the date hereof, she has not received any written notices or directions of any amendments, rescission or revocation of the Trust.
5. That the Settlor of the Trust, Jean F. Chirila, passed away on March 12, 2004 and that her Death Certificate is attached hereto as Exhibit "A" and incorporated herein by reference.
6. That I make this Certification for the purpose of showing the current status of the Jean F. Chirila Revocable Trust Agreement dated February 24, 2004, and I have the right to act for and on behalf of the Trust as Successor Trustee.
7. Pursuant to the provisions of the above-mentioned Trust, you are hereby authorized and directed to pay all proceeds to: Maxine M. Michaels, as Successor Trustee of the Jean F. Chirila Revocable Trust Agreement dated February 24, 2004.



IN WITNESS WHEREOF, I have executed this Certification this 6th day of May, 2004.

Maxine M. Michaels
MAXINE M. MICHAELS

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

MAY 11 2004

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

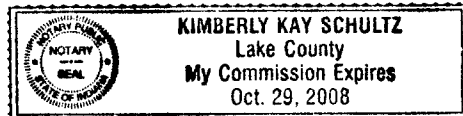
BEFORE ME, the undersigned, a Notary Public, in and for said County and State of Indiana personally appeared **MAXINE M. MICHAELS** and acknowledged the execution of the above and foregoing to be her voluntary act and deed for the uses and purposes expressed therein.

WITNESS my hand and seal this 6th day of May, 2004.

[Signature]

, Notary Public

My Commission Expires: _____
County of Residence: _____



TICOR HBT
924-2518

Prepared by Rhett L. Tauber, Esq. #807-45/
Tauber & Westland, P.C.

2004
1250
H

* 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

State No.

Local No. 514-01

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) JEAN F. CHIRILA		2. SEX Female	3a. TIME OF DEATH 12:03 PM	3b. DATE OF DEATH (Month, Day, Yr) March 12, 2004	
4. SOCIAL SECURITY NUMBER 308-32-1915	5a. AGE—Last Birthday (Years) 70	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) July 25, 1933	
7. BIRTHPLACE (City and State or Foreign Country) Gary Indiana	8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		
9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence					
9b. FACILITY NAME (If not institution, give street and number) 3115 West Old Ridge Road		9c. CITY, TOWN, OR LOCATION OF DEATH Hobart		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) N/A		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Secretary		
12b. KIND OF BUSINESS/INDUSTRY Steel					
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hobart		13d. STREET AND NUMBER 3115 West Old Ridge Road	
13e. ZIP CODE 46342	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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 (9-12) 12 College (1-4 or 5+) 					
18. FATHER'S NAME (First, Middle, Last) Harry Calfas		19. MOTHER'S NAME (First, Middle, Maiden Surname) Eugenia Rektarski			
20a. INFORMANT'S NAME (Type/Print) Maxine Michaels		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1272 Vanderburgh Street, Valparaiso, IN 46385		20c. Relationship Cousin	
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) Mar 16, 2004 Graceland Cemetery		21c. LOCATION—City or Town, State Valparaiso IN	
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. FD01006463		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FD01006463		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488	
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. Lung Cancer					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death years			
a. DUE TO (OR AS A CONSEQUENCE OF)					
b. DUE TO (OR AS A CONSEQUENCE OF)					
c. DUE TO (OR AS A CONSEQUENCE OF)					
d. DUE TO (OR AS A CONSEQUENCE OF)					
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) 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>R. Devanathan</i>		29c. MEDICAL LICENSE NO. 01040141		29d. DATE SIGNED (Month, Day, Year) 3/16/04	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Raja Devanathan MD 1600 S. Lake Park Ave, Ste 1104, Hobart, IN 46342					
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. Best M.D.</i>				32. DATE FILED (Month, Day, Year) March 12, 2004	
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	THIS CERTIFICATE BECOMES A PUBLIC RECORD AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT MAR 17 2004
34d. 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.			