

2

2

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2004 046459

2004 JUN -3 AM 9:38

MORRIS W. GANTER  
RECORDER

Tax Key Number: 10-52-126  
Tax Unit Number: 111

Affidavit of Surviving Trustee

620043083

State of Indiana )  
                                  ) ss:  
County of Lake )

Alex J. Sanders, the Affiant, being first duly sworn, on his oath states:

1) he is the surviving trustee of the trust known as:

The Alex J. Sanders and Patricia R. Sanders Revocable Living Trust;

2) property of the trust includes the land described as follows:

Lot 1417 in Lakes of the Four Seasons; Unit 9, as per plat thereof, recorded in Plat Book 38, page 78, in the Recorder's Office of Lake County, Indiana.

3) the common address of the land is the following:

4031 Walnut Hill Circle  
Crown Point, Indiana 46307

4) Patricia R. Sanders, the former joint trustee, died on

August 21, 2003, as evidenced on the death certificate attached hereto;

5) according to the terms of the trust, he is the surviving trustee;

6) according to the terms of the trust, he has authority to convey the land described above, as surviving trustee.

Affiant further sayeth not.

Signature of Affiant *Alex J Sanders*

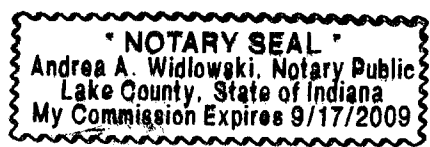
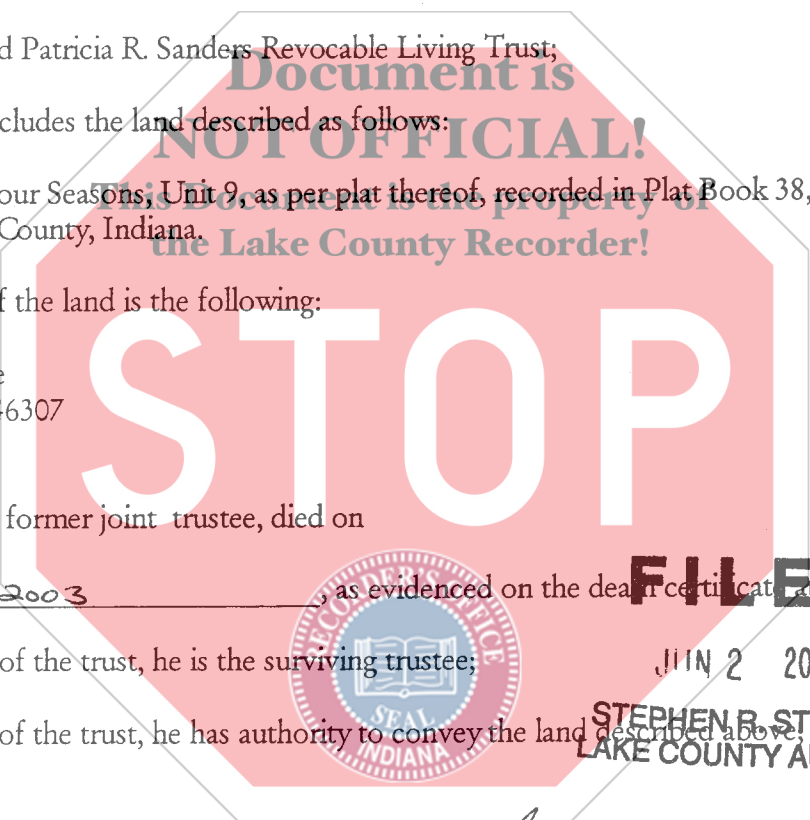
Printed name of Affiant Alex J Sanders

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 28th day of May, 2004.

Signature of Notary Public *Andrea A. Widowski* Notary's County of Residence \_\_\_\_\_

Printed Name of Notary Public \_\_\_\_\_ Notary's Commission Expires \_\_\_\_\_

This instrument was prepared by Alex J Sanders



139  
11/11/04

12  
 \* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.  
 Local No. 1993-03

INDIANA STATE DEPARTMENT OF HEALTH  
 CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
 IN  
 PERMANENT  
 BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

USE OF  
 THIS

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

1. DECEASED - NAME (First, Middle, Last) <b>PATRICIA R SANDERS</b>			2. SEX <b>Female</b>		3a. TIME OF DEATH <b>9:40 PM</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>August 21, 2003</b>				
4. SOCIAL SECURITY NUMBER <b>307-30-7935</b>		5a. AGE - Last Birthday (Years) <b>71</b>		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:		5c. UNDER 1 DAY Hours: Minutes:		6. DATE OF BIRTH (Mo., Day, Yr.) <b>February 12, 1932</b>			
7. BIRTHPLACE (City and State or Foreign Country) <b>CURDSVILLE Kentucky</b>		8a. WAS DECEASED A U.S. VETERAN? <b>No</b>							8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		
9b. FACILITY NAME (If not institution, give street and number) <b>4031 WALNUT HILL CIRCLE</b>											
10. MARITAL STATUS (Specify) <b>Married</b>					11. SURVIVING SPOUSE (If wife, give maiden name) <b>ALEX SANDERS</b>			12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Secretary</b>		12b. KIND OF BUSINESS/INDUSTRY <b>GRIFFITH SCHOOLS</b>	
13a. RESIDENCE - STATE <b>Indiana</b>			13b. COUNTY <b>LAKE</b>		13c. CITY, TOWN OR LOCATION <b>CROWN POINT</b>			13d. STREET AND NUMBER <b>4031 WALNUT HILL CIRCLE</b>			
13e. ZIP CODE <b>46307</b>		13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		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) <b>White</b>		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>	
18. FATHER'S NAME (First, Middle, Last) <b>WINDELL MATTINGLY</b>					19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MURIEL CAHLOUN</b>						
20a. INFORMANT'S NAME (Type/Print) <b>ALEX SANDERS</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4031 WALNUT HILL CIRCLE, CROWN POINT, IN</b>				20c. Relationship <b>Husband</b>			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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>August 24, 2003</b> <b>N.W. Ind. Cremation Services</b>				21c. LOCATION - City or Town, State <b>Crown Point,, Indiana</b>				
22a. EMBALMER'S NAME <b>N/A</b>			22b. EMBALMER'S LICENSE NO. <b>N/A</b>			23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>			24b. LICENSE NUMBER (of Licensee) <b>FD01009461</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BURNS FUNERAL HOME FH83002445</b> <b>10101 Broadway, Crown Point, Indiana</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>Metastatic lung cancer</b>											
IMMEDIATE CAUSE (Final disease or condition resulting in death) 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.											
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) <b>No</b>			28a. WAS AN AUTOPSY 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>					

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) as stated.

SIGNATURE AND TITLE OF CERTIFIER  
*Stephen R. Stiglich*  
**STEPHEN R. STIGLICH**  
**LAKE COUNTY AUDITOR**

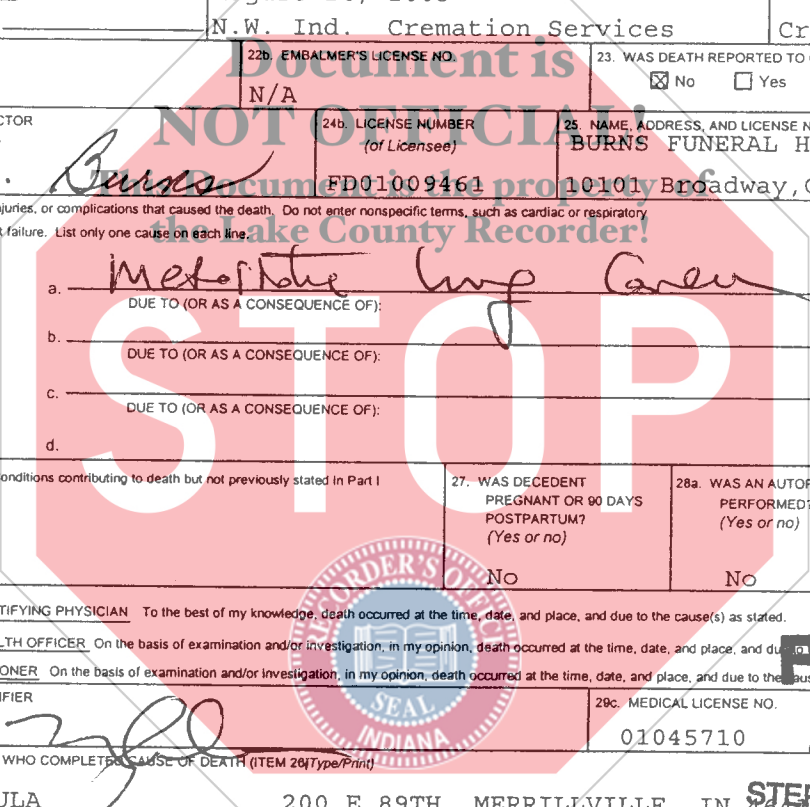
29c. MEDICAL LICENSE NO. **01045710**  
 29d. DATE SIGNED (Month, Day, Year) **JUN 28 2003**

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print)  
**ON TRYBULA 200 E 89TH, MERRILLVILLE, IN 46440**

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)  
 34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  
**AUG 26 2003**

34g. Year **2003**  
 34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.  
**140**



**FILED**

THIS CERTIFIES THE ABOVE STATEMENT IS COMPLETELY CORRECT AND TRUE AND THAT THE DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT  
**AUG 26 2003**  
**140**