STATE OF INDIANA) 2005 044713
) SS:
COUNTY OF LAKE)

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AFFIDAVIT OF SUCCESSOR TRUSTEE
VINCENT E. HOWARD AND FLORENCE L. HOWARD
DECLARATION OF TRUST

We, Judith K. Howard, Barbara G. Lyons and Joyce L. Stage, being of legal age and duly sworn upon oath, depose and state as follows:

1. That Vincent E. Howard and Florence L. Howard were married on January 3, 1942.

2. That Vincent E. Howard and Florence L. Howard executed a Declaration of Trust dated October 23, 1997.

3. That the Trust was not revoked or amended.

4. That Vincent E. Howard died on January 9, 1998, at which time his surviving spouse, Florence L. Howard, became the sole Trustee (Death Certificate).

5. That Florence L. Howard died on January 31, 2003 (Death Certificate).

6. That Article VII of the above-referenced Trust provides that Judith K. Howard and Barbara G. Lyons, will serve as Successor Co-Trustees. In the event that either of the aforementioned individuals is unable or unwilling to serve in this capacity, then Joyce L. Stage shall serve as Successor Co-Trustee.

7. That the beneficiaries of the Vincent E. Howard and Florence L. Howard Declaration of Trust are:

Judith K. Howard	464 Anthony Street, Glen Ellyn, IL 60137
Barbara G. Lyons	8348 Parrish Place, Highland, IN 46322
Joyce L. Stage	9904 Tyler Street, Crown Point, IN 46307

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8. That Affiants make this affidavit for the purpose of causing the proper title and transfer of trust assets.

Judith K. Howard S.T.
Judith K. Howard, Co-Successor Trustee of the
Vincent E. Howard and Florence L. Howard Trust

Barbara G. Lyons S.T.
Barbara G. Lyons, Successor Trustee of the
Vincent E. Howard and Florence L. Howard Trust

Joyce L. Stage
Joyce L. Stage, Successor Trustee of the
Vincent E. Howard and Florence L. Howard Trust

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public, in and for said County and State, this 9th day of May, 2005, personally appeared Judith K. Howard, Barbara G. Lyons and Joyce L. Stage, Co-Successor Trustees of the Vincent E. Howard and Florence L. Howard Trust dated October 23, 1997 and acknowledged the execution of the above instrument to be their voluntary act and deed, for the uses and purposes therein stated.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal the day and year last above written.

Notary Public

This instrument prepared by: Brian P. Popp, Attorney at Law
200 East 89th Place, Suite 200, Merrillville, IN 46410
Telephone: 219/756-7677

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE / COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

Date Issued Jan 12, 1998 — Hammond Health Commission

Local No. 20 — St

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Vincent Edward HOWARD
2. SEX: Male
3a. TIME OF DEATH: 7:45 A
3b. DATE OF DEATH (Month, Day, Yr): January 9, 1998
4. *SOCIAL SECURITY NUMBER: 712-16-7655
5a. AGE—Last Birthday (Years): 91
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): April 5, 1906
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a. WAS DECEDENT A U.S. VETERAN?: YEs
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 6824 Waveland Ave.
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Florence Liesenfelt
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Chief clerk
12b. KIND OF BUSINESS/INDUSTRY: Transportation R.R.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 6824 Waveland Ave.
13e. ZIP CODE: 46323
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Howard
19. MOTHER'S NAME (First, Middle, Maiden Surname): Victoria Unknown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Florence Howard
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6824 Waveland Ave.,Hammond, IN 46323
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 12, 1998 St. John Cemetery
21c. LOCATION—City or Town, State: Hammond, INdiana
22a. EMBALMER'S NAME: James W. Gholston
22b. EMBALMER'S LICENSE NO.: 1004194
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR
24b. LICENSE NUMBER (of Licensee): 1045362
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Virgil Huber Funeral Home 7051 Kennedy Ave., Hammond, IN 4632 — 3002869

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Colon Cancer — Approximate Interval Between Onset and Death: 1 yr
DUE TO (OR AS A CONSEQUENCE OF)
b. primary metastasis — 1 yr
DUE TO (OR AS A CONSEQUENCE OF)
c. liver metastasis — 1 yr

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
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 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

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: Donald E Stork DO
29c. MEDICAL LICENSE NO: 02001 33L
29d. DATE SIGNED (Month, Day, Year): 1/9/98 (JAN)

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Donald E. Stork D.O. —7905 Calumet Ave., Munster, IN 46321
31. HEALTH OFFICER'S SIGNATURE: Granblum L. Bermuda M.D.
32. DATE FILED (Month, Day, Year): JANUARY 12, 1998

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

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

Local No. 87

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Feb 4, 2003 Date Issued — Franklin J. Grenada M.D. Hammond Health Commissioner

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

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)
Florence Rose Howard		Female	1:17PM	January 31, 2003
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)
712-16-7635	95			June 15, 1907
7. BIRTHPLACE (City and State or Foreign Country)				
West Hammond, IL				
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)		
No	N/A	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	
6824 Waveland Avenue		Hammond	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	
Widowed	None	Clerk	Railroad	
13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER	
Indiana	Lake	Hammond	6824 Waveland Avenue	
13e. ZIP CODE	13f. INSIDE CITY LIMITS ☐ No ☒ Yes	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE - American Indian Black, White, etc. (Specify)
46323	13g. ON A FARM? ☒ No ☐ Yes	USA		White
17. DECEDENT'S EDUCATION (Specify only highest grade completed)				
Elementary/Secondary (0-12)	College (1-4 or 5+)			
12				

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John Henry Liesenfelt	Margaret Hoffman

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
Judith Calleia	464 Anthony Street, Glen Ellyn, IL 60137	Daughter

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)	February 3, 2003 St. John/St. Joseph Cemetery	Hammond, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Jody Zeese	FD20100056	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Jody James Zeese	FD20100056	FH19900009 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

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. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b. Hypertension	
	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 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	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)
	01040407A	2-4-03 (February)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
L. Stork M.D., 9660 Wicker Avenue, St. John, IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
Franklin J. Grenada M.D.

32. DATE FILED (Month Day Year)
February 4, 2003

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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				
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 10110-04 (R4 / 3-93) DEATHCER/PD 1