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Successor Trustee Notice

TO WHOM IT MAY CONCERN:

The undersigned Successor Trustee, under The Russell E. Hoffman Grantor Trust Agreement dated ~~September 10~~, 1995 executed by Russell E. Hofman, hereby gives notice that the said Grantor Russell E. Hoffman being now deceased as of the 29th day of July, 1996, in accordance with Article VII, paragraph A of the said Trust Agreement, I, Susan J. Hegyi have assumed the duties of Successor Trustee of the said Trust Agreement. *January 9,

WHEREFORE, I hereby serve notice that in my capacity as such Successor Trustee, I have this day assumed title to the real property and /or other assets covered by the said Trust Agreement, and will hereafter administer the same in accordance with the instructions set forth in the said Russell E. Hoffman Grantor Trust Agreement.

This instrument dated the 9th day of June, 2005

Susan J. Hegyi, Trustee
Susan J. Hegyi Successor Trustee

Witness (1)

Signature

Printed Name

City / Town

State

Zip

State

Zip

Witness (2)

Signature

Printed Name

City / Town

State

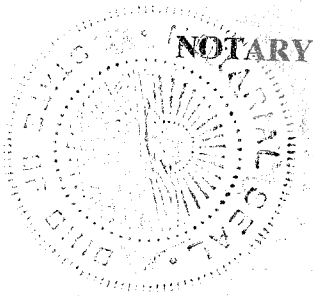
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STATE OF OHIO)
) SS:
COUNTY OF CLERMONT)

On the 9th day of June, 2005, personally appeared, **Susan J. Hegyi**, known to me and proven by drivers Ohio Drivers license picture identification to be the individual who executed the foregoing instrument, and acknowledged the same to be her free act and deed, before me.

My commission expires 6/4/2006

GINGER E. HITTLE
Notary Public, State of Ohio
My Commission Expires June 4, 2006



Ginger E. Hittle
Notary Public

FILED

JUN 14 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

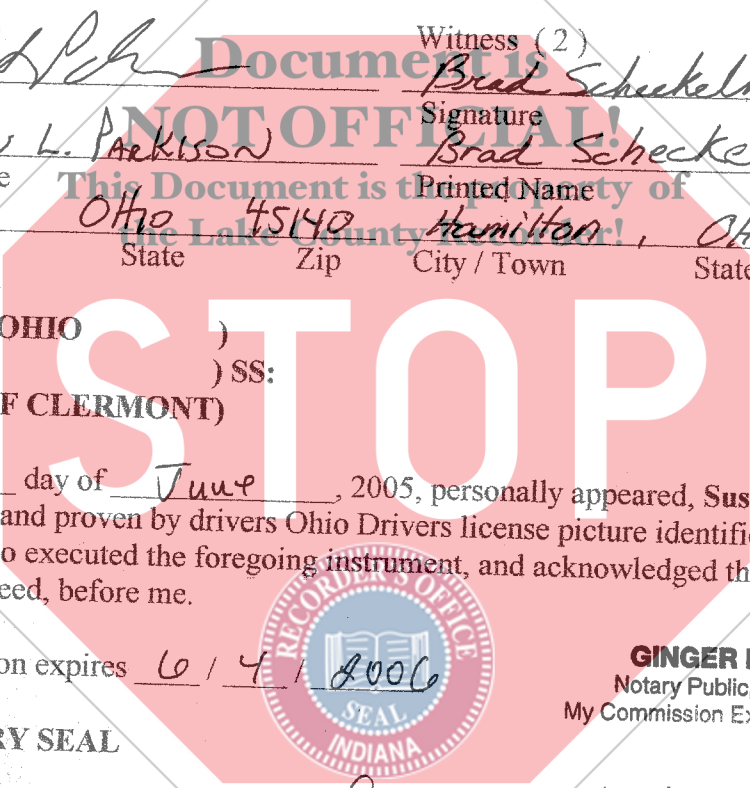
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2005 JUN 15 AM 9:18

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD



* 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

State No.

Local No. 2478-96

40854

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-18-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) Russell E. Hoffman		2. SEX Male	3a. TIME OF DEATH 11:50AM	3b. DATE OF DEATH (Month Day Yr) July 29, 1996
4. SOCIAL SECURITY NUMBER 315-10-7048	5a. AGE - Last Birthday (Years) 75	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Apr 5, 1921
7. BIRTHPLACE (City and State or Foreign Country) Cedar Lake, IN	8a. PLACE OF DEATH (Check only one; See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) St Anthony Medical Center	9b. CITY TOWN OR LOCATION OF DEATH Crown Point	9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) NONE	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crane Machinist		12b. KIND OF BUSINESS INDUSTRY Steel Mills
13a. RESIDENCE - STATE IN	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Cedar Lake	13d. STREET AND NUMBER 8920 West 141st Ave.	
13e. ZIP CODE 46303	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) 10		17. DECEASED'S EDUCATION (Specify only highest grade completed) College (1-4 of 14)		
18. FATHER'S NAME (First, Middle, Last) Irvin Hoffman		19. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Spencer		
20a. INFORMANT'S NAME (Type/Print) Susan Hegyi		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19700 Birch St., Cedar Lake, IN 46303		20c. Relationship Daughter
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) Aug 1, 1996 German Methodist		21c. LOCATION - City or Town State Cedar Lake, IN
22a. EMBALMER'S NAME Fred T. Oparka		22b. EMBALMER'S LICENSE NO. FD01016076	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Fred T. Oparka</i>		24b. LICENSE NUMBER of Licensee FD01016076	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Eller Brady Funeral Home, Inc. 8510 Lakeshore dr., Cedar Lake, IN 46303	
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. Approximate Interval Between Onset and Death Unknown				
IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (OR) AS A CONSEQUENCE OF Vascular collapse is the property of Due to arteriosclerotic heart and vascular disease Due to (OR) AS A CONSEQUENCE OF 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 DECEASED 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 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 checked="" 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) as stated. Deputy				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donna Malyon</i>		29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month Day Year) August 1, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) Donna Malyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>				
32. DATE FILED (Month Day Year) August 1, 1996				
33. MANNER OF DEATH <input checked="" 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) No	
34d. PLACE OF INJURY - At home, farm, street, factory, office, bus, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town State) 147-21-1997		
35a. DATE PRONOUNCED DEAD (Month, Day, Year) July 29, 1996		35b. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. No		
36. SIGNATURE AND TITLE OF HEALTH OFFICER <i>Alexander Williams, MD</i> LAKE COUNTY HEALTH COMMISSIONER				