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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 FEB -3 PM 1:58

MICHAEL A. BROWN
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

FILED

AFFIDAVIT OF SURVIVORSHIP

FEB 03 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

undersigned, DR. HENRY B. FEINBERG, being first duly sworn upon his oath, deposes

and states as follows:

1. I am over 18 years of age and am in all respects competent to testify to the matters set forth herein.

2. I make this Affidavit based upon my personal knowledge. If called upon to do so, I will testify personally regarding the information contained herein.

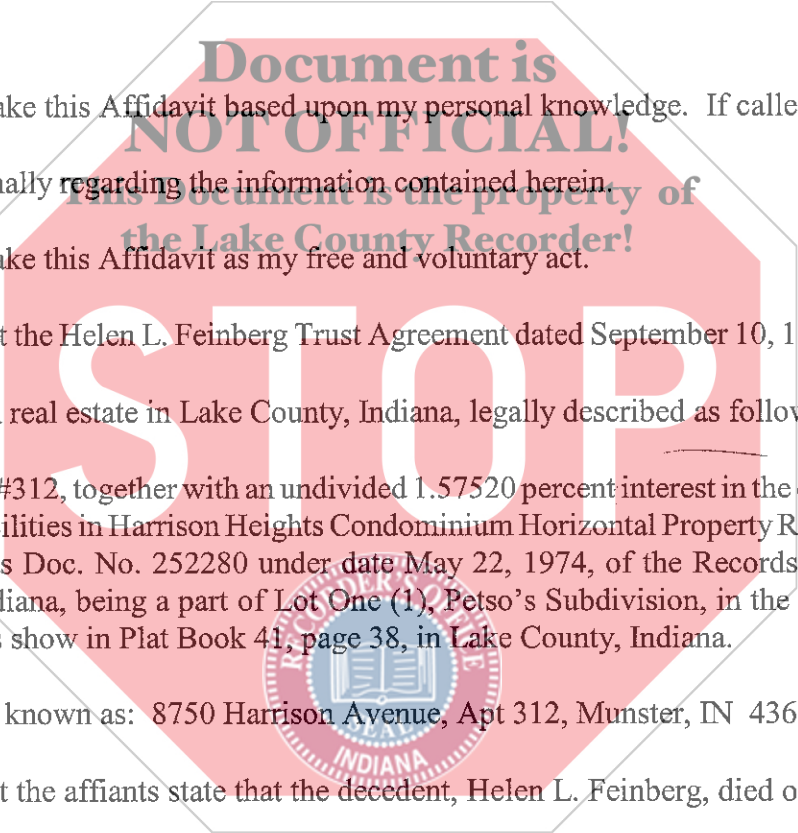
3. I make this Affidavit as my free and voluntary act.

4. That the Helen L. Feinberg Trust Agreement dated September 10, 1990 is the owner of record of certain real estate in Lake County, Indiana, legally described as follows:

Apartment #312, together with an undivided 1.57520 percent interest in the common area and facilities in Harrison Heights Condominium Horizontal Property Regime as Recorded as Doc. No. 252280 under date May 22, 1974, of the Records of Lake County, Indiana, being a part of Lot One (1), Petso's Subdivision, in the Town of Munster, as show in Plat Book 41, page 38, in Lake County, Indiana.

Commonly known as: 8750 Harrison Avenue, Apt 312, Munster, IN 43621.

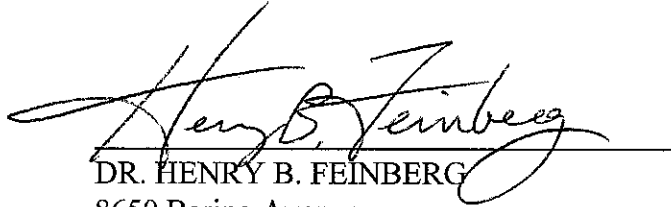
5. That the affiants state that the decedent, Helen L. Feinberg, died on the 20th day of June 2005, in Lake County, Indiana, as confirmed by a copy of the Certificate of Death issued by the Indiana State Department of Health which is attached hereto as Exhibit "A."



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002377

6. Pursuant to Article XV, paragraph B of the Helen L. Feinberg Trust dated September 10, 1990, states that "in the event the Trustor should die, resign or become incapacitated, then the son of the Trustor, Dr. Henry B. Feinberg, shall act as Successor Trustee." A certified and abbreviated copy of the Helen L. Feinberg Trust is attached hereto as Exhibit "B."

FURTHER THE AFFIANT SAITH NOT.



DR. HENRY B. FEINBERG
8650 Baring Avenue
Munster, IN 46321

STATE OF INDIANA

COUNTY OF LAKE

Document is

NOT OFFICIAL!

This Document is the property of
the Lake County Recorder!

Before me, the undersigned Notary Public in and for said County and State, do hereby certify that **Dr. Henry B. Feinberg** personally appeared and executed the above document as his voluntary act and deed, for the uses and purposes therein stated.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 17 day of January 2005.

MELISSA M. PULIDO
NOTARY PUBLIC - LAKE COUNTY, INDIANA
MY COMMISSION EXPIRES JUNE 29, 2011
RESIDENT LAKE COUNTY INDIANA

My Commission expires:

6/29/2011


Notary Public
A resident of Lake County, Indiana

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. 1681-05
87005

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) Helen Feinberg		2. SEX Female		3a. TIME OF DEATH 9:25A		3b. DATE OF DEATH (Month, Day, Yr) June 20, 2005	
4. *SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) 90		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) Oct. 20, 1914		7. BIRTHPLACE (City and State or Foreign Country) Springfield, IL					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None		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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) 8750 Harrison #312				9c. CITY, TOWN, OR LOCATION OF DEATH Munster		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		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) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Munster		13d. STREET AND NUMBER 8750 Harrison #312	
13e. ZIP CODE 46321		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 (0-12) 2 College (1-4 or 5+) 2					
18. FATHER'S NAME (First, Middle, Last) Joseph Katz				19. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Wolfson			
20a. INFORMANT'S NAME (Type/Print) Dr. Henry Feinberg			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8650 Baring Ave. Munster, IN 46321			20c. Relationship Son	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) June 23, 2005 Elmwood Cemetery			21c. LOCATION—City or Town, State Hammond, IN		
22a. EMBALMER'S NAME		22b. EMBALMER'S LICENSE NO.		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) 1021590		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321			
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. Myeloproliferative disorder					Approximate Interval Between Onset and Death 10 yrs.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. Hypertension with renal failure					2 yrs.
		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)
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. Y01019251			29d. DATE SIGNED (Month, Day, Year) June 20, 2005	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) F. Adler, M.D. 800 MacArthur Blvd. Munster, IN 46321							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) June 21, 2005	
33. MANNER OF DEATH <input 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)	34d. DESCRIBE HOW INJURY OCCURRED	
34a. 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. JUN 21 2005					

Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security numbers;
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, the undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.

