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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2006 018358

2006 MAR -6 AM 8:56

MICHAEL A. BROWN  
RECORDER

**AFFADAVIT OF SUCCESSOR TRUSTEE**

Affiant: **Ralph G. Scheeringa**, as **Successor Trustee**, does herin state that: Jack R. Scheeringa and Theresa Scheeringa are deceased. Jack R. Scheeringa date of death: June 19, 2001 and Theresa Scheeringa date of death: October 24, 2005.

Per Trust Agreement dated the 8<sup>th</sup> day of May, 2000, known as the **Scheeringa Family Trust**, Ralph G. Scheeringa is Successor Trustee and has the authority to mortgage, sell, or convey the following property. 3721 Highway Avenue, Highland, In., 46322

**Copy of Death Certificates are attached**

In Witness Whereof, the undersigned has executed this instrument under the day and year first above written.

*Ralph G. Scheeringa*  
Ralph G. Scheeringa

State Of: Indiana

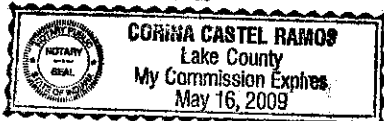
County Of: Lake

Before me, Corina Castel Ramos, a Notary Public in and for said County and State, Ralph G. Scheeringa, has personally appeared and executed the above and foregoing instrument his/her/their free and voluntary acts and deeds for the uses and purposes therein set forth.

Given under my hand and official seal the 27<sup>th</sup> day of February, 2006.

My commission expires: May 16, 2009 County of residence: Lake

Notary Public: Corina Castel Ramos



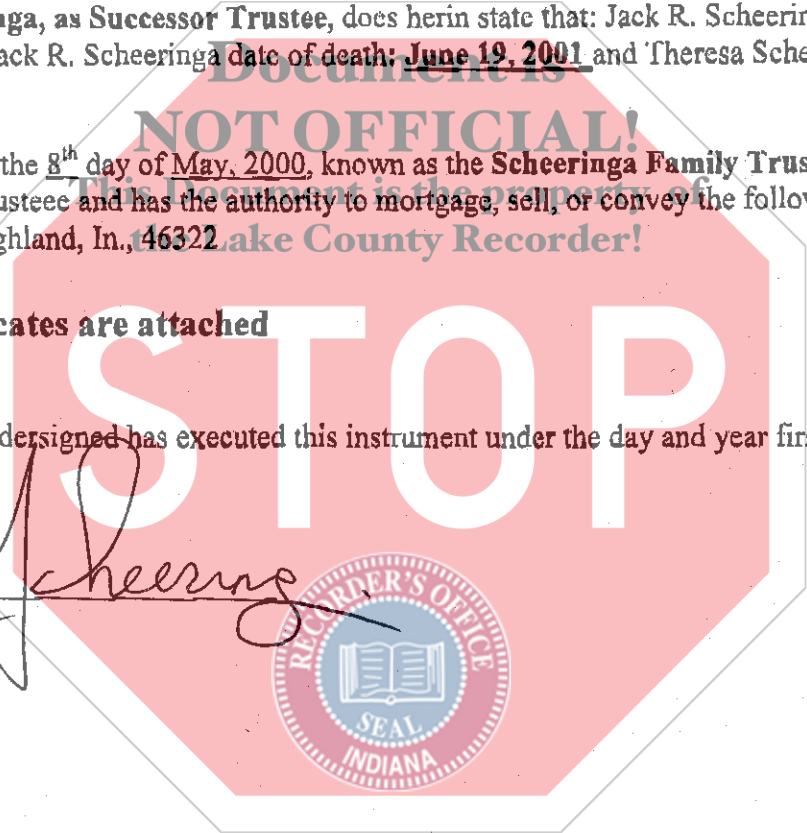
SOUTHSHORE TITLE LLC  
11055 BROADWAY  
CROWN POINT, IN 46307

**FILED**

MAR 03 2006

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

004694



SOUTHSHORE TITLE LLC 99006 0124

\$15  
SS  
CA

**MEDICAL CERTIFICATE OF DEATH**

REGISTRATION DISTRICT NO. **16.0**  
 REGISTERED NUMBER

1. DECEASED-NAME FIRST **Jack** MIDDLE **Jacob** LAST **Scheeringa** SEX **2. Male** DATE OF BIRTH (MONTH, DAY, YEAR) **June 19, 2001**

2. COUNTY OF DEATH **Cook**

3. CITY, TOWN, TWP. OR ROAD DISTRICT NUMBER **Palos Heights** HOSPITAL OR OTHER INSTITUTION-NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) **Palos Community Hospital**

4. AGE-LAST BIRTHDAY (YRS) **81** UNDER 1 YEAR **81** UNDER 1 DAY **81** UNDER 1 HOUR **81** UNDER 1 MIN. **81** DATE OF DEATH (MONTH, DAY, YEAR) **June 19, 2001**

5. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) **Married** NAME OF SURVIVING SPOUSE (MAIDEN NAME IF WIFE) **Theresa Amptmever**

6. SOCIAL SECURITY NUMBER **312-16-0937** KIND OF BUSINESS OR INDUSTRY **Dairy** EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED) **Elementary/Secondary (0-12)**

7. RESIDENCE (STREET AND NUMBER) **3721 Highway Ave.** CITY, TOWN, TWP. OR ROAD DISTRICT NO. **Highland** INSIDE CITY (YES/NO) **Yes** COUNTY **Lake**

8. STATE **Indiana** ZIP CODE **46322** OF HISPANIC ORIGIN? (SPECIFY NO OR YES-IF YES, SPECIFY CUBAN, MEXICAN, PUERTO RICAN, ETC.) **Yes**

9. FATHER-NAME FIRST **Ralph** MIDDLE **Scheeringa** LAST **Porter** MOTHER-NAME FIRST **Theresa** MIDDLE **Amptmever** LAST **Porter**

10. INFORMANT'S NAME (TYPE OR PRINT) **Theresa Scheeringa** RELATIONSHIP **Wife** MAILING ADDRESS (STREET AND NO. OR R.F.D., CITY OR TOWN, STATE, ZIP) **173721 Highway Ave. Highland IN 46322**

11. IMMEDIATE CAUSE (Final disease or condition resulting in death) **Myocardial Infarction**

12. CONDITIONS IF ANY WHICH GIVE RISE TO IMMEDIATE CAUSE (a) **(a) DUE TO, OR AS A CONSEQUENCE OF** (b) **(b) DUE TO, OR AS A CONSEQUENCE OF** (c) **(c) DUE TO, OR AS A CONSEQUENCE OF**

13. PART II. Other significant conditions contributing to death together resulting in the underlying cause given in PART I.

14. DATE OF OPERATION, IF ANY **June 18, 2001** MAJOR FINDINGS OF OPERATION **Myocardial Infarction**

15. (101) DID NOT ATTEND THE DECEASED AND LAST SAW HIM/HER ALIVE ON **June 18, 2001** WAS CORONER OR MEDICAL EXAMINER NOTIFIED (YES/NO) **YES**

16. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED.

17. SIGNATURE **[Signature]** DATE SIGNED (MONTH, DAY, YEAR) **June 19, 2001**

18. NAME AND ADDRESS OF CERTIFIER **John Humphrey Dr. Orland Pk** ILLINOIS LICENSE NUMBER **036-054842**

19. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (TYPE OR PRINT)

20. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** CEMETERY OR CREMATORY-NAME **Hope Cemetery** CITY OR TOWN **Highland, Indiana** STATE **Indiana** DATE (MONTH, DAY, YEAR) **June 21, 2001**

21. FUNERAL HOME **Agent for: Kuiper Funeral Home** FUNERAL DIRECTOR'S SIGNATURE **[Signature]** FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER **034-011832**

22. LOCAL REGISTRAR'S SIGNATURE **[Signature]** LOCAL REGISTRAR'S SIGNATURE **[Signature]** LOCAL REGISTRAR'S SIGNATURE **[Signature]** LOCAL REGISTRAR'S SIGNATURE **[Signature]** LOCAL REGISTRAR'S SIGNATURE **[Signature]**

23. REGISTERED NUMBER **16.0** DATE FILED BY LOCAL REGISTRAR (MONTH, DAY, YEAR) **JUN 20 2001**

I HEREBY CERTIFY THAT the foregoing is a true and correct copy of the death record in my office in accordance with the provisions of Illinois statutes relating to the registrar of birth, stillbirth and death.

Signed **[Signature]** Date **JUN 20 2001**

At Cook County Department of Public Health, Official Title Deputy Registrar  
 1010 Lake Street Suite 300 Oak Park, Illinois 60301

\* 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

Local No. 3709-05

State No. \_\_\_\_\_

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) <b>Theresa "Tress" Scheeringa</b>		2. SEX <b>Female</b>		3a. TIME OF DEATH <b>5:05 PM</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>October 24, 2005</b>	
4. SOCIAL SECURITY NUMBER <b>332-09-9903</b>		5a. AGE-Last Birthday (Years) <b>86</b>		5b. UNDER 1 YEAR Months: _____ Days: _____		5c. UNDER 1 DAY Hours: _____ Minutes: _____	
6. DATE OF BIRTH (Mo, Day, Yr.) <b>January 15, 1919</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>South Holland, Illinois</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		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 checked="" type="checkbox"/> Other (Specify) <b>Hospice Facility</b>			
9b. FACILITY NAME (If not institution, give street and number) <b>Riley Hospice Residence</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster, IN</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Widowed</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>None</b>		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
13a. RESIDENCE-STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Highland</b>		13d. STREET AND NUMBER <b>3721 Highway Ave.</b>	
13a. ZIP CODE <b>46322</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. AS 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) <b>White</b>		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)					
18. FATHER'S NAME (First, Middle, Last) <b>Gerben Amptmeyer</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Ketelaar</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Ralph Scheeringa</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3702 41st. Lane, Highland, IN 46322</b>		20c. Relationship <b>Son</b>	
21a. METHOD OF DISPOSITION <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) <b>October 27, 2005 Hope Cemetery</b>				21c. LOCATION-City or Town, State <b>Highland, IN</b>	
22a. EMBALMER'S NAME <b>Leonard G. Gregorczyk</b>		22b. EMBALMER'S LICENSE NO. <b>FD08800305</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>CA Heip</i>		24b. LICENSE NUMBER (of Licensee) <b>FD0101451</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home 9039 Kleinman Road Highland, IN 46322 FH10300021</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.  IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <b>R. Coronary vascular accident</b> b. <b>Renal failure</b> c. <b>Atrial Fibrillation</b> d. <b>Rhabdomyolysis</b>  Conditions if any, which gave rise to the immediate cause, stating the underlying cause last.  PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>- Retroperitoneal bleed - L. hip contusion - HTN</b>							
27. WAS DECEDENT 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>			
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>Susan J. ...</i>				29c. MEDICAL LICENSE NO. <b>01042431</b>		29d. DATE SIGNED (Month, Day, Year) <b>10/25/05</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>PYARALI KESHUANI, M.D. 8731 INDIANAPOLIS BLVD, HIGHLAND, IN 46322</b>							
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. ...</i>							
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)	
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.			

Prescribed by the  
State Board of Accounts  
(2005)

County form 170

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 number in attached document.
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

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



*Carol J. Hall*

Signature of Declarant

CAROL J. HALL

Printed Name of Declarant

Verified for Recording by  
Southshore Title LLC