

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 095192

2006 OCT 31 AM 9:49

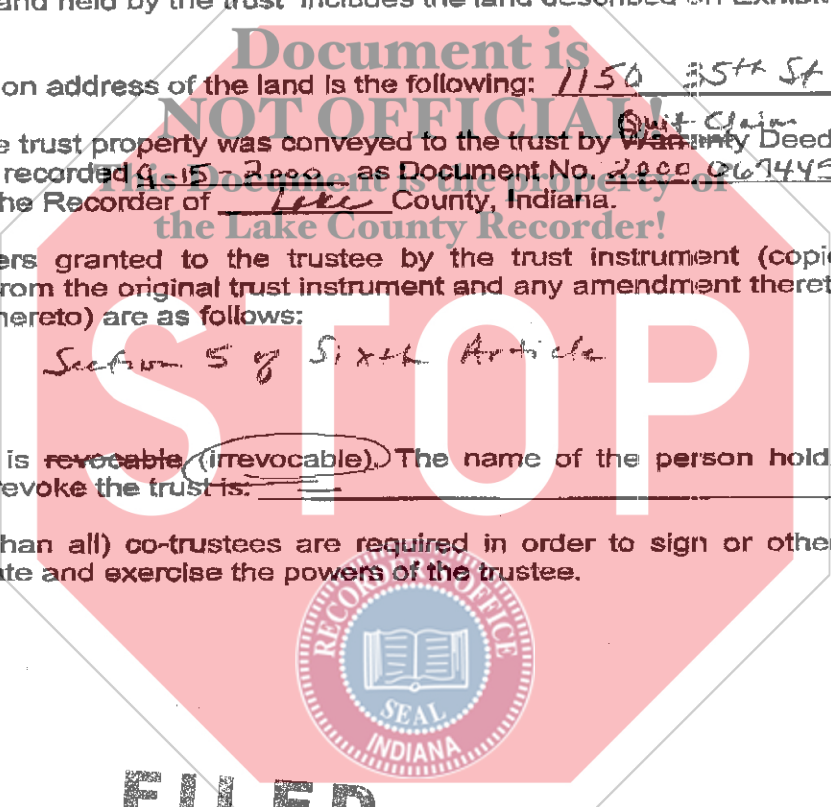
MICHELLE A. CROWN
RECORDER

6200
66168

CERTIFICATION OF TRUST

I, the undersigned Trustee under a trust agreement dated 04-16-1988 and know as the Jean R. Kovach Trust, in accordance with IC 30-4-4-5, do hereby affirm under penalties of perjury:

1. That the above referenced trust is in existence and that the trust instrument was executed on the 16th day of April, ~~2006~~ 1988;
2. The settler/grantor of the trust is/was Jean R. Kovach;
3. That the name and address of the current acting trustee(s) is(are) as follows: Jill E Hunt
5103 WATERS EDGE DRIVE
VALPARAISO, IN 46383
4. That the land held by the trust includes the land described on Exhibit A attached;
5. the common address of the land is the following: 1150 35th St Munster IN
6. Title to the trust property was conveyed to the trust by Quit Claim Deed dated 9/7/00 and recorded 9-15-2000 as Document No. 2000 067445, in the Office of the Recorder of Lake County, Indiana.
7. The powers granted to the trustee by the trust instrument (copies of excerpts from the original trust instrument and any amendment thereto are attached hereto) are as follows:
See Section 5 of Sixth Article
8. The trust is revocable (~~irrevocable~~). The name of the person holding a power to revoke the trust is: _____
9. All (less than all) co-trustees are required in order to sign or otherwise authenticate and exercise the powers of the trustee.



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PEGGY HOLINGHATTON
LAKE COUNTY AUDITOR

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Chicago Title Insurance Company

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10. The trust's taxpayer identification number is 14-6297160.

11. The trust has not been revoked, modified, or amended in any manner that would cause the representations contained herein to be incorrect.

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

Dated this 12 day of 10, 2006

Jill E. Hunt, Jill E. Hunt, Affiant
(Typed Name)

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Before me the undersigned, a Notary Public, in and for said County and State, personally appeared Jill E. Hunt, and he/she being first duly sworn by me upon his/her oath, says that the facts alleged in the foregoing instrument are true. Signed and sealed this 12th day of October 2006.

Signature Susan D. Tipton-Hutte

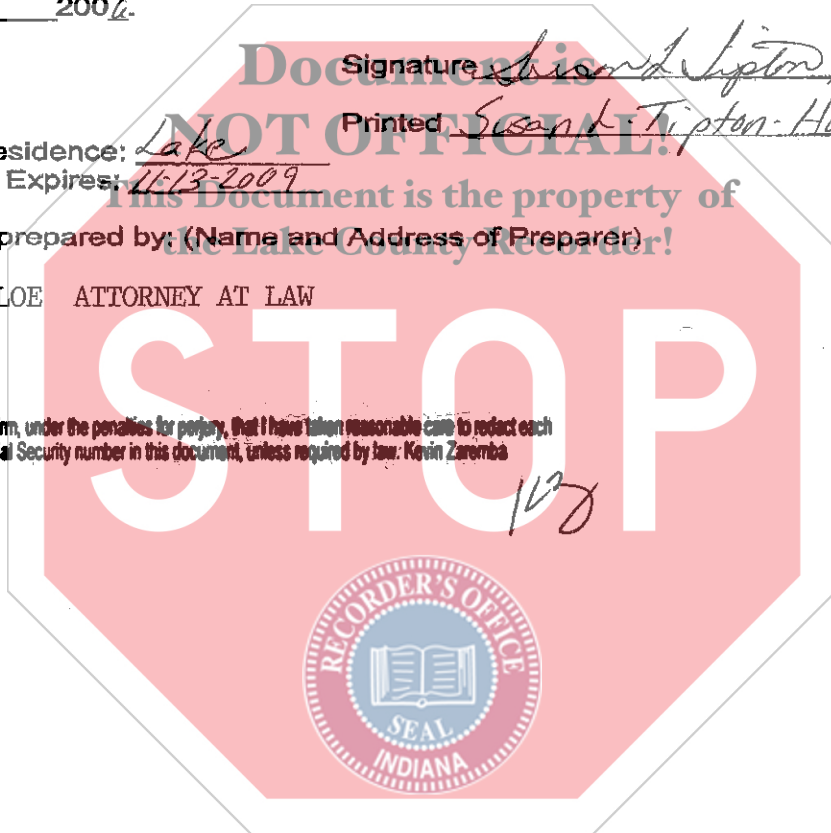
Printed Susan D. Tipton-Hutte

My County of Residence: Lake
My Commission Expires: 11-13-2009

This instrument prepared by: (Name and Address of Preparer)

NOREEN A COSTELLOE ATTORNEY AT LAW

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law: Kevin Zaremba



No: 620066168

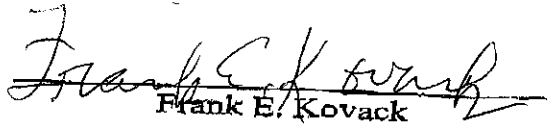
LEGAL DESCRIPTION

Lot 2 in Monaldi-Chayes Manor of Munster, as per plat thereof, recorded in Plat Book 34 page 51, in the Office of the Recorder of Lake County, Indiana.



RESIGNATION

I, Frank E. Kovack of Munster, Indian do hereby resign as successor trustee of the Jean R. Kovack Declaration of Trust dated April 16, 1988. This resignation is effective immediately and is irrevocable.


Frank E. Kovack

Signed and sworn to before me this 12th day of October, 2006.


Notary Public

*Commission expires 11-13-2009
Lake County Indiana*



RESIGNATION

I, Bernard Anthony of Munster, Indiana, do hereby resign as successor trustee of the Jean R. Kovack Declaration of Trust dated April 16, 1988. This resignation is effective immediately and is irrevocable.

Bernard Anthony
Bernard Anthony

Signed and sworn to before me this 12th day of October, 2006.

Melani Tremery
Notary Public
exp: 07.10.2014



ATTENTION ESTATE: The Social Security # is requested by this state agency in order to sue its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

620066168

CERTIFICATE OF DEATH

State No.

Local No. 1622-00

30505 THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-18-3

PE/PRINT IN PERMANENT ACK INK

DECEDENT

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1 DECEASED—NAME (First, Middle, Last) JEAN R. KOVACK		2. SEX FEMALE		3a. TIME OF DEATH 8:20 AM		3b. DATE OF DEATH (Month, Day, Year) JULY 3, 2006	
4. SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) 79		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6a. WAS DECEDENT A U.S. VETERAN? NO		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? NONE		6. DATE OF BIRTH (Mo, Day, Yr) NOV. 17, 1926		7. BIRTHPLACE (City and State or Foreign Country) BLUE ISLAND, ILLINOIS	
8a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				8b. FACILITY NAME (If not institution, give street and number) COMMUNITY HOSPITAL		8c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER	
8d. COUNTY OF DEATH LAKE		10. MARITAL STATUS (Specify) MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) FRANK E. KOVACK		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 INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION MUNSTER	
13d. STREET AND NUMBER 1150 - 35TH STREET		13e. ZIP CODE 46321		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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 (9-12) 1 College (1-4 or 5+) 1	
18. FATHER'S NAME (First, Middle, Last) RAYMOND PATNO				19. MOTHER'S NAME (First, Middle, Maiden Surname) KATHRYN WILDER			
20a. INFORMANT'S NAME (Type/Print) FRANK E. KOVACK				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1150 - 35TH STREET, MUNSTER, IN 46321		20c. Relationship HUSBAND	
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) JULY 6, 2006 COMMUNITY CREMATION SERVICE		21c. LOCATION—City or Town, State SCHERERVILLE, INDIANA			
22a. EMBALMER'S NAME NA		22b. EMBALMER'S LICENSE NO. NA		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Henry D. Anthony</i>		24b. LICENSE NUMBER (of Licensee) 01001447		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ F.H. #83002916 9445 CALUMET AVE, MUNSTER, IN 46321			
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. STROKE		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 FOR COMPLETION OF CAUSE OF DEATH? (Yes or no) NO	
IMMEDIATE CAUSE (Final disease or condition resulting in death) HTN		DUE TO (OR AS A CONSEQUENCE OF) RESPIRATORY PARALYSIS		THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. JUL 06 2006			
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I		29a. DATE OF INJURY (Month, Day, Year)		29b. TIME OF INJURY		29c. INJURY AT WORK? (Yes or no)	
29d. DESCRIBE HOW INJURY OCCURRED		29e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) PYARALI KESHVANI, M.D. 8731 INDIANAPOLIS BLVD, HIGHLAND, INDIANA 46322		31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, M.D.</i>		32. DATE SIGNED (Month, Day, Year) JULY 5, 2006		32. DATE FILED (Month, Day, Year) July 6, 2006	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE PRONOUNCED DEAD (Month, Day, Year)		34b. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			