AFFIDAVIT OF CERTIFICATION OF TRUST

2009 079781

Mary Ann Mestrich, being sworn upon oath, states and certifies that:

1. I am the duly appointed and acting Successor Trustee for Joseph Dobrowolski and Victoria Dobrowolski, Trustees under the provisions of Trust No. LTJD-101
2. The original Trustee Joseph Dobrowolski, died on 10/31/2006 and Victoria Dobrowolski died on 03/04/2009.

3. The Trust No. LTJD-101 U/T/D 8/19/96 is in existence and is in full force and effect;

4. There have been no amendments made to the Trust since its creation;

5. As of the date hereof, I have not received any written notices or directions of any amendment, rescission or revocation of the Trust;

6. I make this Affidavit of Certification of Trust for the purpose of showing the current status of the Trust No. LTJD-101 U/T/D 8/19/96, that I am the Successor Trustee, that I have been acting as Successor Trustee since 03/04/2009, the date of death of Joseph Dobrowolski and Victoria Dobrowolski and that I have the right to act for and on behalf of the Trust.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2009 DEC -2 AM 9:31
MICHAEL A. BROWN
RECORDER

IN WITNESS WHEREOF, I have executed this Affidavit of Certification of Trust on November 18th, 2009

Mary Ann Mestrich

Mary Ann Mestrich, Successor Trustee

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said County and State, Personally appeared, Mary Ann Mestrich, Successor Trustee of the Joseph Dobrowolski and Victoria Dobrowolski, as Trustees under the provisions of Trust LTJD-101 U/T/D 8/19/96 and acknowledged the execution of the foregoing instrument to be her free and voluntary act.

Witness my hand and seal this 18th day of November, 2009

My Commission Expires: 05/27/2016

"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."

Prepared by: Mary Ann Mestrich

THOMAS G. SCHILLER
Lake County
My Commission Expires
May 27, 2016

FILED
NOV 30 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

16.00 TJ

021193

TICOR HO
9/1124RR

REGION TITLE

982006

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 1116-09 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
VICTORIA M. DOBROWOLSKI	ZURAWSKI	FEMALE	6:11 AM	MARCH 4, 2009

5. Social Security Number	6a. Age – Yrs	6b. Under 1 Year: Months	6c. Under 1 Month: Days	6d. Under 1 Day: Hours	6e. Under 1 Hour: Minutes	7. Date Of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)
[redacted]	88					JULY 1, 1920	HAMMOND, INDIANA

9. Ever in U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☒ Emergency Department Outpatient ☐ Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): ST. MARGARET MERCY HOSPITAL

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
DYER, INDIANA 46311	LAKE	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
NONE	N/A	HOMEMAKER	OWN HOME

18. Residence – State	18a. County	18b. City Or Town
INDIANA	LAKE	HAMMOND

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
4403 TORRENCE AVENUE	N/A	46327	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
10 YEARS	NO	WHITE

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
JOHN ZURAWSKI	MARY ZURAWSKI	BROTON

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
MARY ANN MESTRICH	DAUGHTER	9965 NORTHCOTE COURT, ST. JOHN, INDIANA 46373

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify)	MARCH 7, 2009 HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☒ Yes ☐ No	ANTHONY & DZIADOWICZ FUNERAL HOME 4404 CAMERON AVENUE HAMMOND, INDIANA 46327	83002835

27b. Signature Of Indiana Funeral Service Licensee: Kent D Anthony

27c. License Number (Of Licensee): 01011911

Cause Of Death (See Instructions And Examples)

Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.

		Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. acute Cardio respiratory arrest	
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last	B. Due To (Or As A Consequence Of): Cardiomyopathy	
	C. Due To (Or As A Consequence Of): ~~HTN~~ Hypertension	
	D. Due To (Or As A Consequence Of):	

Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I: Chr. renal failure

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☒ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☒ Probably ☐ No ☐ Unknown

32. If Female: ☒ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ No

38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code

39. Describe How Injury Occurred:

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death: Vijay Dave 3/5/09

42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death: VIJAY DAVE MD 3229 BROADWAY, GARY, INDIANA 46408

License Number: 01026051

45. Date Certified: MARCH 5, 2009

46. Additional Funeral Service Provider:

47. *Akas:

48. Signature of Local Health Officer: Susan J Bart D.O.

49. For Registrar Only – Date Filed (Month/Day/Year): March 6, 2009

State Form 10110 (R7/9-07) 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. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

* 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.

Local No. 694

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

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

Nov. 3 2006 — Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JOSEPH F. DOBROWOLSKI
2. SEX: MALE
3a. TIME OF DEATH: 12:35 P M
3b. DATE OF DEATH (Month, Day, Yr.): OCTOBER 31, 2006
4. *SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 89
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): FEBRUARY 9, 1917
7. BIRTHPLACE (City and State or Foreign Country): WHITING, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
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): 4403 TORRENCE AVENUE
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): VICTORIA ZURAWSKI
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): RESEARCH TECHNICIAN
12b. KIND OF BUSINESS/INDUSTRY: OIL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 4403 TORRENCE AVENUE
13e. ZIP CODE: 46327
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): JOSEPH DOBROWOLSKI
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARY TADA

INFORMANT

20a. INFORMANT'S NAME (Type/Print): VICTORIA DOBROWOLSKI
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4403 TORRENCE AVE., HAMMOND, INDIANA 46327
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): NOVEMBER 4, 2006 HOLY CROSS CEMETERY
21c. LOCATION—City or Town, State: CALUMET CITY, ILLINOIS
22a. EMBALMER'S NAME: KEITH D. ANTHONY
22b. EMBALMER'S LICENSE NO.: 01011911
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D. Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327

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. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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.
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: [signature], MD
29c. MEDICAL LICENSE NO.: 01060626
29d. DATE SIGNED (Month, Day, Year): 11/2/06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): O. OLARU M.D. 5454 HOHMAN AVENUE, HAMMOND, INDIANA 46320 — NOVEMBER 2, 2006

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month, Day, Year): November 3, 2006

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or 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.

SDH06-004 State Form 10110 (R5/1-99)