

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2010 076257

2010 DEC 28 AM 10:13

REC'D

STATE OF INDIANA)
)
COUNTY OF LAKE)

Return to:

AFFIDAVIT OF CERTIFICATION OF TRUST

Carolyn R. Waskiewicz _____, being sworn upon oath, states and certifies that:

1. I am the duly appointed and acting Successor Trustee of the 2010 Maybelle Camadeca Trust
2. 2010 Maybelle Camadeca Trust is in existence and is in full force and effect.
3. The original Trustee, Maybelle Camadeca, died on 8-21-10.
4. There were no amendments made to the Trust prior to the death of Maybelle Camadeca.
5. At the death of Maybelle Camadeca was the owner of the following described real estate:
Lot 124 in Edgewood Unit 6A, an Addition to the Town of St. John, as per plat thereof, recorded in Plat Book 80 page 67, in the Office of the Recorder of Lake County, Indiana.

Parcel No.: 45-11-30-352-007.000-035
Common Address: 9238 Calumet Ave.
Saint John, IN 46373

6. I make this Affidavit of Certification of Trust for the purpose of showing the current status of 2010 Maybelle Camadeca Trust, that I am the Successor Trustee named in the Trust, that I have been acting as Successor Trustee since 8-21-10, the date of death of Maybelle Camadeca, and that I have the right to act for and on behalf of the Trust.

7. The Estate of Maybelle Camadeca, deceased, was not subject to federal estate tax.

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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3056-10

State No. _____

1. Decedent's Legal Name (First, Middle, Last) MAYBELLE CAMADECA				1a. Maiden Last Name (If Female) JAMES		2. Sex F	3. Time Of Death 8:02 AM	4. Date Of Death (Month/Day/Year) AUGUST 21, 2010
5. Social Security Number 3649	6a. Age Yrs 85	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) NOVEMBER 5, 1924		8. Birthplace (City And State Or Foreign Country) CLINTON, IN.
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival			10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (If Not Institution, Give Street And Number) 9238 CALUMET AVENUE								
12. City Or Town, State, And Zip Code ST. JOHN, INDIANA 46373				13. County Of Death LAKE		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name NONE			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation SALES		17. Kind Of Business/Industry SEARS
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town ST. JOHN				
18c. Street And Number 9238 CALUMET AVENUE						18d. Apt. No.	18e. Zip Code 46373	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education High school graduate or GED completed		20. Decedent Of Hispanic Origin No, not Spanish/Hispanic/Latino		21. Decedent's Race White				
22. Father's Name (First, Middle, Last) PATRICK JAMES			23. Mother's Name (First, Middle, Last) MINNIE JAMES			23a. Mother's Maiden Last Name GIANOTTI		
24. Informant's Name CAROLYN WASKIEWICZ		24a. Relationship To Decedent DAUGHTER		24b. Mailing Address (Street And Number, City, State, Zip Code) 9101 SCHILLTON DR. ST. JOHN, INDIANA 46373				
25. Place Of Disposition								
25a. Method Of Disposition: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) HOLY CROSS CEMETERY			25c. Location - City, Town, And State CALUMET CITY, ILLINOIS			
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility ELMWOOD CHAPEL 11300 W. 97TH LANE ST. JOHN, INDIANA 46373					27a. Funeral Home License Number: 19900052	
27b. Signature Of Indiana Funeral Service Licensee: 						27c. License Number (Of Licensee) FD09200077		
28. 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.								
Immediate Cause (Final Disease Or Condition Resulting In Death)			A. <u>Neuroendocrine Carcinoma-Carcinoid</u>			Approximate Interval: Onset To Death		
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):		
			C. _____			Due To (Or As A Consequence Of):		
			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						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		
41. Signature Of Person Certifying Cause Of Death: 						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: DR. RAY DRASGA 1205 S. MAIN ST. CROWN POINT, IN. 46307						44. License Number #01031484A		45. Date Certified 08/24/2010
46. Additional Funeral Service Provider:						47. *Akas:		
48. Signature of Local Health Officer: 						49. For Registrar Only - Date Filed (Month/Day/Year): August 24, 2010		