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TRUSTEE CERTIFICATE

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2011 AUG 18 AM 9:33

2011 044418

I, Joan B. Cannon, being the present Trustee of The RFRJ Realty Trust under Declaration Trust dated October 4, 2000, said trust recorded with the Lake County Indiana Recorder as document number 200083901, hereby certify as follows:

1. That I have been authorized by the Beneficiaries of said Trust to sell the premises commonly known as 5117 Indianapolis Boulevard, East Chicago, Indiana 46312.
2. That the RFRJ Realty Trust is presently in existence.
3. That there are no unrecorded amendments in connection with said Trust.
4. All the beneficiaries are of full age.
5. All the beneficiaries are competent.
6. That the Trustee and Beneficiaries of the Trust are not the same persons.
7. The Beneficiary is not a corporation.

Witness my hand and seal this 27 day of July, 2011.

FILED

AUG 12 2011

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

COMMONWEALTH OF MASSACHUSETTS

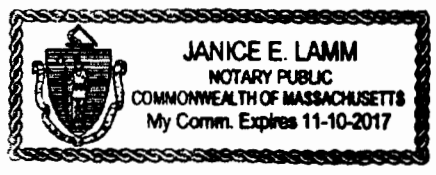
County of Essex, SS.

028230

Joan B. Cannon
Joan B. Cannon, Trustee

On this 27th day of July, 2011, before me, the undersigned notary public, personally appeared Joan B. Cannon, Trustee as aforesaid, proved to me through satisfactory evidence of identification, which was a Massachusetts driver's license, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that she signed it voluntarily for its stated purpose.

Janice E. Lamm



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FIDELITY HO

FR1106072

* 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. 296

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

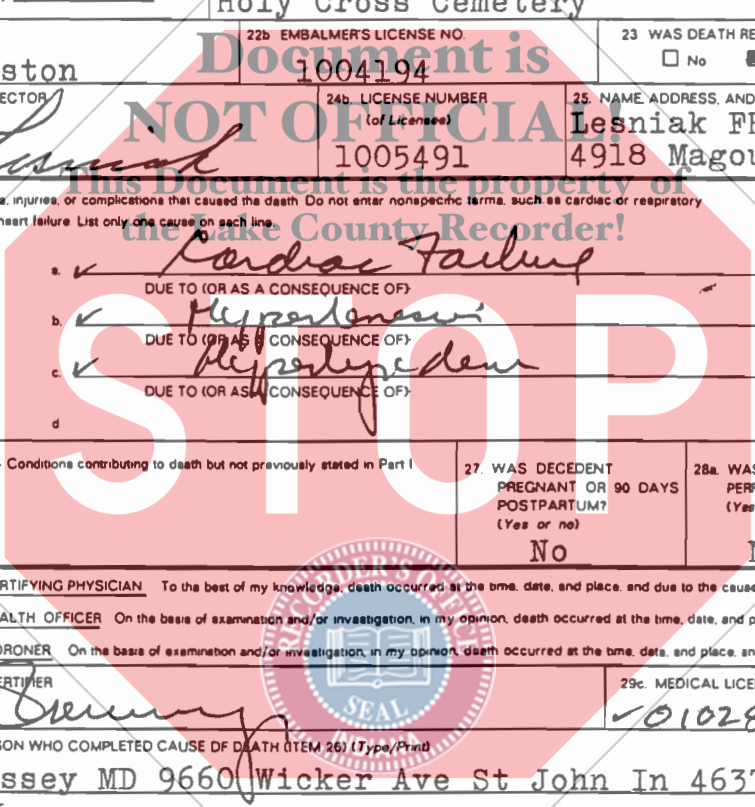
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Robert F Bartczak		2 SEX Male	3a. TIME OF DEATH 7:21a M	3b. DATE OF DEATH (Month, Day, Yr.) Nov 11 2005	
4. *SOCIAL SECURITY NUMBER 317 09 3439	5a. AGE—Last Birthday (Years) 87	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Mo, Day, Yr.) Jun 7 1918	
7. BIRTHPLACE (City and State or Foreign Country) Gary In	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	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 checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) 5117 Indianapolis Blvd		9c. CITY, TOWN, OR LOCATION OF DEATH East Chicago	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) N/A	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Millwright	12b. KIND OF BUSINESS/INDUSTRY Steel Mill		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION East Chicago	13d. STREET AND NUMBER 5117 Indianapolis Blvd		
13e. ZIP CODE 46312	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) 12 College (1-4 or 5+) 		16. FATHER'S NAME (First, Middle, Last) Vincent Bartczak			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Genevieve Skaczowska			20a. INFORMANT'S NAME (Type/Print) Joan Cannon		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Abbot St Andover Mass 01810		20c. Relationship Daughter			
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) Nov 15 2005 Holy Cross Cemetery		21c. LOCATION—City or Town, State Calumet City Il	
22a. EMBALMER'S NAME James W Gholston		22b. EMBALMER'S LICENSE NO. 1004194		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John B. Lesniak</i>		24b. LICENSE NUMBER (of Licensee) 1005491		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Lesniak FH83001601 4918 Magoun E Chicago In 46312	
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Cardiac Failure DUE TO (OR AS A CONSEQUENCE OF)		yes	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. Hypertension DUE TO (OR AS A CONSEQUENCE OF)		yes	
		c. Hypertension DUE TO (OR AS A CONSEQUENCE OF)		yes	
		d.			
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	
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>Alonzo Morrissey</i>			29c. MEDICAL LICENSE NO. 01028441		
29d. DATE SIGNED (Month, Day, Year) 11/15/05					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Alonzo Morrissey MD 9660 Wicker Ave St John In 46373					
31. HEALTH OFFICER'S SIGNATURE <i>Alonzo Morrissey MD</i>				32. DATE FILED (Month, Day, Year) 11/15/05	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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
		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.			



LEGAL DESCRIPTION
EXHIBIT "A"

THE LAND REFERRED TO HEREIN BELOW IS SITUATED IN THE COUNTY OF LAKE, STATE OF INDIANA,
AND IS DESCRIBED AS FOLLOWS:

Lot 46 in Champion Addition, in the City of East Chicago, as per plat thereof, recorded in Plat Book 10 page 30
in the Office of the Recorder of Lake County, Indiana.

