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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2011 069399

2011 DEC -2 AM 10:07

MICHAEL J. TAJMAN
RECORDER

TRUSTEE=S DEED

620114022

TAX: I.D. NO. 45-07-34-202-022.000-006

THIS INDENTURE WITNESSETH, That LORI L. HUYNH-PORTER, AS TRUSTEE UNDER THE PROVISIONS OF THE RAS REVOCABLE TRUST DATED APRIL 6, 2010, GRANTOR, of LAKE County in the State of INDIANA, CONVEYS to MARY*GALAMBOS, GRANTEE of LAKE County in the State of INDIANA, in consideration of One Dollar (\$1.00) and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the following described real estate in LAKE County, in the State of Indiana: *E.

APARTMENT UNIT 104 IN THE BUILDING KNOWN AS 935 WEST GLEN PARK AVENUE, GRIFFITH, INDIANA, IN FOUNTAINHEAD HORIZONTAL PROPERTY REGIME, AS PER DECLARATION RECORDED JULY 8, 1982 AS DOCUMENT NUMBER 673971, AS AMENDED BY INSTRUMENT RECORDED AUGUST 26, 1982 AS DOCUMENT NUMBER 679101, AND AS AMENDED BY THE SECOND AMENDMENT RECORDED APRIL 1983 AS DOCUMENT NUMBER 705568, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA TOGETHER WITH THE UNDIVIDED INTEREST IN THE COMMON AREAS AND FACILITIES APPERTAINING THERETO.

COMMONLY KNOWN AS: 935 W. GLEN PARK, 104, GRIFFITH, INDIANA 46319

SUBJECT TO SPECIAL ASSESSMENTS, IF ANY, 2010 TAXES PAYABLE 2011, 2011 TAXES PAYABLE 2012 AND ALL REAL ESTATE TAXES DUE AND PAYABLE HEREAFTER.

SUBJECT TO EASEMENTS, RESTRICTIONS AND COVENANTS OF RECORD, IF ANY.

THE GRANTOR CERTIFIES THAT THIS DEED IS EXECUTED IN ACCORDANCE WITH AND PURSUANT TO, THE TERMS AND PROVISIONS OF THE UNRECORDED TRUST AGREEMENT UNDER WHICH TITLE TO THE ABOVE DESCRIBED REAL ESTATE IS HELD AND THAT THE TRUSTEE HAS FULL POWER AND AUTHORITY TO EXECUTE THIS DEED AS OF THE DATE OF EXECUTION.

Dated this 22 day of NOVEMBER, 2011.

Lori L. Huynh-Porter trustee
LORI L. HUYNH-PORTER, TRUSTEE

STATE OF INDIANA, COUNTY OF LAKE SS:

Before me, the undersigned, a Notary Public in and for said County and State, this 22 day of NOVEMBER, 2011, personally appeared: LORI L. HUYNH-PORTER, TRUSTEE, and acknowledged the execution of the foregoing deed. In witness whereof, I have hereunto subscribed my name and affixed my official seal.

My commission expires: 9-17-17
Resident of LAKE County

Signature *Andra A. Wiodowski*
Printed ANDRA A WIODOWSKI, Notary Public

This instrument prepared by: PATRICK J. McMANAMA, Attorney at Law, ID No. 9534-45
No legal opinion given to Grantor. All information used in preparation of document was supplied by title company.

RETURN DEED TO: GRANTEE
GRANTEE'S STREET OR RURAL ROUTE ADDRESS: 935 W. GLEN PARK, 104, GRIFFITH, INDIANA 46319
SEND TAX BILLS TO: GRANTEE

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.

Andra A. Wiodowski
Signature of Preparer

ANDREA A WIODOWSKI
Printed Name of Preparer

AMOUNT \$ 13
CASH _____ CHARGE CT
CHECK # _____
OVERAGE _____
COPY _____
NON-COM _____
CLERK AD

DULY ENTERED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER

DEC 01 2011

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

004525

CHICAGO TITLE INSURANCE COMPANY

45-07-34-202-000+000-006

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



Local No. 3057-10

State No.

1. Decedent's Legal Name (First, Middle, Last) RUSSELL A. SHAFER				1a. Maiden Last Name (If Female)		2. Sex M	3. Time Of Death 12:20 AM	4. Date Of Death (Month/Day/Year) SEPTEMBER 11, 2010
5. Social Security Number [REDACTED]	6a. Age Yes 79	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) SEPTEMBER 30, 1930	8. Birthplace (City And State Or Foreign Country) GARY, INDIANA	
9. Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		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 checked="" type="checkbox"/> Hospice Facility <input 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) WILLIAM J. RILEY								
12. City Or Town, State, And Zip Code MUNSTER				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 N/A			15a. (If Wid.) Give Maiden Last Name N/A		16. Decedent's Usual Occupation SUPERVISOR		17. Kind Of Business/Industry UNION CARBIDE	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town GRIFFITH				
18c. Street And Number 935 W. 45TH AVENUE				18d. Apt. No.		18e. Zip Code 46319		18f. In care City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education 9-12th grade, no diploma		20. Decedent Of Hispanic Origin No, not Spanish/Hispanic/Latino		21. Decedent's Race White				
22. Father's Name (First, Middle, Last) ALLEN SHAFER				23. Mother's Name (First, Middle, Last) LOUISE SHAFER		24. Mother's Maiden Last Name MOONEY		
24a. Relationship To Decedent DAUGHTER		24b. Mailing Address (Street And Number, City, State, Zip Code) 8471 WHEELER PLACE, CROWN POINT, INDIANA 46307						
25a. Method Of Disposition: <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) CHAPEL LAWN MEMORIAL GARDENS		25c. Location - City, Town, And State SCHERERVILLE, INDIANA				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility WHITE FUNERAL HOME & CREMATION SERVICE 921 W. 45TH AVENUE GRIFFITH				27a. Funeral Home License Number: FH10600026		
27b. Signature Of Indiana Funeral Service Licensee <i>[Signature]</i>		27c. License Number (Of Licensee) FD08700086						
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.								Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Mesothelioma</u>								
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. _____ C. _____ D. _____								
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. Was Autopsy Finding Available To Coroner To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 45 Days To 1 Year Before Death		32. (Cont.) <input type="checkbox"/> Not Pregnant, But Pregnant Within 45 Days Of Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year		33. Manner Of Death: <input 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 checked="" type="checkbox"/> No	
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Zip Code		
39. Describe How Injury Occurred Transportation Injury, Specify:								
41. Signature Of Person Certifying Cause Of Death: <i>[Signature]</i>				42. Certifier (Check One Box) <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: Mohamad Kassar, M.D. Munster, IN.				44. License Number 01064684A		45. Date Certified 9-13-10		
46. Additional Funeral Service Provider:								
48. Signature of Local Health Officer: <i>[Signature]</i>				49. For Registrar Only - Date Filed (Month/Day/Year): September 14, 2010				

