

FEET EAST OF THE SOUTHWEST CORNER THEREOF, THENCE EAST PARALLEL TO THE SOUTH LINE THEREOF, 801.95 FEET, MORE OR LESS, TO A POINT, SAID POINT BEING 165 FEET WEST OF THE EAST LINE THEREOF; THENCE NORTH AND PARALLEL TO SAID EAST LINE 480.4 FEET, MORE OR LESS, TO A POINT, SAID POINT BEING 435.60 FEET SOUTH OF THE NORTH LINE THEREOF; THENCE WEST 801.95 FEET TO A POINT 435.60 FEET SOUTH OF THE NORTH LINE AND 363 FEET EAST OF THE WEST LINE THEREOF; THENCE SOUTH 480.4 FEET, MORE OR LESS, TO THE PLACE OF BEGINNING.

Commonly described as: 1733 South Fairbanks, Lot A, Griffith, Indiana 46319
a/k/a 1733 South Arbogast, Griffith, Indiana 46319

6. That, therefore, after the death of James E. Bivins, title to the aforementioned property passed to Decedent by operation of law.

7. That, therefore, at the time of her death, the Decedent owned the above-described real property located in Lake County, Indiana individually.

8. That it appears that the Decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of Fifty Thousand Dollars (\$50,000.00), the costs and expenses of administration, and reasonable funeral expenses.

9. That the following people are entitled to an interest in the above-described real property as a result of the Decedent's death:

- a. Sandra Pabst, daughter and only legal heir of Decedent.

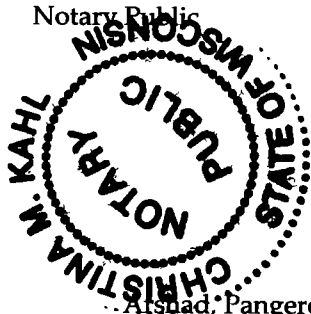
 Sandra Pabst
Sandra Pabst

STATE OF Wisconsin)
COUNTY OF Dane) SS:

Before me, a Notary Public, in and for said County and State, this 18 day of July, 2012, personally appeared Sandra Pabst and acknowledged the execution of the foregoing instrument to be her free and voluntary act.

Christina M. Kahl

exp July 20, 2014



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.

This instrument prepared by:

Sophia J. Arshad, Esq.

Arshad, Pangere and Warring LLP, 7899 Taft Street, Merrillville, IN, 46410; (219) 736-6500.



ATTENTION STATE. 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

Local No. 077-06

CERTIFICATE OF DEATH

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) James Earl Bivins		2 SEX Male	3a TIME OF DEATH 5 00 P M	3b DATE OF DEATH (Month, Day, Yr) March 18, 2006	
4 SOCIAL SECURITY NUMBER 404-40-3069	5a AGE--Last Birthday (Years) 72	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) March 22, 1933	
7 BIRTHPLACE (City and State or Foreign Country) DePoy, Kentucky	8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1956	8c 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"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) Regency Place of Dyer		9c CITY TOWN, OR LOCATION OF DEATH Dyer		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Margaret Reynolds	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Kiln Operator		12b KIND OF BUSINESS/INDUSTRY Great Lakes Carbon	
13a RESIDENCE- STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Griffith		13d STREET AND NUMBER 1733 South Fairbanks Lot A	
13e ZIP CODE 46319	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 8		College (1-4 or 5+)			
18 FATHER'S NAME (First, Middle, Last) Earl Bivins		19 MOTHER'S NAME (First, Middle, Maiden Surname) Lena Beatrice Coombs			
20a INFORMANT'S NAME (Type/Print) Margaret Bivins		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1733 South Fairbanks Lot A Griffith, Indiana 46319		20c Relationship Wife	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) March 22, 2006 Oakland Memory Lanes		21c LOCATION--City or Town State Dolton, Illinois	
22a EMBALMER'S NAME NOT APPLICABLE		22b EMBALMER'S LICENSE NO		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) FD20500007		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Chapel Lawn Funeral Home, FH19900051 8178 Cline Avenue, Schererville, Indiana, 46375	
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 ARF (ACUTE RENAL FAILURE) DUE TO (OR AS A CONSEQUENCE OF)					
b SEVERE PVD (PERIPHERAL VASCULAR DISEASE) DUE TO (OR AS A CONSEQUENCE OF)					
c BLE DUE TO (OR AS A CONSEQUENCE OF)					
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 			29c MEDICAL LICENSE NO 01025591	29d DATE SIGNED (Month, Day, Year) 3-20-06	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) ALEXANDER JEMER, M.D., 761-45th ST., MUNSTER, IN.					
31 HEALTH OFFICER'S SIGNATURE Susan W Best, D.O.					
THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT March 21, 2006					
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 APR 10 2006
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			



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 002090

EDR No 00000269078

State No

1 Decedent's Legal Name (First, Middle, Last) MARGARET E BIVINS		1a Maiden Name (If female) REYNOLDS		2 Sex FEMALE	3 Time Of Death 11 07 AM	4 Date Of Death (Month/Day/Year) 07/08/2012	
5 Social Security Number 231-22-9139	6a Age - Yrs 84	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) 12/26/1927	8 Birthplace (City and State or Foreign Country) ALEXANDRIA, VA
9 Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" 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 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) 1733 SOUTH FAIRBANKS STREET							
12 City Or Town, State, And Zip Code GRIFFITH, IN, 46319				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		15a (If Wife) Give Maiden Last Name		16 Decedent's Usual Occupation HOMEMAKER		17 Kind Of Business/Industry OWN HOME	
18 Residence - State INDIANA		18a County LAKE		18b City Or Town GRIFFITH		18c Street And Number 1733 SOUTH FAIRBANKS STREET	
18d Apt No		18e Zip Code 46319		18f Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
19 Decedent's Education 9TH - 12TH GRADE, NO DIPLOMA		20 Decedent Of Hispanic Origin NOT HISPANIC		21 Decedent's Race White			
22 Father's Name (First, Middle, Last) JAMES HARVEY REYNOLDS		23 Mother's Name (First, Middle, Last) DELLA REYNOLDS		23a Mother's Maiden Last Name SPINKS			
24 Informant's Name SANDRA S PABST		24a Relationship To Decedent DAUGHTER		24b Mailing Address (Street And Number, City, State, Zip Code) 712 SPELLMAN STREET APT 105, MOUNT HOREB, WI 53572			
25 Place Of Disposition							
25a Method Of Disposition <input type="checkbox"/> Burial <input checked="" 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) OAKLAND MEMORY LANES		25c Location - City, Town, And State DOLTON, IL			
26 Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27 Name And Complete Address Of Funeral Facility CHAPEL LAWN FUNERAL HOME AND MEMORIAL GARDENS, 8178 S CLINE AVE., SCHERERVILLE, IN 46375				27a Funeral Home License Number FH19900051	
27b Signature Of Indiana Funeral Service Licensee MICHELLE L HANRAHAN, BY ELECTRONIC SIGNATURE		27c License Number (Of Licensee) FD20900062				27d Signature of Indiana Funeral Service Licensee	
28 Part I Enter The Chain Of Events - Diseases, Injuries Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events. Enter Only One Cause On A Line. Add Additional Lines If Necessary.							
Cause Of Death (See Instructions And Examples) THIS CERTIFICATE IS A TRUE AND COMPLETE STATEMENT OF THE CAUSE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT							
Immediate Cause (Final Disease Or Condition Resulting In Death)		A ACUTE CARDIOPULMONARY ARREST		Due to (Or As A Consequence Of)		Approximate Interval Onset To Death AT TIME OF 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 ATRIAL FIBRILLATION		Due to (Or As A Consequence Of)		JUL 10 2012	
		C HTN		Due to (Or As A Consequence Of)		20 PLUS YEARS	
		D SEVER OSTEO ARTHRITIS		Due to (Or As A Consequence Of)		20 PLUS YEARS	
Part II Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I S/P PACE MAKER PLACEMENT, MORBID OBESITY						29 Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
30 Were Autopsy Finding 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 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 PYARALI M KESHVANI, BY ELECTRONIC SIGNATURE						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 PYARALI M KESHVANI, 8731 INDIANAPOLIS BOULEVARD, HIGHLAND, IN 46322-1551						44 License Number 01042431A	
46 Additional Funeral Service Provider						45 Date Certified 07/09/2012	
47 *Akas							
48 Signature of Local Health Officer SUSAN W BEST, VIA ELECTRONIC SIGNATURE						49 For Registrar Only - Date Filed (Month/Day/Year) JUL 10 2012	
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)							