

4

AFFIDAVIT

On this July 17, 2013 before me personally appeared Gregory ~~Arnold~~ RANDALL ^B

to me personally known, who being duly sworn on oath did say that:

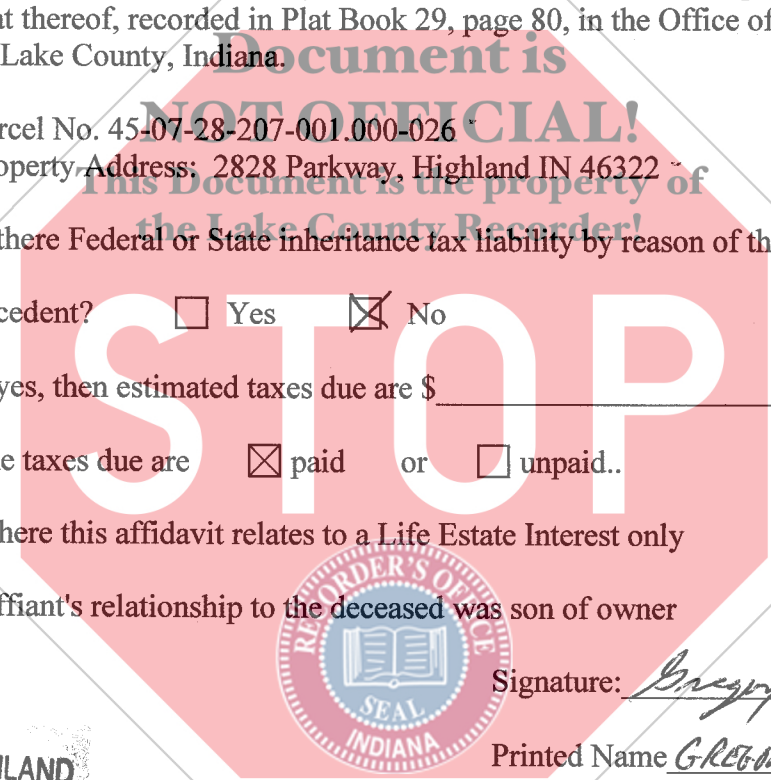
1. Affiant resides at the address given below affiant's signature:
2. Affiant is son of owner
3. Said Eleanor Z Randall who died on April 2, 2009 and Richard E Randall who died on March 17, 2010
4. The legal description of the premises in question is:

Lot 71, in Lincoln Parkway Subdivisi8on, in the Town of Highland ,as per plat thereof, recorded in Plat Book 29, page 80, in the Office of the Recorder of Lake County, Indiana.

Parcel No. 45-07-28-207-001.000-026
Property Address: 2828 Parkway, Highland IN 46322

5. Is there Federal or State inheritance tax liability by reason of the death of said decedent? Yes No
6. If yes, then estimated taxes due are \$ _____
7. The taxes due are paid or unpaid..

Where this affidavit relates to a Life Estate Interest only
Affiant's relationship to the deceased was son of owner



2013 054915

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2013 JUL 29 AM 9:05
MICHAEL BROWN
RECORDER

Signature: Gregory Randall

Printed Name GREGORY RANDALL

Address: 6791 S. ST RD 45
BLOOMFIELD, IN 47424

18
FN
Ca
DON
Comp

004467

FIDELITY - HIGHLAND
920132436

FILED
JUL 26 2013

FIDELITY NATIONAL
TITLE COMPANY
92013-2430

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Subscribed and sworn to before me by the affiant This July 17, 2013



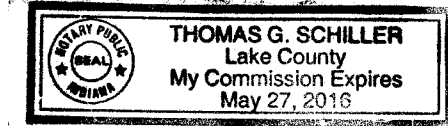
Notary Public

Printed Name: Thomas G Schiller

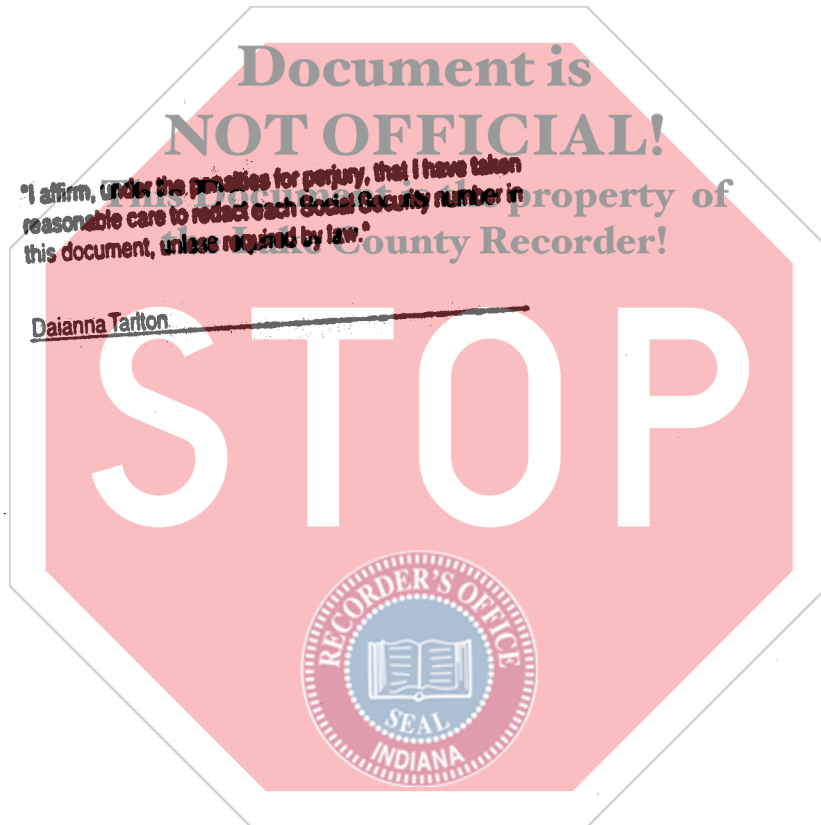
My County of Residence is: Lake

In the State of Indiana

My Commission Expires: May 27, 2016



This instrument prepared by Gregory Randall





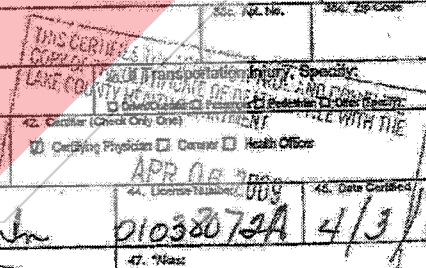
INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

6

Local No. 1924-09

State No.

1. Decedent's Legal Name (First, Middle, Last) ELEANOR Z. RANDALL		12. Maiden Last Name (If Female) Gruener		2. Sex F	3. Time Of Death 3:20 PM	4. Date Of Death (Month/Day/Year) APRIL 2, 2009	
5. Social Security Number 85	6a. Age (Yr) 85	6b. Under 1 Year Months: _____ Days: _____	6c. Under 1 Month Days: _____ Hours: _____	6d. Under 1 Day Hours: _____ Minutes: _____	7. Date Of Birth (Month/Day/Year) August 9, 1923	8. Birthplace (City And State Or Foreign Country) Hammond, Indiana	
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) 2828 PARKWAY DR.							
12. City Or Town, State, And Zip Code HIGHLAND, INDIANA 46322				13. County Of Death LAKE		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name RICHARD RANDALL		15a. If Widowed, Maiden Last Name		16. Decedent's Usual Occupation Secretary		17. Field Of Business/Industry Education	
18. Residence - State INDIANA		18a. County LAKE		18c. City Or Town HIGHLAND			
16a. Street And Number 2828 PARKWAY DR.				16b. Apt. No. N/A	16c. Zip Code 46322		16d. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education Please select education level: 12		20. Decedent Of Hispanic Origin No, not Spanish/Hispanic/Latino		21. Decedent's Race White			
22. Father's Name (First, Middle, Last) Edward Gruener		23. Mother's Name (First, Middle, Last) Caroline Zoe Gruener Bush		24a. Mother's Maiden Last Name			
24. Decedent's Name RICHARD RANDALL		24b. Relationship To Decedent HUSBAND		24c. Mailing Address (Street And Number, City, State, Zip Code) 2828 PARKWAY DR. HIGHLAND, INDIANA 46322			
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) CHAPEL LAWN MEMORIAL GARDENS		25c. Location - City, Town, And State SORBERSVILLE, INDIANA			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility KUIPER FUNERAL HOME 9039 KLEINMAN RD. HIGHLAND, INDIANA 46322				27a. Funeral Home License Number FH1030021	
27b. Signature Of Indiana Funeral Service Director <i>Leonard [Signature]</i>				27c. License Number (Of Licensee) FD0800085			
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. Spleen Cancer						Due To (Or As A Consequence Of):	
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						Approximate Interval; Onset To Death: (Weeks)	
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 checked="" 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"/> Pregnant, But Pregnant 43 Days To 1 Year Before Death		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 checked="" 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. Apt. No. 38d. Zip Code	
39. Describe How Injury Occurred							
41. Signature Of Person Certifying Cause Of Death: <i>[Signature]</i>				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: ERWIN L. ROBIN, MD 801 Madelchen Blvd, Munster, In				44. License Number: 01038072A		45. Date Certified: 4/3/09	
46. Additional Funeral Service Provider:				47. Was:			
48. Signature of Local Health Officer: <i>Suzanne W. Burt, DO</i>				49. For Registrar Only - Date Filed (Month/Day/Year) April 6, 2009			



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



Local No. **844-10**

State No.

1. Decedent's Legal Name (First, Middle, Last) RICHARD E. RANDALL		2. Sex MALE		3. Time of Death 10:06 A.M.		4. Date of Death (Month/Day/Year) MARCH 17, 2010	
5. Social Security Number 89		6. Date of Birth (Month/Day/Year) September 19, 1920		7. Birthplace (City and State or Foreign Country) Hammond, IN			
8. Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		9. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)		10. If Death Occurred Somewhere Other Than A Hospital <input 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) THE COMMUNITY HOSPITAL 901 MACARTHUR BLVD.							
12. City or Town, State, and Zip Code MUNSTER, INDIANA 46321				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		16. Decedent's Usual Occupation Meat Cutter		17. Kind of Business/Industry Food			
18. Residence - State Indiana		19. County Lake		20. City or Town Highland			
21. Street and Number 2828 Parkway Drive		22. Apt. No. N/A		23. Zip Code 46322		24. Viewed Cag Under? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Decedent's Education 12		26. Decedent Of Hispanic Origin No		27. Decedent's Race White			
28. Father's Name (First, Middle, Last) Lloyd Randall		29. Mother's Name (First, Middle, Last) Olive Randall		30. Mother's Maiden Last Name Randall			
31. Informant's Name Larry Randall		32. Relationship to Decedent Son		33. Mailing Address (Street, P.O. Number, City, State, Zip Code) 378 S. 150 E. Valparaiso, IN 46383			
34. 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)		35. Place of Disposition Evergreen Crematory		36. Location - City, Town, and State Evergreen Park, Illinois			
37. Name and Complete Address of Funeral Facility Kulper Funeral Home 9039 Kleinman Road Highland, Indiana 46322		38. Funeral Home License Number PH10300021		39. License Number of Licenses PD08800305			
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. CAD (Coronary Artery Disease) B. _____ C. _____ D. _____ 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. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I. Conjunctive Heart Failure, Diabetes, Colon Cancer							
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 Fatalist <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, Did Pregnant 49 Days To 1 Year Before Death <input type="checkbox"/> Pregnant 50 Days To 1 Year Before Death		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. Location Of Injury - State		36. City Or Town		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
38. Describe How Injury Occurred		39. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		40. Signature of Person Certifying Cause Of Death Pankaj Arora		41. Name, Address And Zip Code Of Person Certifying Cause Of Death 5529 HOHMAN AVENUE HAMMOND, INDIANA 46320	
42. Signature of Local Health Officer Susan J. Best, D.O.		43. License Number 01050432A		44. Date Certified MARCH 18, 2010		45. For Registrar Use - Date Filed (Month/Day/Year) March 19, 2010	



State Form 10110 (02-07) ATTENTION: EGATED: The Social Security file being requested by this same agency in order to pursue its statutory responsibility. Signature is voluntary and there will be no penalty for refusal. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IO 19-0-0-0