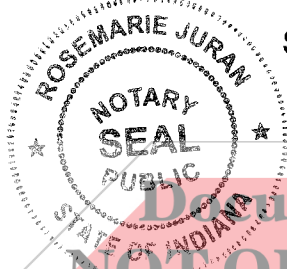


STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Judith A. Havran, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 10th day of February, 2014.

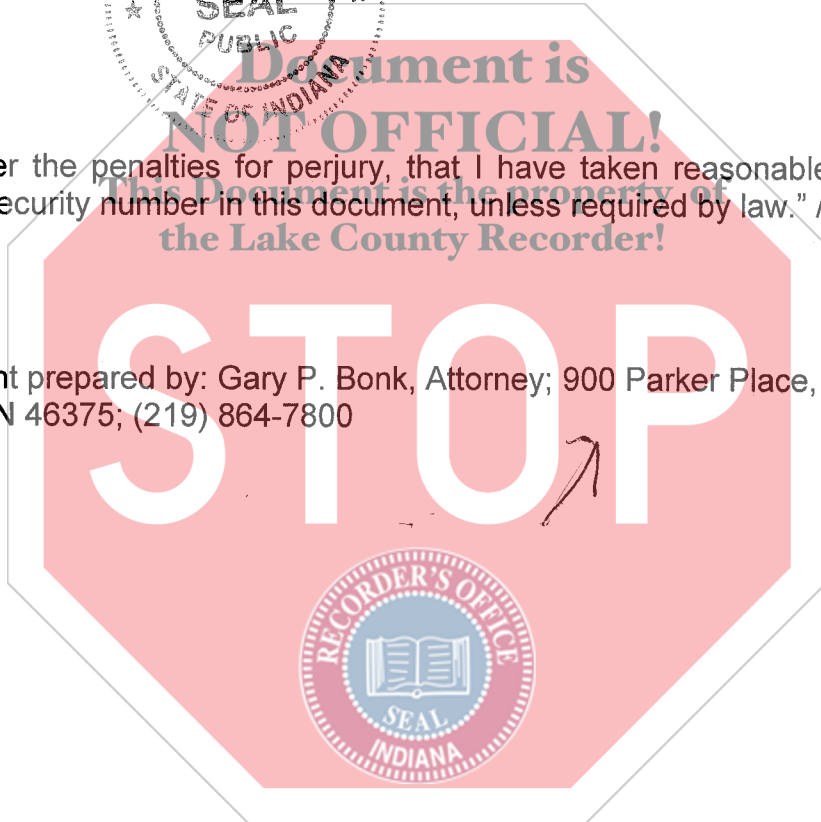
My commission expires: 09/06/2014



Signature: Rosemarie Juran
Rosemarie Juran
Resident of: Lake County, Indiana

Document is NOT OFFICIAL!
"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." /s/Gary P. Bonk
the Lake County Recorder!

This instrument prepared by: Gary P. Bonk, Attorney; 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800





**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

Local No **002473**

EDR No **00000274136**

State No

1. Decedent's Legal Name (First, Middle, Last) RICHARD M HAVRAN				1a. Maiden Name (If female)		2. Sex MALE		3. Time Of Death 08:00 PM		4. Date Of Death (Month/Day/Year) 08/07/2012			
5. Social Security Number		6a. Age - Yrs 75		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) 03/18/1937		8. Birthplace (City and State or Foreign Country) EAST CHICAGO, IN											
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) ST ANTHONY HOSPICE-CROWN POINT													
12. City Or Town, State, And Zip Code CROWN POINT, IN, 46307						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 JUDITH HAVRAN				15a. (If Wife) Give Maiden Last Name FOSTER				16. Decedent's Usual Occupation SALES		17. Kind Of Business/Industry AUTO PARTS			
18. Residence - State INDIANA				18a. County LAKE				18b. City Or Town CEDAR LAKE					
18c. Street And Number 13900 BUTTERNUT STREET						18d. Apt. No.		18e. Zip Code 46303		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 NOT HISPANIC				21. Decedent's Race White					
22. Father's Name (First, Middle, Last) MICHAEL HAVRAN				23. Mother's Name (First, Middle, Last) MARY HAVRAN				23a. Mother's Maiden Last Name ZIEMKOWSKI					
24. Informant's Name JUDITH HAVRAN				24a. Relationship To Decedent WIFE				24b. Mailing Address (Street And Number, City, State, Zip Code) 13900 BUTTERNUT STREET, CEDAR LAKE, IN 46303					
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) COMMUNITY CREMATION SERVICE				25c. Location - City, Town, And State SCHERERVILLE, IN					
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility BURDAN FUNERAL HOME INC, 12901 WICKER AVENUE, CEDAR LAKE, IN 46303						27a. Funeral Home License Number. FH83002461					
27b. Signature Of Indiana Funeral Service Licensee SCOTT A. BURDAN, BY ELECTRONIC SIGNATURE						27c. License Number (Of Licensee) FD20700051							
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. LUNG CANCER WITH BONE AND LIVER METASTASIS 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													
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 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 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)					
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 KATHRYN HENKLE MULLIGAN, 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 KATHRYN HENKLE MULLIGAN, 919 MAIN STREET, SUITE 102, DYER, IN 46311						44. License Number 01052342A		45. Date Certified 08/09/2012					
46. Additional Funeral Service Provider						47. *Ages.							
48. Signature Of Local Health Officer. SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year) AUG 10 2012							
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)													