

3

### AFFIDAVIT

On this March 31, 2015 before me personally appeared Charlene Wagner  
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 Successor Trustee  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
3. Said Donald D. McMahan  
(fill in name of life estate tenant who died)  
died on 11/13/2014
4. The legal description of the premises in question is:

The North 50 Ft. of Lot 1, Block 3 in Hobart Park Addition to the city of Hobart as per plat thereof, recorded in Plat book 12, Page 30 in the Office of the Recorder of Lake County, Indiana

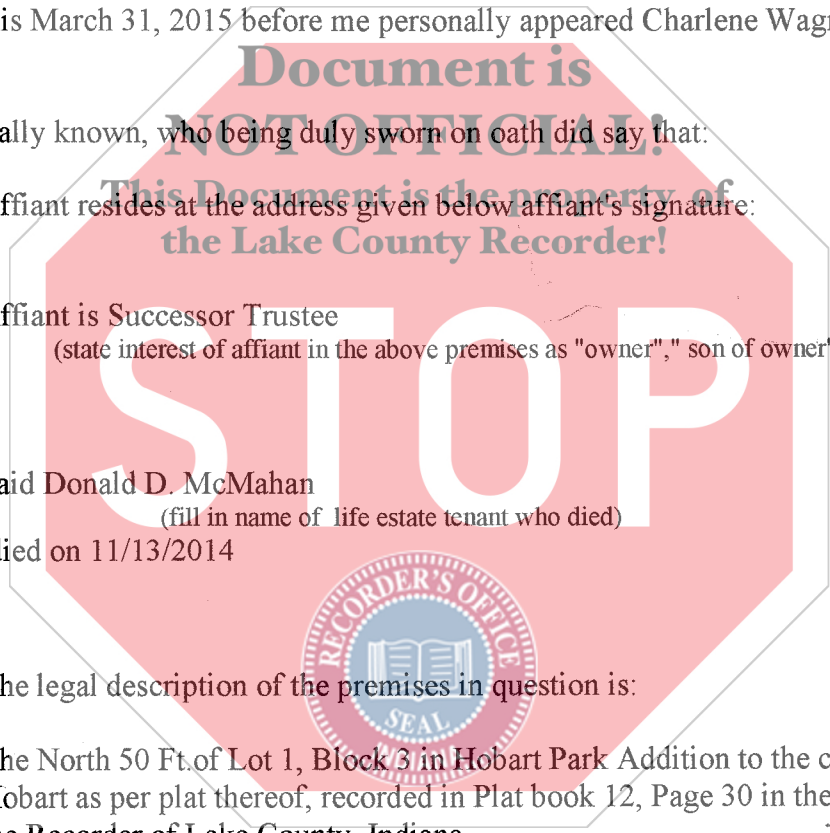
45-09-31-202-013-000-018

5. Is there Federal or State inheritance tax liability by reason of the death of said decedent?  Yes  No

If yes, then estimated taxes due are \$ \_\_\_\_\_

The taxes due are  paid or  unpaid..

6. Where this affidavit relates to a Life Estate Interest only.



2015 021809

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
MICHAEL B. BROWN  
RECORDER  
2015 APR 15 AM 10:07

**FILED**

APR 10 2015

20369 JOHN E. PETALAS LAKE COUNTY AUDITOR

000150300  
**FIDELITY HBT**

\$ 16  
FN  
CA  
NON  
Caml

LAKE COUNTY RECORDERS OFFICE

92015-0360

7. Affiant's relationship to the deceased was Sister

Signature: Charlene Wagner

Printed Name Charlene Wagner

Address: 163 East 8th Street  
Hobart, Indiana

Subscribed and sworn to before me by the affiant

This March 31, 2015  
(insert date)

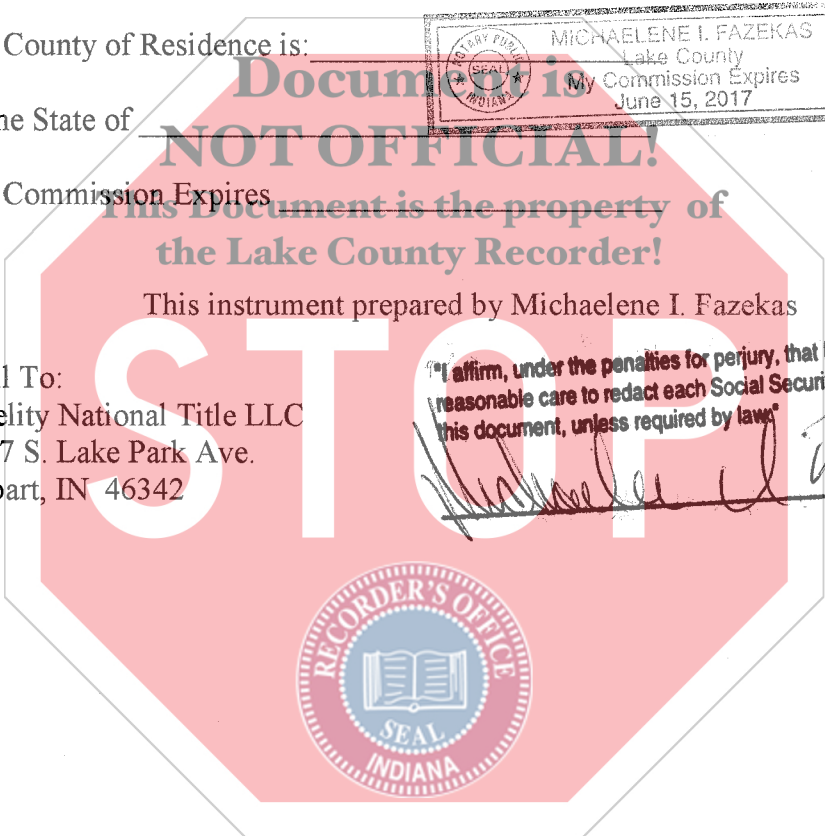
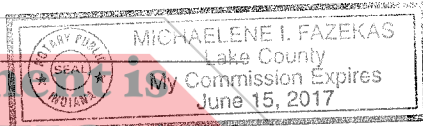
Michaelene I. Fazekas  
Notary Public

Printed Name \_\_\_\_\_

My County of Residence is: \_\_\_\_\_

In the State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_



This instrument prepared by Michaelene I. Fazekas

Mail To:  
Fidelity National Title LLC  
1457 S. Lake Park Ave.  
Hobart, IN 46342

"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."

Michaelene I. Fazekas





INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tracking No. 35251

Local No 003622

EDR No 000000414884

State No 051658

1. Decedent's Legal Name (First, Middle, Last) <b>DONALD D MC MAHAN</b>		1a. Maiden Name (If Female)		2. Sex <b>MALE</b>	3. Time Of Death <b>09:00 PM</b>	4. Date Of Death (Month/Day/Year) <b>11/13/2014</b>	
5. Social Security Number <b>██████████</b>	8a. Age - Yrs <b>82</b>	8b. Under 1 Year Months	8c. Under 1 Month Days	8d. Under 1 Day Hours	8e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) <b>03/27/1932</b>	
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 checked="" 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 type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)			8. Birthplace (City and State or Foreign Country) <b>EAST GARY, IN</b>
11. Facility Name (If Not Institution, Give Street and Number) <b>METHODIST HOSPITAL SOUTHLAKE</b>							
12. City Or Town, State, And Zip Code <b>MERRILLVILLE, IN, 46410</b>			13. County Of Death <b>LAKE</b>		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input checked="" type="checkbox"/> Divorced <input 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 <b>MILLWRIGHT</b>		17. Kind Of Business/Industry <b>CONSTRUCTION</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>HOBART</b>		18c. Street And Number <b>100 SOUTH PENNSYLVANIA AVENUE</b>	
18d. Apt. No.		18e. Zip Code <b>46342</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>		20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>		21. Decedent's Race <b>White</b>			
22. Father's Name (First, Middle, Last) <b>CHARLES PRENTICE MC MAHAN</b>		23. Mother's Name (First, Middle, Last) <b>MARY JANE MC MAHAN</b>		23a. Mother's Maiden Last Name <b>SWAFFORD</b>			
24. Informant's Name <b>CHARLENE WAGNER</b>		24a. Relationship To Decedent <b>SISTER</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>163 EAST 8TH STREET, HOBART, IN 46342</b>			
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) <b>CHAPEL LAWN MEMORIAL GARDENS</b>		25c. Location - City, Town, And State <b>SCHERERVILLE, IN</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>REES FUNERAL HOME, HOBART CHAPEL, 600 W OLD RIDGE RD, HOBART, IN 46342</b>		27a. Funeral Home License Number <b>FH83003069</b>			
27b. Signature Of Indiana Funeral Service Licensee <b>JAMES J. KRAUSE, BY ELECTRONIC SIGNATURE</b>		27c. License Number (Of Licensee) <b>FD01006463</b>		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. <b>VASCULAR COMPROMISE</b> Due to (Or As A Consequence Of): <b>DAY</b> B. _____ Due to (Or As A Consequence Of): _____ C. _____ Due to (Or As A Consequence Of): _____ D. _____ 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			
Part II. Enter Other Significant Conditions Contributing To Death. Do Not Repeat 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 Finding 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 type="checkbox"/> No <input checked="" 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		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. Location Of Injury - State <b>INDIANA</b>			
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			
41. Signature, Of Person Certifying Cause Of Death <b>RUPESH J. SHAH, BY ELECTRONIC SIGNATURE</b>		42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> State Health Officer		43. License Number (Of Licensee) <b>02002108A</b>			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death <b>RUPESH J. SHAH, 202 E 26TH PLACE, MERRILLVILLE, IN 46411</b>		44. Date Of Death <b>11/13/2014</b>		45. Date Of Signature <b>11/13/2014</b>			
46. Additional Funeral Service Provider		47. Signature Of Local Health Officer <b>SUSAN W. BEST, VIA ELECTRONIC SIGNATURE</b>		48. For Registrar Only - Date Filed (Month/Day/Year) <b>NOV 18 2014</b>			

