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

2015 021809

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

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..

FILED
APR 10 2015
JOHN E. PETALAS
LAKE COUNTY AUDITOR

20369 Q20150360

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

FIDELITY HBT NON COMM

#14 FN CA

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 _____

MICHAELENE I. FAZEKAS
Lake County
My Commission Expires
June 15, 2017

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): DONALD D MC MAHAN	1a. Maiden Name (If female):			2. Sex: MALE	3. Time Of Death: 09:00 PM	4. Date Of Death (Month/Day/Year): 11/13/2014	
5. Social Security Number: [redacted]	6a. Age - Yrs: 82	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): 03/27/1932	8. Birthplace (City and State or Foreign Country): EAST GARY, IN
9. Ever in U.S. Armed Forces? ☒ Yes ☐ No ☐ Unknown	10. If Death Occurred In A Hospital: ☒ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival				10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-term Care Facility ☐ Other (Specify)		
11. Facility Name (If Not Institution, Give Street and Number): METHODIST HOSPITAL SOUTHLAKE							
12. City Or Town, State, And Zip Code: MERRILLVILLE, IN, 46410		13. County Of Death: LAKE			14. Marital Status At Time Of Death: ☐ Married ☐ Married, But Separated ☒ Divorced ☐ Widowed ☐ Never Married ☐ Unknown		
15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation: MILLWRIGHT		17. Kind Of Business/Industry: CONSTRUCTION		
18. Residence - State: INDIANA	18a. County: LAKE	18b. City Or Town: HOBART					
18c. Street And Number: 100 SOUTH PENNSYLVANIA AVENUE			18d. Apt. No.	18e. Zip Code: 46342	18f. Inside City Limits? ☒ Yes ☐ 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): CHARLES PRENTICE MC MAHAN		23. Mother's Name (First, Middle, Last): MARY JANE MC MAHAN		23a. Mother's Maiden Last Name: SWAFFORD			
24. Informant's Name: CHARLENE WAGNER	24a. Relationship To Decedent: SISTER	24b. Mailing Address (Street And Number, City, State, Zip Code): 163 EAST 8TH STREET, HOBART, IN 46342					
25a. Method Of Disposition: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place): CHAPEL LAWN MEMORIAL GARDENS	25c. Location - City, Town, And State: SCHERERVILLE, IN					
26. Was Coroner Contacted? ☐ Yes ☒ No	27. Name And Complete Address Of Funeral Facility: REES FUNERAL HOME, HOBART CHAPEL, 600 W OLD RIDGE RD, HOBART, IN 46342			27a. Funeral Home License Number: FH83003069			
27b. Signature Of Indiana Funeral Service Licensee: JAMES J. KRAUSE , BY ELECTRONIC SIGNATURE			27c. License Number (Of Licensee): FD01006463				

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.

Cause Of Death (See Instructions And Examples) | Approximate Interval: Onset To Death

Immediate Cause (Final Disease Or Condition Resulting In Death): a. VASCULAR COMPROMISE — Due to (Or As A Consequence Of): — DAY

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. — Due to (Or As A Consequence Of):
c. — Due to (Or As A Consequence Of):
d. — Due to (Or As A Consequence Of):

Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I: NATURAL

29. Was An Autopsy Performed? ☐ Yes ☒ No
30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☐ No
31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☐ No ☒ Unknown
32. If Female: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year
33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ 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? ☐ Yes ☐ 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: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other/Unknown

41. Signature, Of Person Certifying Cause Of Death: RUPESH J. SHAH , BY ELECTRONIC SIGNATURE
42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: RUPESH J. SHAH , 202 E 86TH PLACE, MERRILLVILLE, IN 46411
44. License Number: 02002106A
45. Date Certified: 11/17/2014
46. Additional Funeral Service Provider:
47. "Amended"
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE
49. For Registrar Only - Date Filed (Month/Day/Year): NOV 18 2014

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

THIS IS THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT
NOV 18 2014
LAKE COUNTY HEALTH OFFICER

NOT VALID UNLESS RAISED SEAL AFFIXED

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and will not affect any benefits.