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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2015 067762

2015 OCT 21 PM 1:33

MICHAEL B. BROWN  
RECORDER

STATE OF INDIANA)  
 ) SS:  
COUNTY OF LAKE)

**AFFIDAVIT**

The undersigned, being duly sworn, depose and says as follow:

- 1. That he is an adult competent to make this Affidavit;
- 2. That he is the designated Successor Trustee under a certain Trust Agreement establishing the K. JOAN KIECHLE TRUST dated September 30, 2010, by K. Joan Kiechle, Trustor; further that he has executed an Acceptance of Office and Certification of Successor Trustee Status dated August 21, 2013, a copy of which is attached as Exhibit "A" hereto.

3. That the real estate held in said Trust by virtue of the said Trust Agreement and the Warranty Deed conveying the property into the Trust is legally described as follows:

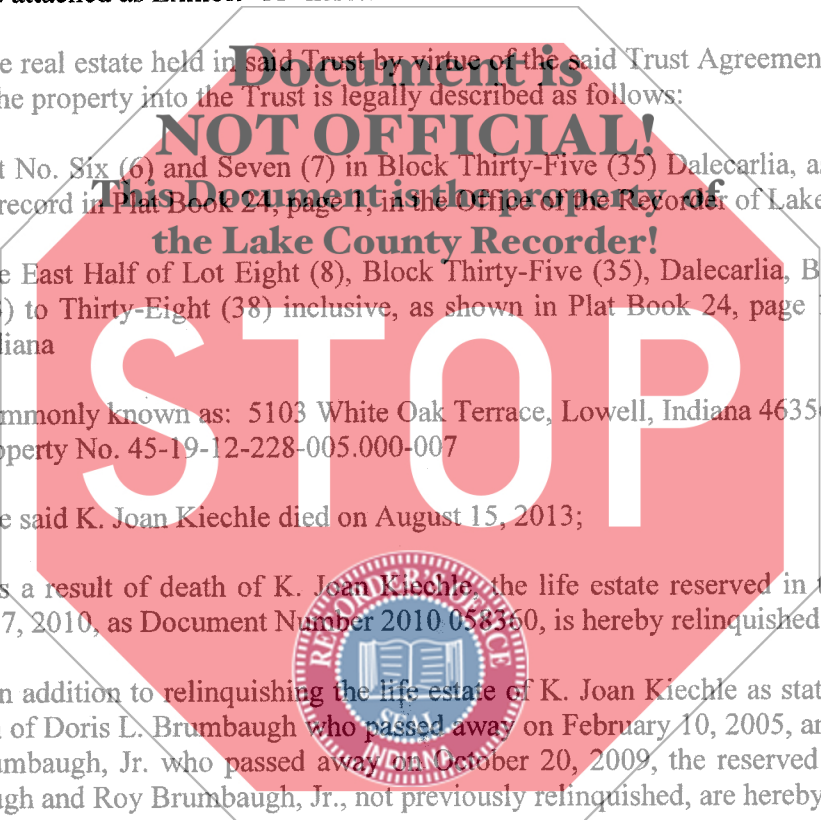
Parcel 1: Lot No. Six (6) and Seven (7) in Block Thirty-Five (35) Dalecarlia, as the same appears of record in Plat Book 24, page 1, in the Office of the Recorder of Lake County, Indiana.

Parcel 2: The East Half of Lot Eight (8), Block Thirty-Five (35), Dalecarlia, Blocks Thirty-Three (33) to Thirty-Eight (38) inclusive, as shown in Plat Book 24, page 1, in Lake County, Indiana

Commonly known as: 5103 White Oak Terrace, Lowell, Indiana 46356  
Property No. 45-19-12-228-005.000-007

- 4. That the said K. Joan Kiechle died on August 15, 2013;
- 5. That as a result of death of K. Joan Kiechle, the life estate reserved in the Trustee's Deed recorded October 7, 2010, as Document Number 2010 058360, is hereby relinquished;
- 6. That in addition to relinquishing the life estate of K. Joan Kiechle as stated above, that as a result of the death of Doris L. Brumbaugh who passed away on February 10, 2005, and as a result of the death of Roy Brumbaugh, Jr. who passed away on October 20, 2009, the reserved life estate of both Doris L. Brumbaugh and Roy Brumbaugh, Jr., not previously relinquished, are hereby relinquished.

7. That pursuant to the said Trust Agreement, Successor Trustee, Deby Brumbaugh, has the power to convey the said real estate;



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CMM

**FILED**

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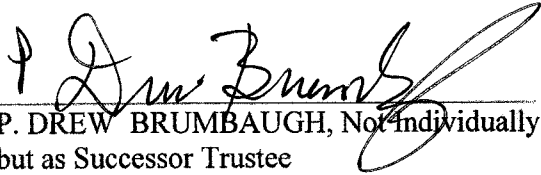
JOHN E. PETALAS  
LAKE COUNTY AUDITOR

Community Title Company  
File No. 158570


8. That the purpose of this Affidavit is to perfect the rights of the Successor Trustee, to alienate and convey the said real estate.

FURTHER YOUR AFFIANTS SAYETH NOT.

Dated 21 day of September, 2015.

  
P. DREW BRUMBAUGH, Not Individually  
but as Successor Trustee

21 Subscribed and sworn to before me, a Notary Public in and for the above County and State this day of September, 2015.

  
Notary Public -  
Residing in Los Angeles County

My Commission Expires:

July 20, 2019



*I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law. David M. Austgen. This document prepared by: David M. Austgen, Austgen Kuiper Jasaitis P.C., 130 North Main Street, Crown Point, Indiana 46307.*

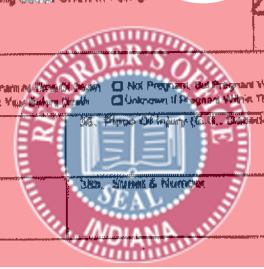
INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH



Local No. 3619-09

State No. ....

1. Decedent's Legal Name (First, Middle, Last) <b>Roy Brumbaugh Jr.</b>				10. Maiden Last Name (If Female)		2. Sex <b>Male</b>	3. Time Of Death <b>10:30 PM</b>	4. Date Of Death (Month/Day/Year) <b>October 20, 2009</b>	
5. Social Security Number [REDACTED]		6a. Age - Yrs <b>92</b>	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	7. Date Of Birth (Month/Day/Year) <b>April 18, 1917</b>		8. Birthplace (City And State Or Foreign Country) <b>Roan, Indiana</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 type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival			11a. 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) <b>5103 White Oak Terrace</b>									
12. City Or Town, State, And Zip Code <b>Lowell</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name <b>N/A</b>			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation <b>Owner</b>		17. Kind Of Business/Industry <b>Lumber Yard</b>	
18. Residence - State <b>Indiana</b>		18a. County <b>Lake</b>		18b. City Or Town <b>Lowell</b>		18c. Apt. No.		18d. Zip Code <b>46356</b>	18e. Inside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
19a. Street And Number <b>5103 White Oak Terrace</b>		19b. Apt. No.		19c. Zip Code		19d. Inside City Limits?		19e. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19. Decedent's Education <b>Some College, no degree</b>			20. Decedent Of Hispanic Origin <b>No</b>			21. Decedent's Race <b>White</b>			
22. Father's Name (First, Middle, Last) <b>Roy Brumbaugh Sr.</b>			23. Mother's Name (First, Middle, Last) <b>Eva Brumbaugh</b>			24. Mother's Maiden Last Name <b>Stump</b>			
25. Informant's Name <b>Joan Kiechle</b>			26. Relationship To Decedent <b>Daughter</b>			27. Mailing Address (Street And Number, City, State, Zip Code) <b>5103 White Oak Terrace, Lowell, IN 46356</b>			
28a. 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):		28b. Place Of Disposition (Name Of Cemetery, Crematory, Donation Office) <b>Heritage Crematory</b>		28c. Disposition - City, Town, And State <b>Portage, IN</b>		27a. License Number (If Licensed) <b>FD08900045</b>		27b. Funeral Home License Number <b>FH83004277</b>	
29. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>Sheets Funeral Home &amp; Cremation Services 604 E. Commercial Ave., Lowell, IN 46356</b>			27c. License Number (If Licensed) <b>FD08900045</b>		27d. Funeral Home License Number <b>FH83004277</b>		
27e. Signature Of Indiana Funeral Service Licenses: <b>Ken Sheets</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>Acute Myocardial Infarction</b> B. <b>Coronary Atherosclerosis</b> C. <b>Arteriosclerosis (Atherosclerosis)</b> D. <b>End Stage Alzheimer's Disease</b> Approximate Interval: Onset To Death									
28. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I. <input type="checkbox"/> Yes <input checked="" 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 Date 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		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (Toilets, Decedent's Home, Construction Site, Restaurant, Wooded Area)		38a. Apt. No.		38b. Zip Code	
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: <b>Bernardo S. Lucena</b>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certified Physician <input type="checkbox"/> Certified Health Officer		43. Date Certified <b>10/22/09</b>	
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>Bernardo S. Lucena MD 12800 Mississippi Pkwy, Crown Point, IN 46307</b>						44. License Number <b>0103930DA</b>		45. State Certified <b>IN</b>	
46. Additional Funeral Service Provider:						47. "AAR"		48. Signature of Local Health Officer: <b>Susan J Best, D.O.</b>	
48. Signature of Local Health Officer:						49. Date Certified <b>October 22, 2009</b>			



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

State No. ....

Local No. 428-05

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-18-3

(PE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) **Doris L. Brumbaugh**

2. SEX **Female**

3a. TIME OF DEATH **06:30 AM**

3b. DATE OF DEATH (Month, Day, Year) **February 10, 2005**

4. SOCIAL SECURITY NUMBER **[REDACTED]**

5a. AGE—Last Birthday (Years) **88**

5b. UNDER 1 YEAR (Months, Days)

5c. UNDER 1 DAY (Hours, Minutes)

6. DATE OF BIRTH (Mo, Day, Yr) **March 10, 1916**

7. BIRTHPLACE (City and State or Foreign Country) **Seymour IN**

8a. WAS DECEDENT A U.S. VETERAN? **No**

8b. YEAR LAST SERVED IN U.S. ARMED FORCES? **N/A**

9a. PLACE OF DEATH (Check only one. See instructions.)  
 HOSPITAL  Inpatient  ER/Outpatient  OOA  
 OTHER:  Nursing Home  Other (Specify)  Residence

9b. FACILITY NAME (If not institution, give street and number) **St. Anthony's Nursing Home**

9c. CITY, TOWN, OR LOCATION OF DEATH **Crown Point**

9d. COUNTY OF DEATH **Lake**

10. MARITAL STATUS (Specify) **Married**

11. SURVIVING SPOUSE (If wife, give maiden name) **Roy Brumbaugh**

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Homemaker**

12b. KIND OF BUSINESS/INDUSTRY **Own Home**

13a. RESIDENCE—STATE **Indiana**

13b. COUNTY **Lake**

13c. CITY, TOWN, OR LOCATION **Lowell**

13d. STREET AND NUMBER **5103 White Oak Terrace**

13e. ZIP CODE **46356**

13f. INSIDE CITY LIMITS  No  Yes

13g. ON A FARM?  No  Yes

14. CITIZEN OF WHAT COUNTRY? **USA**

15. WAS DECEDENT OF HISPANIC ORIGIN?  No  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) **12** College (1, 4 or 5 +)

18. FATHER'S NAME (First, Middle, Last) **Wright Payne**

19. MOTHER'S NAME (First, Middle, Maiden Surname) **Mildred Newman**

20a. INFORMANT'S NAME (Type/Print) **K. Joan Kiechle**

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **625 S. Lakeview Dr., Lowell, IN 46356**

20c. Relationship **Daughter**

21a. METHOD OF DISPOSITION  Burial  Cremation  Entombment  Removal from State  Donation  Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **Feb 14, 2005 Heritage Crematory**

21c. LOCATION—City or Town, State **Portage IN**

22a. EMBALMER'S NAME **N/A**

22b. EMBALMER'S LICENSE NO. **N/A**

23. WAS DEATH REPORTED TO CORONER?  No  Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *Mildred Newman*

24b. LICENSE NUMBER (of Licensee) **FD09200061**

24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **Sheets Funeral Home FH83004277 604 E. Commercial Ave. Lowell, IN 46356**

25. PART I. Enter the disease, 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. (Specify) **Acute Pulmonary Edema**

IMMEDIATE CAUSE (Final disease or condition resulting in death)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause first

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)  
 CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.  
 HEALTH OFFICER On the basis of examination and/or investigation in the person death occurred at the time, date, and place, and due to the cause(s) as stated.  
 CORONER On the basis of examination and/or investigation in my office, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER *Bernard S. Lucena*

29c. MEDICAL LICENSE NO. **16430**

29d. DATE SIGNED (Month, Day, Year) **2/11/05**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If not informant) **Bernard S. Lucena MD 1121 South Indiana, Crown Point, IN 46307**

31. HEALTH OFFICER'S SIGNATURE *Susan J. Butts*

31a. DATE FILED (Month, Day, Year) **SEP 05 2013**

31b. DATE FILED (Month, Day, Year) **FEBRUARY 15, 2013**

33. MANNER OF DEATH  
 Natural  Pending Investigation  
 Accident  Could not be Determined  
 Suicide  Homicide

34a. DATE OF INJURY (Month, Day, Year)

34b. TIME OF INJURY

34c. INJURY AT WORK? (Yes or No)

34d. DESCRIBE HOW INJURY OCCURRED

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.

