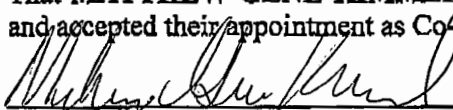
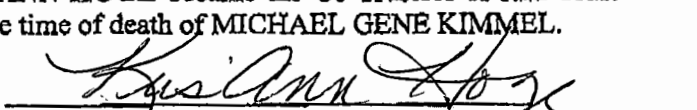


4. That the undersigned are the named Successor Co-Trustees of said MICHAEL GENE KIMMEL LIVING TRUST dated June 8, 1993.
5. That **MATTHEW GENE KIMMEL** and **KRIS ANN HOGE** became the Co-Trustees of said Trust and accepted their appointment as Co-Trustees at the time of death of MICHAEL GENE KIMMEL.



MATTHEW GENE KIMMEL



KRIS ANN HOGE

THIS AFFIDAVIT SUBSCRIBED and SWORN to before me, by the Affiant, on this 20th day of March, 2017.

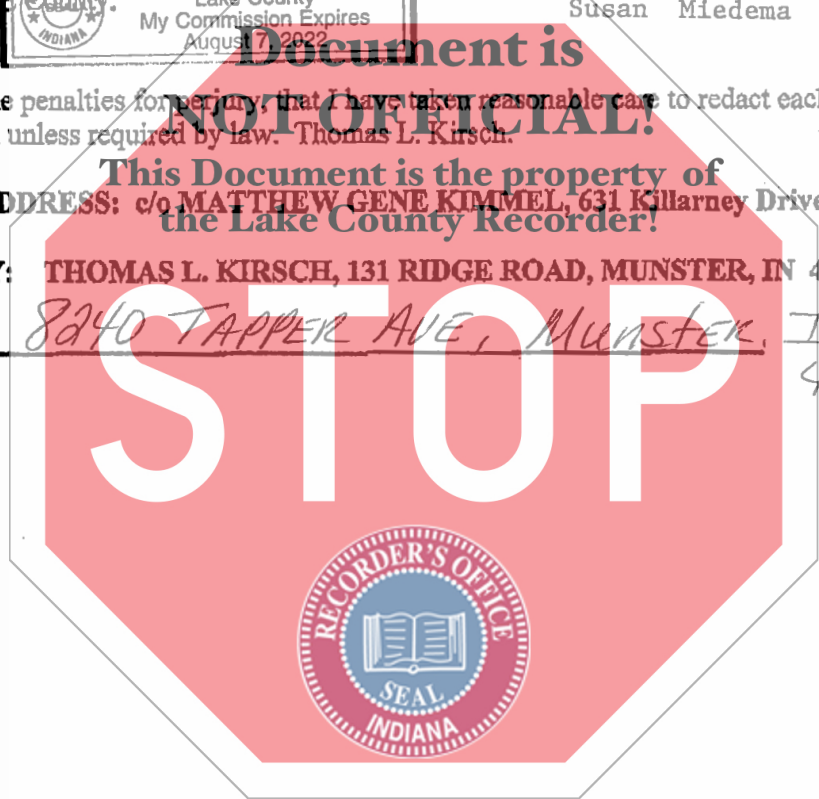
My commission expires
 Resident of LAKE
 Public





 Susan Miedema, Notary

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. Thomas L. Kirsch.



GRANTEES' ADDRESS: c/o **MATTHEW GENE KIMMEL**, 631 Killarney Drive, Dyer, IN 46311

PREPARED BY: **THOMAS L. KIRSCH**, 131 RIDGE ROAD, MUNSTER, IN 46321

MAIL TO: 8240 TAPPER AVE, MUNSTER, IN.
46321



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Tracking No. 106114

Local No. 003887

EDR No 00000545514

State No 056532

1. Decedent's Legal Name (First, Middle, Last) MICHAEL GENE KIMMEL				1a. Maiden Name (If female)		2. Sex MALE		3. Time Of Death 09:00 PM		4. Date Of Death (Month/Day/Year) 11/28/2016	
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5. Social Security Number		6a. Age - Yrs 84		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) 02/19/1932		8. Birthplace (City and State or Foreign Country) EAST ST. LOUIS, IL	
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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 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)					
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11. Facility Name (If Not Institution, Give Street and Number) 9615 BOULEVARD DRIVE											
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12. City Or Town, State, And Zip Code HIGHLAND, IN, 46322						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		
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15. Surviving Spouse's Name				15a. Last Name Before First Marriage				16. Decedent's Usual Occupation SUPERINTENDENT				17. Kind Of Business/Industry SCHOOL			
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18. Residence - State INDIANA				18a. County LAKE				18b. City Or Town HIGHLAND			
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18c. Street And Number 9615 BOULEVARD DRIVE						18d. Apt. No.		18e. Zip Code 46322		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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19. Decedent's Education MASTER'S DEGREE (MA, MS, MENG, MED, MSW, MBA)				20. Decedent Of Hispanic Origin NOT HISPANIC				21. Decedent's Race White			
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22. Parent's Name (First, Middle, Last) IRA LEON KIMMEL						23. Parent's Name (First, Middle, Last) WILMA KIMMEL						23a. Parent's Last Name Before First Marriage THEISS					
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24. Informant's Name MATT KIMMEL				24a. Relationship To Decedent SON				24b. Mailing Address (Street And Number, City, State, Zip Code) 681 KILBUCK DRIVE, DYER, IN 46311							
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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) OAKLAND MEMORY LANES				25c. Location - City, Town, And State DOLTON, IL			
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26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				27. Name And Complete Address Of Funeral Facility SMITS FUNERAL HOME, 2121 PLEASANT SPRINGS LANE, DYER, IN 46311								27a. Funeral Home License Number FH11000037			
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27b. Signature Of Indiana Funeral Service Licensee TIMOTHY G. SMITS, BY ELECTRONIC SIGNATURE						27c. License Number FD206000101						Of Licensee:					
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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 One Line. Add Additional Lines If Necessary.												Approximate Interval - Onset To Death	
Immediate Cause (Final Disease Or Condition Resulting In Death) A. CARDIOPATHY												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												Due to (Or As A Consequence Of):	
B. PULMONARY FIBROSIS												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												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 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 <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			
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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 type="checkbox"/> No			
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38. Location Of Injury - State				38a. City Or Town				38b. Street & Number				38c. Apt. No.				38d. Zip Code			
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39. Describe How Injury Occurred												40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian	
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41. Signature, Of Person Certifying Cause Of Death LYLE R MUNN, BY ELECTRONIC SIGNATURE						42. Certifier (Check Only One): <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer					
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43. Name, Address And Zip Code Of Person Certifying Cause Of Death LYLE R MUNN, 85 E US HIGHWAY 6, MEDICAL PLAZA, STE 235, VALPARAISO, IN 46383						44. License Number 01031582A						45. Date Certified 11/30/2016					
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46. Additional Funeral Service Provider:												47. *Fax:	
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48. Signature Of Local Health Officer CHANDANA VAVILALA, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year) DEC 01 2016					
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AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)											
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