2

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2017 DEC 19 AM 10: 45
MICHAEL B. BROWN
RECORDER

2017 086126

AFFIDAVIT OF DEATH OF TRUSTEE

State of Indiana
County of Lake

STANFORD J.LEVIN, of legal age, being first duly sworn, deposes and says:

1. Saul S. Levin, the decedent mentioned in the attached certified copy of Certificate of Death, is the same person named as CO- Trustee in the Saul S. Levin Declaration of Trust dated MARCH 3, 1989.

2. At the time of the decedent's death, decedent was the co-owner, as Trustee, of certain real property acquired by a deed recorded on JUNE 16, 1989, as instrument No. 042375 in the Official Records of LAKE County, State of Indiana, covering the following described property situated in the said County, State of INDIANA :

The South 76.96 feet of Lot 4 (4), Block Three (3), South View Addition in the City of Hammond, as shown in Plat Book 12, page 32, in Lake County, Indiana. 45-06-12-104-015.000-023

3. I am the successor Trustee of the same trust under which said decedent held title as trustee pursuant to the deed described above, and am designated and empowered pursuant to the terms of said trust to serve as Trustee thereof.

Dated 12-18-17

By: Stanford J. Levin

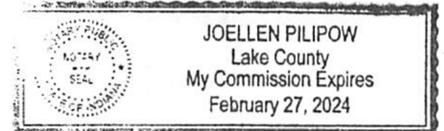
State of Indiana) SS
County of Lake)
Before me, the undersigned, a Notary Public, in and for said County and State, personally appeared Stanford J. Levin, Grantor, and acknowledged the execution of said deed to be his voluntary act and deed for the uses and purposes expressed therein.

WITNESS MY HAND AND SEAL THIS 18th Day of December, 2017.

Notary Public

Resident of Lake County, Indiana

My commission expires:



FILED

DEC 19 2017

JOHN E. PETALAS
LAKE COUNTY AUDITOR

032362

25.00
CK# 1005
CP

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. ...020270/............ State No. ....

265470

TYPE/PRINT IN PERMANENT BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

DECEDENT

- 1. DECEASED—NAME (First, Middle, Last): Saul S. Levin
- 2. SEX: Male
- 3a. TIME OF DEATH: 1:15P M
- 3b. DATE OF DEATH (Month, Day, Yr): September 12, 2001
- 4. *SOCIAL SECURITY NUMBER: [redacted]
- 5a. AGE—Last Birthday (Years): 92
- 5b. UNDER 1 YEAR: Months / Days
- 5c. UNDER 1 DAY: Hours / Minutes
- 6. DATE OF BIRTH (Mo, Day, Yr): Oct. 31, 1908
- 7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL
- 8a. WAS DECEDENT A U.S. VETERAN? Yes
- 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
- 9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
- 9b. FACILITY NAME (If not institution, give street and number): Dyer Nursing & Rehabilitation
- 9c. CITY, TOWN, OR LOCATION OF DEATH: Dyer
- 9d. COUNTY OF DEATH: Lake
- 10. MARITAL STATUS (Specify): Married
- 11. SURVIVING SPOUSE (If wife, give maiden name): Lillian A. Abrahmson
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Dentist
- 12b. KIND OF BUSINESS/INDUSTRY: Medical
- 13a. RESIDENCE—STATE: FL
- 13b. COUNTY: Palm Beach
- 13c. CITY, TOWN, OR LOCATION: Lake Worth
- 13d. STREET AND NUMBER: 3595 Birdie Dr. #602B
- 13e. ZIP CODE: 33467
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM? ☒ No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY? U.S.A.
- 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+): 5+

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): Morris Levin
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna A. Abramson

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Lillian Levin
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3595 Birdie Dr. Lake Worth, FL 33467
- 20c. Relationship: Wife

DISPOSITION

- 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): September 16, 2001 Kneseth Israel Cemetery
- 21c. LOCATION—City or Town, State: Hammond, IN
- 22a. EMBALMER'S NAME: ----
- 22b. EMBALMER'S LICENSE NO: ----
- 23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas J Burns
- 24b. LICENSE NUMBER (of Licensee): 1045184
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Munster, IN 46321

CAUSE OF DEATH

26. PART I. Enter the diseases, 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 on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

- a. Cardiopulmonary arrest
- DUE TO (OR AS A CONSEQUENCE OF)
- b. Arteriosclerotic heart disease
- DUE TO (OR AS A CONSEQUENCE OF)
- c.
- DUE TO (OR AS A CONSEQUENCE OF)
- d.

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Diabetes mellitus, Hypothyroidism, Atrial fibrillation

- 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): --

CERTIFIER

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 my opinion, 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 opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated.

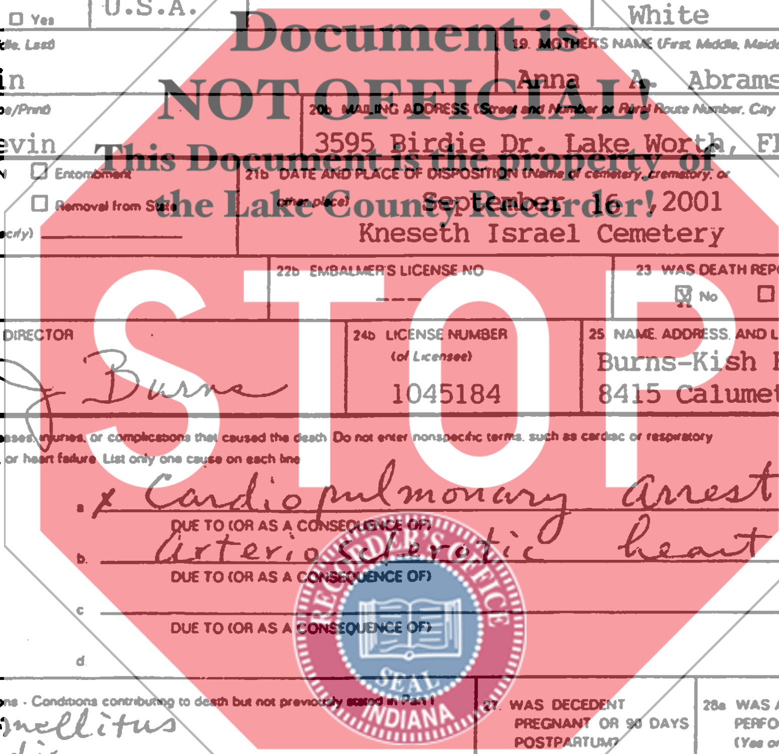
- 29b. SIGNATURE AND TITLE OF CERTIFIER: x J. Paik, M.D.
- 29c. MEDICAL LICENSE NO: x 30770
- 29d. DATE SIGNED (Month, Day, Year): Sept. 13, 2001
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Paik, M.D. 200 Monticello Dr. Dyer, IN 46311

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Susan W Best, D.O.
- 32. DATE FILED (Month, Day, Year): September 13, 2001
- 33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
- 34a. DATE OF INJURY (Month, Day, Year):
- 34b. TIME OF INJURY:
- 34c. INJURY AT WORK? (Yes or no):
- 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.

THIS CERTIFIES THE ABOVE TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

SEP 13 2001



SDH06-004 State Form 10110 (R5/1-99)