

AFFIDAVIT OF SURVIVORSHIP

STATE OF WYOMING)
) ss.
County of Sheridan)

I, **SANDRA ARNIERI MILLS**, being first duly sworn upon oath, do depose
and say:

1.

I am one of the surviving children of Catherine M. Harker.

2.

A Warranty Deed between Homer A. Scott and Mildred S. Scott, as the Grantors, and Catherine M. Harker and Sandra A. Mills, Grantees, was recorded March 26, 1991, in the County Clerk and Recorder's Office in Sheridan County, Wyoming, Book 340, Page 310, No. 77851, and includes the following property:

Lot 27, Scott Addition.

A subdivision in Sheridan County, Wyoming, as recorded in Book 1 of Plats, page 124.

3.

A Quitclaim Deed between Catherine M. Harker, as the Grantor, and Catherine M. Harker and Sandra Arneri Mills, Grantees, was recorded September 3, 1998, in the County Clerk and Recorder's Office in Sheridan County, Wyoming, Book 396, Page 152, No. 295158, and includes the following property:

Lot 28, Scott Addition, a subdivision in Sheridan County, Wyoming, as recorded in Book 1 of Plats, page 124.

4.

On the 11th day of June, 2004, Catherine M. Harker passed away and appended hereto is a certified copy of her death certificate.

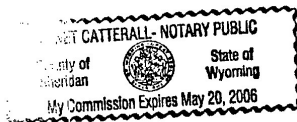
5.


By reason of the death of Catherine M. Harker, her right, title and interest in and to said real property terminated and the sole title in said property is now vested in Sandra A. Mills, also known as Sandra Arneri Mills.

Further your affiant saith not.


SANDRA ARNIERI MILLS

Subscribed and sworn to before me this 6th day of August, 2004, by Sandra Arneri Mills.




Notary Public

My Commission expires: May 20, 2006

CERTIFICATION OF VITAL RECORD

STATE OF WYOMING

DEPARTMENT OF HEALTH

STATE OF WYOMING DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

LOCAL FILE NUMBER 1083

STATE FILE NUMBER

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) Catherine M. Harker		2. SEX Female		3. DATE OF DEATH (Mo/Day/Yr) (Spell Month) June 11, 2004	
4. SOCIAL SECURITY NUMBER 520-10-8788		5a. AGE - Last Birthday (Years) 88		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:	
6. DATE OF BIRTH (Mo/Day/Yr) April 8, 1916		7a. PLACE OF DEATH (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home / Long Term Care Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
7b. FACILITY NAME (If not institution, give street and number) 177 Scott Drive		7c. CITY, TOWN, OR LOCATION OF DEATH Sheridan		7d. COUNTY OF DEATH Sheridan	
8. BIRTHPLACE (City and state or foreign country) Kansas City, KS		9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input checked="" type="checkbox"/> Married but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> R/S <input type="checkbox"/> Unknown		10. SURVIVING SPOUSE (If wife, give name prior to first marriage) None	
11. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		12a. RESIDENCE - STATE Wyoming		12b. COUNTY Sheridan	
12c. STREET AND NUMBER 177 Scott Drive		12d. ZIP CODE 82801		12e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13. FATHER'S NAME (First, Middle, Last) Pete Melneck		14. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Cady Roman			
15a. INFORMANT'S NAME Sandy Mills		15b. RELATIONSHIP TO DECEDENT Daughter			
15c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 24350-18 N. Whispering Ridge Way, A2 85255		15d. ADDRESS OF FACILITY Champion Ferries F. H. 244 S. Brooks St., Sheridan, WY			
16. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Donation <input type="checkbox"/> Removal from Wyoming <input type="checkbox"/> Other		17a. PLACE OF DISPOSITION (Name of cemetery or crematory) Sheridan Municipal		17b. LOCATION - CITY OR TOWN AND STATE Sheridan, Wyoming	
18a. SIGNATURE OF FUNERAL SERVICE LICENSEE (If certifier acting as agent) <i>Mark E. Berry</i>		18b. LICENSE NO. 359		18c. NAME OF FACILITY Champion Ferries F. H.	
20. ACTUAL OR PRESUMED TIME OF DEATH 3:00		21. DATE PRONOUNCED DEAD (Mo/Day/Yr) June 11, 2004		22. TIME PRONOUNCED DEAD 300	
23. WAS CORONER CONTACTED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24. 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. C.A.D.			
25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. IF FEMALE AGED 10-54 <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			
29. MANNER OF DEATH <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		30. DATE OF INJURY (Mo/Day/Yr)			
31. TIME OF INJURY		32. PLACE OF INJURY (Decedent's home, construction site, forest, etc.)		33. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
34. LOCATION OF INJURY (Street and number, City or Town, State)		35. IF TRANSPORTATION ACCIDENT, SPECIFY: <input type="checkbox"/> Driver / Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)			
36. DESCRIBE HOW INJURY OCCURRED, AND IF TRANSPORTATION INJURY, THE TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.)					
37a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> PHYSICIAN - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> 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 stated.					
37b. DATE CERTIFIED (Mo/Day/Yr) 6-15-04		37c. NAME, TITLE AND ADDRESS OF CERTIFIER (Type or print) William Williams, M.D., Dr. 1456 West 5th Street, Sheridan, WY			
38a. REGISTRAR'S SIGNATURE <i>Andrew Marwood, Deputy</i>		38b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr) June 21, 2004			

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This is a true and exact reproduction of the document on file in the office of Vital Records Services, Cheyenne, Wyoming.

DATE ISSUED: **JUN 24 2004**

Lucinda McCaffrey
Lucinda McCaffrey
Deputy State Registrar

This copy is not valid unless prepared on paper with an engraved border displaying the date, seal and signature of the Deputy State Registrar.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE