



KAREN ELLISON, RECORDER

APN Parcel No. 1318-15-818-001 PTN  
Contract No.: 000570605451  
Recording requested by: Gunter-Hayes & Associates  
WHEN RECORDED RETURN TO:  
Gunter-Hayes & Associates  
3200 West Tyler Street, Suite D  
Conway, AR 72034

**AFFIDAVIT OF DEATH**

STATE OF FLORIDA  
COUNTY OF ORANGE

The undersigned Affiant, of legal age being first duly sworn, deposes and says: THAT CAROL L WILKISON, the decedent mentioned in the attached certified copy of Certificate of Death, was the same person as CAROL L WILKISON, named as one of the parties in that certain deed executed by Wyndham Vacation Resorts, Inc., to Leroy Wilkison and Carol Wilkison Joint Tenants With The Right of Survivorship, , recorded as instrument No. 01076700 on January 24th, 2007 of Official Records in the Office of County Recorder of Douglas County, State of Nevada.

Legal Description of Property:

A 105,000/109,787,500 undivided fee simple interest as tenants in common in **Units 8101, 8102, 8103, 8201, 8202, 8203, 8301, 8302 and 8303 in South Shore Condominium** ("Property"), located at 180 Elks Point Road in Zephyr Cove, Nevada 89449, according to the Final Map #01-026 and Condominium Plat of South Shore filed of record in Book 1202, Page 2181 as Document Number 559872 in Douglas County, Nevada, and subject to all provisions thereof and those contained in that certain Declaration of Condominium - South Shore ("Timeshare Declaration") dated October 21, 2002 and recorded December 5, 2002 in Book 1202, Page 2182 as Instrument Number 559873, and also subject to all the provisions contained in that certain Declaration of Restrictions for Fairfield Tahoe at South Shore and recorded October 28, 2004 in Book 1004, Page 13107 as Instrument Number 628022, Official Records of Douglas County, Nevada, which subjected the Property to a timeshare plan called Fairfield Tahoe at South Shore ("Timeshare Plan").

Being more particularly described in the deed recorded concurrently herewith and hereby incorporated in its entirety by this reference

Affiant: Lashunda Thomas

**ACKNOWLEDGEMENT**

Dated this 09/08/2014

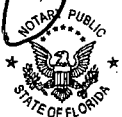
Subscribed and Sworn before me, Notary Public, on 09/08/2014 personally appeared Lashunda Thomas, personally known to me (~~or proved to me on the basis of satisfactory evidence~~) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/~~her~~/their authorized capacity(ies) and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal

SIGNATURE: \_\_\_\_\_

Printed Name: **Onzalo Pullin**

My Commission Expires



**ONZALO PULLIN**  
MY COMMISSION # EE 122431  
EXPIRES: September 24, 2015  
Bonded Thru Budget Notary Services

**CERTIFICATION OF VITAL RECORD**

**STATE OF MARYLAND**  
 Department of Health and Mental Hygiene  
 Division of Vital Records  
 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

**Certificate of Death**

Reg. No. \_\_\_\_\_

1. Decedent's Name (First, Middle, Last) <b>CAROL L WILKISON</b>				2. Date of Death Month <b>12</b> Day <b>3</b> Year <b>2013</b>		3. Time of Death <b>10:28</b> M		
4a. Facility Name (if not institution, give street and number) <b>UNIV OF MARYLAND</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>		
5. Social Security Number <b>6576</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 15, 1951</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
10a. State <b>Maryland</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Newcomb</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>25896 Miles Haven Road</b>				10f. Zip Code <b>21653</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Airline Station Manager</b>		16b. Kind of Business/Industry <b>Air Canada Jazz</b>			
17. Father's Name (First, Middle, Last) <b>John Swigert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lorraine Ogden</b>				
19a. Informant's Name/Relationship (Type, Print) <b>LeRoy A. Wilkison (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25896 Miles Haven Road Newcomb, Maryland 21653</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Pk. Cem.</b>		20c. Date <b>12/09/2013</b>		20d. Location - City or Town, State <b>Elkridge, Maryland</b>		
21. Signature of Funeral Service Licensee <b>[Signature]</b> <b>MOO-732</b>			22. Name and Address of Facility <b>McCully-Polyniak Funeral Home, P.A.</b> <b>3204 Mountain Road Pasadena, Maryland 21122</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Ruptured Intracranial Aneurysm</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated 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):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month _____ Day _____ Year _____		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Abdominal Aortic Aneurysm, Peripheral Vascular Disease</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: 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. <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>[Signature] MD</b>			29c. License number <b>FT0496782</b>		29d. Date signed (Month, Day, Year) <b>December 3, 2013</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RONALD TESORIENO, 22 S. Greene Street Baltimore MD 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 12 2013</b>		32. Registrar's Signature <b>[Signature]</b>						

Department of Health and Mental Hygiene  
 Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.  
 To Be Completed by Funeral Director  
 To Be Completed by Physician/Medical Examiner

77 Rev 06-2011

1621849

Date Issued December 12, 2013

ORIGINAL

I HEREBY CERTIFY THAT THIS DOCUMENT IS A TRUE COPY OF A RECORD ON FILE IN THE DIVISION OF VITAL RECORDS.

**Geneva S. Sparks**  
STATE REGISTRAR

DO NOT ACCEPT UNLESS ON SECURITY PAPER WITH SEAL OF VITAL RECORDS CLEARLY EMBOSSED.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE