



MEMORANDUM OF TRUST

KNOW ALL MEN BY THESE PRESENTS:

We, Gary Cook and Debra Weis, of lawful age, being first duly sworn do depose and state as follows:

1. The Allen C. Anderson Trust dated November 12, 2004 (the "Trust") was created on November 12, 2004.
2. The Trust was Amended and Restated on September 26, 2016
3. The name of the sole trustee of the Trust was Allen C. Anderson.
4. Article VI of the Trust provides that upon the death or incapacity of Allen C. Anderson, Gary Cook, Debra Weis and Coleman Robinson would serve as Successor Trustees.
5. Coleman Robinson declined to server as a Co-Trustee.
6. Allen C. Anderson, Settlor/Trustee, died on September 3, 2020, a resident of Wagoner County, State of Oklahoma. Attached hereto is a certified copy of the Certificate of Death of Allen C. Anderson. The Estate is not of sufficient size to require the filing of an United States Estate Tax Return.

IN WITNESS WHEREOF, this Memorandum of Trust has been executed as of the date set forth above.

Gary Cook
Gary Cook, Trustee

Debra Weis
Debra Weis, Trustee

Community Title Services, LLC
3130 E 71st
Tulsa, OK 74136
407402

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Gary Clark, Trustee



Debra Weis, Trustee

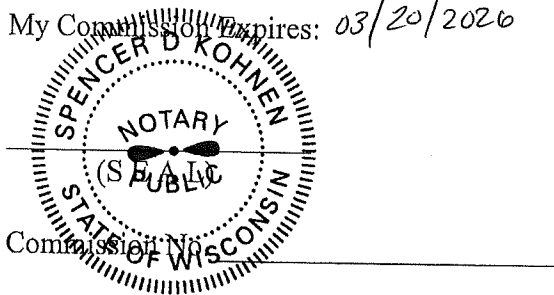
ACKNOWLEDGMENT

STATE OF WISCONSIN)
) ss
COUNTY OF WOOD)

This instrument was acknowledged before me on this 25 day of July, 2022, by Gary Cook as Trustee of The Allen C. Anderson Trust.

S. D. H.
Notary Public

My Commission Expires: 03/20/2026



STATE OF WINCONSIN)
) ss
COUNTY OF DANE)

This instrument was acknowledged before me on this _____ day of July, 2022, by Debra Weis as Trustee of The Allen C. Anderson Trust.

Notary Public

My Commission Expires:

(SEAL)

Commission No. _____

ACKNOWLEDGMENT

STATE OF WISCONSIN)
) ss
COUNTY OF WOOD)

This instrument was acknowledged before me on this _____ day of July, 2022, by Gary Cook as Trustee of The Allen C. Anderson Trust.

Notary Public

My Commission Expires:

(SEAL)

Commission No. _____

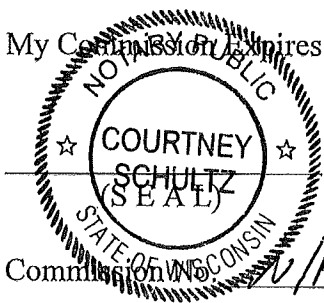
STATE OF WISCONSIN)
) ss
COUNTY OF DANE)

This instrument was acknowledged before me on this 26th day of July, 2022, by Debra Weis as Trustee of The Allen C. Anderson Trust.

Courtney Schultz

Notary Public

My Commission Expires: 4-27-26



Commission No. _____

CERTIFICATE OF VITAL RECORD



STATE OF OKLAHOMA
CERTIFICATE OF DEATH

STATE FILE NUMBER 2020-028604

1. DECEDENT'S LEGAL NAME (First, Middle, Last, Suffix) ALLEN C ANDERSON			1a. LAST NAME PRIOR TO FIRST MARRIAGE ANDERSON		2. SEX MALE
3. SOCIAL SECURITY NUMBER 394-28-5895	4. EVER IN US ARMED FORCES? YES	5a. AGE- Last birthday (years) 87	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo/Day/Yr) DECEMBER 15, 1932
7. BIRTHPLACE (City and State or Foreign Country) MILWAUKEE, WISCONSIN		8a. RESIDENCE-State OKLAHOMA	8b. RESIDENCE-County WAGONER		8c. RESIDENCE-City or Town PORTER
8d. RESIDENCE-Zip Code 74454	8e. RESIDENCE-Inside City Limits? NO	8f. RESIDENCE-Street and Number 43643 E. 191 ST. S			8g. RESIDENCE-Apt. Number
9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married, but separated <input type="checkbox"/> Unknown			10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)		
11a. FATHER'S NAME (First, Middle, Last) HENRY MAURICE ANDERSON		11b. FATHER'S LAST NAME PRIOR TO FIRST MARRIAGE ANDERSON		12a. MOTHER'S NAME (First, Middle, Last) JOSEPHINE ANDERSON	
12b. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE ANDERSON		13. DECEDENT OF HISPANIC ORIGIN? NO, NOT SPANISH/HISPANIC/LATINO		14. DECEDENT'S RACE WHITE	
15. DECEDENT'S EDUCATION BACHELOR'S DEGREE (E.G. BA, AB, BS)		16. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED.) BUSINESS OWNER		17. KIND OF BUSINESS / INDUSTRY OWN BUSINESS	
18a. INFORMANT'S NAME GARY NEIL COOK		18b. RELATIONSHIP TO DECEDENT NEPHEW		18c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 5920 ASHBURY DRIVE, WISCONSIN RAPIDS, WISCONSIN 54494	
19. 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)		20. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) SHIPMAN FUNERAL HOME AND CREMATORY		21. LOCATION - City, Town and State WAGONER, OKLAHOMA	
22. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY SHIPMAN FUNERAL HOME AND CREMATORY - WAGONER, 2809 S. HWY 69, WAGONER, OKLAHOMA 74467			23. FUNERAL HOME DIRECTOR OR FAMILY MEMBER ACTING AS SUCH JASON R. SHIPMAN		
			24. FH ESTABLISHMENT LICENSE # 1306ES		

25. PLACE OF DEATH (Check only one; see instructions)					
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival			IF DEATH OCCURRED OTHER THAN IN A HOSPITAL: <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):		
26. FACILITY NAME (If not institution, give street & number) 43643 E. 191 ST. S		27. CITY OR TOWN, STATE AND ZIP CODE OF LOCATION OF DEATH PORTER, OKLAHOMA, 74454		28. COUNTY OF DEATH WAGONER	
29. DATE OF DEATH (Mo/Day/Yr) SEPTEMBER 3, 2020	30. TIME OF DEATH 20:09	31. WAS MEDICAL EXAMINER CONTACTED? YES	32. WAS AN AUTOPSY PERFORMED? NO	33. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?	
CAUSE OF DEATH (See Instructions and examples)					
34. 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 ventilator fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.			Approximate interval: Onset to death	35. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):			UNKNOWN	DIABETES MELLITUS	
Sequentially list conditions, if any, leading to the cause listed on line a. b. Due to (or as a consequence of):					
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST. c. Due to (or as a consequence of):					
2067437 d. Due to (or as a consequence of):					
36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		37. 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		38. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
39. DATE OF INJURY (Mo/Day/Yr)	40. TIME OF INJURY	41. PLACE OF INJURY (e.g., Decedent's home; construction site; wooded area)		42. DESCRIBE HOW INJURY OCCURRED:	
43. INJURY AT WORK?		44. LOCATION OF INJURY: State: City or Town: Zip Code:			
Street & Number:		Apartment Number:			
45. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (specify)			46. CERTIFIER (Check only one) ATTENDING PHYSICIAN: <input type="checkbox"/> Physician in charge of the patient's care <input type="checkbox"/> Physician in attendance at time of death only 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 checked="" 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.		
47. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 34) JOSHUA LANTER, MD 1115 WEST 17TH STREET TULSA, OKLAHOMA 74107			48. LICENSE NUMBER 262950K		
49. DATE DEATH CERTIFIED (Mo/Day/Yr) SEPTEMBER 16, 2020			50. REGISTRAR'S SIGNATURE <i>Kelly M Baker</i>		
51. DATE RECEIVED BY STATE REGISTRAR (Mo/Day/Yr) SEPTEMBER 17, 2020			52. REGISTRAR'S SIGNATURE		

To be completed by the Funeral Home

To be completed by the Attending Physician or Medical Examiner

VOID IF ALTERED OR ERASED

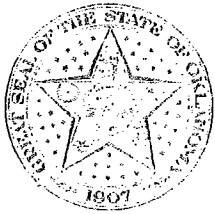
Friday, September 18, 2020 11:30:00 AM



D04577573

This is a true and correct copy of the official record on file in the Office of Vital Statistics, Oklahoma City, Oklahoma, certified on the date stamped.

Kelly M. Baker
State Registrar
Office of Vital Statistics,
Department of Health



It is in violation of Oklahoma Statutes, Title 63, Section 1-324.1, to "prepare or issue any certificate which purports to be original, certified copy or copy of a certificate of birth, death or stillbirth, except as authorized in this act or rules and regulations adopted under this act."

CERTIFIED COPIES WILL BE PRODUCED ON MULTI-COLOR SECURITY PAPER.

VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIGURES. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.
THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND. THE BACK CONTAINS SPECIAL LINES WITH TEXT, EMBOSSED SEAL AND THERMOCHROMIC INK.