

IN THE GRAND COURT OF THE CAYMAN ISLANDS
IN THE CIVIL DIVISION (PROBATE AND ADMINISTRATION)

Cause No. 42 of 2020

IN THE ESTATE OF DIETER JURGEN ACHIM SCHERFENBERG, Deceased



APPLICATION FOR GRANT OF PROBATE OF A WILL

Succession Law (2006 Revision)



I, **Karin Johanne Scherfenberg**, of 607 West Bay Road, Villa 24, Grand Cayman, Cayman Islands being the executor named in the last will of the late Dieter Jurgen Achim Scherfenberg formerly of 607 West Bay Road, Villa 24, Grand Cayman, Cayman Islands, surviving the Deceased, being over the age of eighteen years and not having renounced probate, which said will was made at George Town, Cayman Islands on 9th April 2018 and the said will, at the time of the death of the deceased, having been found lying at George Town, Grand Cayman, Cayman Islands in the custody of Priestleys, Attorneys at Law, which said will, together with the certificate of death, is annexed hereto, hereby apply for a grant of probate of the said will to me and I enclose herewith my affidavit in that behalf and I undertake that in the event of such grant being made to me, I will-

- (a) within six months of the grant to me of probate of the said will, I will prepare a true inventory of the said estate and exhibit and file the same in the Probate Registry; and
- (b) within one year of such grant to me, I will administer the said estate according to the tenor of the will and the directions, if any, of the courts and file in the Probate Registry a general account accounting for the whole of the assets of the said estate.

Dated this 6th day of March 2020


KARIN JOHANNE SCHERFENBERG

STATE OF TEXAS
CERTIFICATION OF VITAL RECORD

DEPARTMENT OF STATE HEALTH SERVICES
VITAL STATISTICS

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS

Nov 18 2019

STATE OF TEXAS

CERTIFICATE OF DEATH

STATE FILE NUMBER

142-19-173072

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| 1. LEGAL NAME OF DECEASED (Include AKA's, if any) (First, Middle, Last) DIETER JUERGEN ACHIM SCHERFENBERG | | | | (Before Marriage) | | 2. DATE OF DEATH - ACTUAL OR PRESUMED (mm-dd-yyyy) NOVEMBER 11, 2019 | |
| 3. SEX MALE | 4. DATE OF BIRTH (mm-dd-yyyy) AUGUST 18, 1935 | 5. AGE-Last Birthday (Years) 84 | IF UNDER 1 YR Mo Days | | IF UNDER 1 DAY Hours Min | | 6. BIRTHPLACE (City & State or Foreign Country) GERMANY |
| 7. SOCIAL SECURITY NUMBER 458-80-0113 | | 8. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced (but not remarried) <input type="checkbox"/> Widowed (but not remarried) <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown | | 9. SURVIVING SPOUSE'S NAME (If spouse, give name prior to first marriage) KARIN JOHANNE THOMAS | | | |
| 10a. RESIDENCE STREET ADDRESS 7 MILE BEACH ROAD | | | | 10b. APT. NO. | | 10c. CITY OR TOWN GEORGE TOWN GRAND CAYMAN | |
| 10d. COUNTY WEST INDIES | | 10e. STATE WEST INDIES | | 10f. ZIP CODE | | 10g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11. FATHER/PARENT 2 NAME PRIOR TO FIRST MARRIAGE GUENTHER SCHERFENBERG | | | | 12. MOTHER/PARENT 1 NAME PRIOR TO FIRST MARRIAGE KATHE ELFRIEDE PAPE | | | |
| 13. PLACE OF DEATH (CHECK ONLY ONE) IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify) | | | | | | | |
| 14. COUNTY OF DEATH HARRIS | | 15. CITY/TOWN, ZIP (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO) HOUSTON, 77024-5232 | | | 16. FACILITY NAME (If not institution, give street address) 669 PINEY POINT RD. | | |
| 17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED ANDREW SCHERFENBERG - SON | | | | 18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code) 11050 WEST LITTLE YORK # F, HOUSTON, TX 77041 | | | |
| 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"/> Mausoleum <input type="checkbox"/> Other (Specify) | | 20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH SAROYA RICHARD, BY ELECTRONIC SIGNATURE - 113432 | | 21. <input checked="" type="checkbox"/> Unknown Section _____ Block _____ Lot _____ Space _____ | | | |
| 22. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) MEMORIAL CREMATORY | | | | 23. LOCATION (City/Town, and State) HOUSTON, TX | | | |
| 24. NAME OF FUNERAL FACILITY CLAIRE BROTHERS FUNERAL HOME | | | | 25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) 7901 HILLCROFT, HOUSTON, TX 77081 | | | |
| 26. CERTIFIER (Check only one) <input checked="" type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/Justice of the Peace - 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. | | | | | | | |
| 27. SIGNATURE OF CERTIFIER GARY ERWIN, BY ELECTRONIC SIGNATURE | | 28. DATE CERTIFIED (mm-dd-yyyy) NOVEMBER 14, 2019 | | 29. LICENSE NUMBER D7024 | | 30. TIME OF DEATH (Actual or presumed) 11:55 PM | |
| 31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) GARY ERWIN 1905 HOLCOMBE, HOUSTON, TX 77030 | | | | 32. TITLE OF CERTIFIER MD | | | |
| 33. PART 1. 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 EACH. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ACUTE MYELOGENOUS LEUKEMIA 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 b. _____ Due to (or as a consequence of): _____ c. _____ Due to (or as a consequence of): _____ d. _____ | | | | | | Approximate interval Onset to death 4 MONTHS | |
| PART 2. ENTER OTHER CAUSE GIVEN IN PART 1. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING ANEMIA, THROMBOCYTOPENIA, ATRIAL FIBRILLATION | | | | 34. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Previously <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 38. 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 one year before death <input type="checkbox"/> Unknown if pregnant within the past year | |
| 39. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) | | | | 35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 40a. DATE OF INJURY (mm-dd-yyyy) | | 40b. TIME OF INJURY | | 40c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 40d. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) | |
| 40e. LOCATION (Street and Number, City, State, Zip Code) | | | | 40f. COUNTY OF INJURY | | | |
| 41. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 42a. REGISTRAR FILE NO. | | 42b. DATE RECEIVED BY LOCAL REGISTRAR | | 42c. REGISTRAR <i>Tara Das</i> | | | |



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WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine up to \$10,000. (Health and Safety Code, Sec. 195, 199a)



This is a true and correct copy of the record as registered in the State of Texas. Issued under the authority of Section 191.051, Health and Safety Code.

ISSUED Nov 20 2019

WARNING: THIS DOCUMENT HAS A DARK BLUE BORDER AND A COLORED BACKGROUND

Tara Das
TARA DAS
STATE REGISTRAR



ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE