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FILED

APR - 8 2009

Jonathan N. Harris
J. S. C.

IN RE ZELNORM[®] LITIGATION

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY

CASE NO. 280

CIVIL ACTION

CASE MANAGEMENT ORDER #2

1. This Order is effective as of March 27, 2009.
2. Subject to reconsideration following plaintiffs' motion to compel, the depositions of all fact witnesses in those cases listed in Schedule A to CMO 1 shall be completed no later than June 30, 2009.
3. Annexed hereto is a Plaintiff's Fact Sheet that shall be applicable to all actions in the instant litigation except (a) for those 27 actions listed in Schedule A to CMO 1; (b) where plaintiffs already have provided fully responsive responses to Defendant's Request for Production and Interrogatories; or (c) where mutually waived. Except where provided in (a) through (c) all Plaintiffs in cases currently filed in Bergen County shall serve on Defendant's counsel fully responsive responses to the Plaintiff's Fact Sheet no later than May 1, 2009. Plaintiffs in all future filed cases in Bergen County shall serve on Defendant's counsel fully responsive responses to the Plaintiff's Fact Sheet no later than thirty (30) days following service of Defendant's answer.

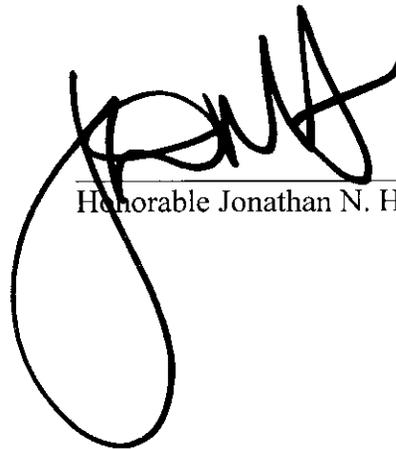
4. Counsel for Plaintiffs and Defendants shall meet and confer either in person or by teleconference no later than April 15, 2009, inter alia, to agree on a mechanism to streamline all aspects of discovery, particularly document productions, to attempt to agree, for example, on search terms or culling mechanisms, and in an effort to agree upon a Defendant's Fact Sheet. If agreement is reached on any of these or other issues, the parties shall be permitted to submit a consent order. If no agreement is reached the parties shall be permitted to seek resolution of disputes by formal notice of motion.

5. To the extent feasible, this CMO shall be applicable to all cases on Schedule Z hereto.

6. The next Case Management Conference shall take place on Friday, June 19, 2009 at 9:00 a.m.

7. This order will be served on all parties within 7 days of the date of this order.

Dated: APRIL 8, 2009

A large, stylized handwritten signature in black ink, appearing to read 'J. N. Harris', is written over a horizontal line.

Honorable Jonathan N. Harris, J.S.C.

PLAINTIFF'S FACT SHEET
Zelnorm® Litigation

Please provide the following information for each individual on whose behalf a claim is being made.

If you are completing this questionnaire in a representative capacity, please respond to all questions in Sections II, III, IV, and VI – IX as though the term “you” refers to the Zelnorm® user. In Sections V, X and XI, asking for information about injuries and damages, be sure to answer in a way that reflects all injuries and damages you are claiming, either on behalf of the Zelnorm® user or in your representative capacity, and that identifies all fact witnesses to these injuries or damages and any benefits you have received as a result of the decedent’s death. Also please answer Section XII B (felony conviction in the last 10 years) as to both the Zelnorm® user and you. In Section XIII, you are to produce documents that relate to the Zelnorm® user or to the damages you claim in this lawsuit. The response to items C.12., 15., 20., 21., or 22., for example, may include documents with respect to either you or the Zelnorm® user. Also please produce any documents in response to items C.8., 9, 10., 19. (if relating to a felony conviction in the last 10 years), and 23. with respect to either you or the Zelnorm® user.

In filling out this form, please use the following definitions: (1) “healthcare provider” means any hospital, clinic, center, physician’s office, infirmary, medical or diagnostic laboratory or other facility that provides medical, dietary, ophthalmology, psychiatric or psychological care or advice, pharmacy, weight loss center, dentist, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) “document” means the original and if the original is unavailable, any copy, of all handwritten, printed, typewritten, computer-generated, recorded, graphic or photographic material of any kind or character, as well as all tapes, discs, nonduplicate copies and transcripts thereof, now or formerly in the actual or constructive possession, custody or control, of you or your agents or representatives (including attorneys), and without limiting the generality of the foregoing definition, but for the purposes of illustration only, “document” includes notes, drafts, letters, correspondence, telegrams, memoranda, calendars, diaries, records, minutes, contracts, agreements, notations of conversations or conferences, inter-office communications, bulletins, circulars, pamphlets, studies, notices, summaries, reports, books, electronic data processing cards and tapes, teletyped messages, tape recordings, photographs, drawings, graphs, charts, tables, financial statements and records, invoices, work sheets, ledgers, and vouchers. **You may attach as many sheets of paper as necessary to fully answer these questions.**

For your convenience, Appendixes have been included for some types of information that might not fit in the space included in the Fact Sheet (for example, a list of all the schools you have attended). You can use these if there is not enough space in the Fact Sheet for you to give a complete answer. If there is enough space in the Fact Sheet, you do not need to repeat the information on the Appendix.

You must NOT dispose of, alter or modify in any way any documents or materials that are requested in this Fact Sheet. This includes, but is not limited to, packaging for Zelnorm®, any remaining Zelnorm®, written materials about Zelnorm® or Novartis, and documents that relate to your claimed injuries or damages. You also are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations please contact your attorney.

In completing this Fact Sheet you are under oath and must provide information that is true and correct to the best of your knowledge.

I. PRELIMINARY INFORMATION

- A. Full name of person who used Zelnorm®: _____
- B. Case No. _____ Court where filed _____
- C. Your Attorney's Name: _____
Firm: _____
Address: _____
Telephone No.: _____
Fax No.: _____
Email Address: _____
- D. Full name, address and phone number of any person other than you or your attorneys who is helping you prepare this form or providing you with information for this form:

If you are completing this Fact Sheet on behalf of the estate of a deceased person or a minor, state:

- Your name and address: _____

- Representative capacity (i.e., administrator, executor, or guardian) _____
- Your relationship to deceased or represented person _____
- Court which appointed you and date of appointment _____

II. PERSONAL INFORMATION FOR ZELNORM® USER

- A. Address: _____
- B. Maiden, or any other names used by you, and dates of use: _____
- C. Social Security Number: _____
- D. Date and city of birth: _____ Date of Death: _____
- E. Sex: Male ___ Female: ___
- F. Ethnicity: African-American ___ Caucasian ___ Hispanic ___ Native American ___
Other (please specify): _____
- G. Marital Status: Have you ever been married? Yes ___ No ___
If yes, please identify the full name and last known address of any spouse, with your dates of marriage and the dates of any termination. If a marriage was terminated, state whether this was due to death or divorce. _____

- H. Have you ever served in any branch of the military? Yes ___ No ___
1. If yes, branch and dates of service: _____
 2. Were you ever rejected or discharged from military service for any reason related to your medical, physical, psychiatric or emotional condition? Yes ___ No ___
If yes, state the condition and the date of occurrence: _____

- I. Schools you have attended (high school and beyond): Reference Appendix A.
1. High School: _____
Name: _____
Address: _____
Grade completed: _____
Dates of attendance: _____
 2. If you attended school beyond high school, as to each school state:
Name: _____
Address: _____
Dates of attendance: _____
Degree awarded and major: _____

* Please attach additional pages as needed.

- J. Do you, or have you ever, maintained a personal blog or website? ___ Yes ___ No
If so, state the web address for each such blog or site: _____

III. EMPLOYMENT INFORMATION

- A. For each employer since 1997, state: Reference Appendix B.

Name of Employer	Address & Phone No.	Job Title/Duties	Dates Employed	If making a wage loss or loss of earning capacity claim, salary or compensation by year

--	--	--	--	--

*Please attach additional pages as needed

B. Since the age of 21, have you ever been unemployed? Yes ___ No ___
 If yes, state date(s) of and reasons for any unemployment: _____

C. Have you ever been out of work for more than thirty (30) days for reasons related to your health (medical, physical, psychiatric or emotional condition)? Yes ___ No ___
 If yes, please state the dates, employer and health condition: _____

D. Are you making a wage loss claim? Yes ___ No ___
 If yes, please state the amount of wages you claim you lost, the period when you lost them and explain your calculation: _____

IV. GI HISTORY AND ZELNORM® USE

A. Have you ever suffered from constipation, abdominal pain, chronic constipation, IBS or IBS-C?
 Yes ___ No ___ Do not remember _____

If yes, please state for each the:

Condition: _____

Date of first onset: _____

Date of first diagnosis: _____

Diagnosing healthcare provider: _____

All treating healthcare providers: _____

Any medications taken (including over the counter): _____

Pharmacy where any prescription drugs were obtained: _____

B. As to your Zelnorm® use, please complete this table:

Date(s) of Use	Dose	Name & Address of Prescribing Physician	Reason for Use	Name & Address of Dispensing Pharmacy	Samples received?

--	--	--	--	--	--

1. Did you stop taking Zelnorm? Yes ___ No ___
 State when you stopped and why: _____

* If you received any written communication about stopping, please attach a copy.

2. Has any healthcare provider recommended that you not use Zelnorm®?
 Yes ___ No ___
 If yes, state the name and address of that healthcare provider and the date of that recommendation was made: _____

* If any such advice or recommendation was in writing, please attach a copy.

C. Have you had any direct communication, oral or written, with Novartis Pharmaceuticals Corporation, Novartis Corporation, Novartis Pharma Stein AG or Novartis AG?
 Yes ___ No ___
 If yes, state when, with whom, and describe the communication fully: _____

* If a communication was in writing, please attach a copy.

V. INJURIES, SYMPTOMS, DIAGNOSES & DAMAGES

A. Do you claim that any physical, mental, psychiatric, psychological or emotional injury or condition resulted from your use of Zelnorm®? Yes ___ No ___

B. If yes, for each injury or condition separately state:

1. Detailed description of injury or condition: _____

2. The date of the injury or the date you first became aware of the condition: _____

3. How you first became aware of it: _____

4. Whether you have consulted with any healthcare provider(s) regarding the injury or condition: Yes ___ No ___
 If yes, please identify all healthcare providers' names, addresses, and for each, the date of first consultation: _____

5. Identify any witnesses to the injury or to your condition: _____

* Please attach additional pages if necessary.

- C. For each medication (prescription or over the counter), drug (licit or illicit), chemical, dietary supplement, appetite suppressant or herbal remedy taken at any time during the thirty (30) days before your injury, complete the following table:

Name of Medication or Product	Date & Time Taken	Amount Taken	Reason for Taking

- D. Communications with Physicians or Other Healthcare Providers regarding conditions allegedly related to the use of Zelnorm®

1. Have you had discussions with healthcare provider(s) about whether your condition is related to the use of Zelnorm®?

Yes ___ No ___ Do not remember ___

If yes, for each provider with whom you had such discussions, please identify:

Name and title: _____

Approximate date(s) of discussion: _____

And check one of the following:

___ I was told my condition is related to the use of Zelnorm®

___ I was told my condition is not related to the use of Zelnorm®

___ I was told my condition may be related to the use of Zelnorm®

___ I was told that my provider does not know if my condition is related to the use of Zelnorm®

___ My provider offered no opinion as to whether my condition is related to the use of Zelnorm®

___ I don't recall what I was told.

- E. Are you claiming that you have paid, or will have to pay, any monetary expenses or fees as a result of having used Zelnorm®? Yes ___ No ___

If yes, please describe what it was for, the amount, and the person or entity owed for each item of expense: _____

- F. Are you claiming any injuries or damages in addition to those already identified in this Section? Yes ___ No ___

If yes, identify and describe them: _____

VI. HEALTHCARE PROVIDERS AND PHARMACIES

A. Identify the following for each healthcare provider, including psychiatrists, psychologists, social workers, or mental health professionals, you have consulted since ten (10) years prior to your first ingestion of Zelnorm® to the present (or if you are a minor, please list *all* healthcare providers): Reference Appendix D. Note: You need only include psychiatrists, psychologists, social workers or mental health professionals if you are making a claim for psychological or emotional injuries from your use of Zelnorm®. Regardless, you must answer as to all other health care providers.

Name & Specialty	Address & Phone No.	Date(s) of Treatment	Reason for Treatment

* Please attach additional pages if necessary.

B. Identify the following for each time you were hospitalized and/or received treatment in an emergency room or an out-patient setting since ten (10) years prior to your first ingestion of Zelnorm® to the present (or if you are a minor, please list *all* hospitalizations): Reference Appendix E.

Name of facility	Address & Phone No.	Date(s) of Treatment	Reason for Treatment

* Please attach additional pages if necessary.

- C. Identify the following for each pharmacy, drug store and/or other supplier (including mail order and internet pharmacies) where you have filled any prescriptions since ten (10) years prior to you first ingestion of Zelnorm® to the present (or if you are a minor, please list *all* pharmacies, etc.): Reference Appendix F.

Name	Address & Phone No.	Date(s) you filled prescriptions	Specify whether prescription was for Zelnorm®

* Please attach additional pages if necessary.

VII. MEDICAL BACKGROUND

- A. Current height and weight: _____
 Highest weight since 1995, with year(s) when it occurred: _____

- B. Have you ever smoked cigarettes, cigars or pipe tobacco? Yes ___ No ___
 If yes, please list:
 Substances smoked: _____
 Amount smoked (packs per day or specify other): _____
 Date you began smoking: _____
 Duration smoked (e.g., number of years): _____
 Any dates when you stopped smoking: _____
 Duration of quit periods: _____

- C. Drinking History:
 1. Do you currently drink alcohol (beer, wine, whiskey, etc.)? Yes ___ No ___
 If yes, how many drinks per day? _____
 2. Have you ever drunk alcohol (beer, wine, whiskey, etc.)? Yes ___ No ___

If yes, what was your greatest alcohol consumption over an extended (six (6) month or greater period with the last ten (10) years): _____ drinks per day
 When was this period? _____ to _____

D. Medical History: Have you ever been diagnosed or treated for any of the following?

Condition	Yes	No	Dates of Diagnosis/Treatment
Obesity (BMI > 30)			
Diabetes			
High blood pressure or hypertension			
High cholesterol or dislipidemia			
Low HDL cholesterol			
High LDL cholesterol			
High triglycerides			
Atrial fibrillation			
Other arrhythmia, irregular heartbeat or conduction disorder			
Atherosclerosis (plaque clogging the arteries)			
Coronary artery disease			
Carotid artery disease			
Peripheral artery disease			
Congestive heart failure			
Myocardial infarction			
Heart attack			
Transient ischemic attack (TIA)			
Stroke			
Migraine headaches			
Cancer			
Autoimmune disease or condition such as lupus, rheumatoid arthritis, psoriasis, scleroderma or mixed connective-tissue disorder			
Arthritis			
Abnormality of blood vessels or circulatory system			
Blood clots or thrombosis			
DVT (deep vein thrombosis)			
PE (pulmonary embolism)			
Blood disorders, including hypercoagulability			
Angina (chest pain)			
Alcoholism			

Other chemical dependency			
Depression			

E. Other than those conditions that you believe were caused by your use of Zelnorm®, do you currently suffer from any physical injuries, illnesses, conditions or disabilities?
 Yes ___ No ___

If yes, please identify:

Injury, illness, condition or disability: _____

Date(s) of onset: _____

Date(s) of diagnosis: _____

Healthcare provider by whom first treated: _____

All healthcare providers treating: _____

F. Since 10 years prior to your first ingestion of Zelnorm® to the present, please identify all injuries, illnesses, physical conditions or disabilities you have had, along with their dates of onset and diagnosis, and the healthcare provider first diagnosing or treating them.

G. If you claim psychological, psychiatric, mental or emotional injury as a result of using Zelnorm®, state whether you have experienced or been treated for any psychological, psychiatric, mental or emotional condition prior to the physical injury event for which you seek damages in your complaint: Yes ___ No ___

If yes, please identify:

Condition _____

Date of onset: _____

Date of diagnosis: _____

Healthcare provider by whom first treated: _____

All healthcare providers treating: _____

VIII. MEDICATIONS

A. Do you currently take, or have you taken, any of the following medications?

Medication	Yes	No	If yes, drug name, dose and dates of usage
Blood pressure medicine			
Diabetes medicine			

Insulin			
Cholesterol lowering medicine			
Beta blockers			
ACE inhibitors			
Anticoagulants (such as aspirin, Warfarin, Coumadin, or Plavix)			
Diuretics (for fluid retention)			
Headache medicine			

B. Please list any other prescription medications you have taken regularly from ten (10) years prior to your first ingestion of Zelnorm® to the present, with the dates taken and the reasons for taking it:

Medication	Dates Taken	Reasons

C. Have you ever taken or used any illicit drugs or methadone? Yes ___ No ___
 If yes, please list drug(s), rates of use or amounts used, and period(s) of use: _____

IX. FAMILY MEDICAL HISTORY

A. To the best of your knowledge, please indicate whether your *parents, siblings, children or grandparents* have ever suffered from or treated for any of the following:

Condition	Yes	No	Dates of Diagnosis/Treatment
Obesity (BMI > 30)			
Diabetes			
High blood pressure or hypertension			
High cholesterol or dislipidemia			
Low HDL cholesterol			
High LDL cholesterol			
High triglycerides			
Atrial fibrillation			
Other arrhythmia, irregular heartbeat or conduction disorder			
Atherosclerosis (plaque clogging the arteries)			
Coronary artery disease			

Carotid artery disease			
Peripheral artery disease			
Congestive heart failure			
Myocardial infarction			
Heart attack			
Transient ischemic attack (TIA)			
Stroke			
Migraine headaches			
Blood clots or thrombosis			
DVT (deep vein thrombosis)			
PE (pulmonary embolism)			
Blood disorders, including hypercoagulability			
Angina (chest pain)			

X. FACT WITNESSES

A. Other than your healthcare providers, please identify all persons whom you believe possess information concerning your injuries or current health condition, and/or any other facts related to your claim(s):

Name	Address & Phone No.	Relation to you	Type of Information

B. Have you obtained a statement, oral or written, from any person not a party to this action? Yes ___ No ___ (If yes, please attach a copy)

XI. INSURANCE AND BENEFITS

A. Has any insurance company or other entity (including Medicare/Medicaid) provided you with medical coverage or paid your medical bills at any time beginning ten (10) years prior to your prescription of Zelnorm® through the present? Yes ___ No ___

If yes, then identify the following as to each such entity: Reference Appendix H.

Name of Company	Address & Phone No.	Policy No.	Named insured, with Social Security No.	Date(s) of coverage

B. Have you ever applied for workers' compensation, social security, state or federal disability benefits or any other form of disability claim? Yes ___ No ___
 If yes, then identify the following as to each application submitted: Reference Appendix I.

Agency	Date of submission	Nature of injury and type of benefits sought	Claim/Docket No.	Disposition of claim	Name & address of office most likely to have your records

C. Have you ever been denied insurance for reasons relating to your health?
 Yes ___ No ___
 If yes, identify: _____

The type of insurance: _____

The name and address of the company denying: _____

The dates of application and denial: _____

The stated reasons: _____

XII. PRIOR LEGAL ACTIONS

- A. Have you ever been a party to a lawsuit, judicial proceeding or made a claim (other than in the present suit) whether civil, criminal or administrative? Yes ___ No ___
 If yes, then identify the following as to each: Reference Appendix J.

Caption & Case No.	Date filed	Nature of action	Outcome	Your lawyer's name & address

- B. Have you been convicted of, or pled guilty to, a felony within the last 10 years?
 Yes ___ No ___
 If yes, describe the crime or offense, the state and county in which convicted, and the outcome of the charge: _____

XIII. DOCUMENTS

- A. Please sign and attach to this Fact Sheet the authorizations for the release of records.
- B. If completing this Fact Sheet on behalf of a deceased person, please attach the legal documentation establishing that you are the legal representative and the Decedent's death certificate and autopsy report (if applicable).
- C. Please indicate whether you or your counsel have any of the following materials in your possession by placing a checkmark next to the word "yes" or "no."
If yes, attach a copy of any such documents.
1. Medical records from any physician, hospital or healthcare provider from ten (10) years prior to your first ingestion of Zelnorm® to the present. (This includes any diagnostic test results.) Yes ___ No ___
 2. Pharmacy records from ten (10) years prior to your first ingestion of Zelnorm® to the present, including receipts, prescriptions or records of purchase. This includes but is not limited to documents showing how you purchased or obtained Zelnorm®. Yes ___ No ___
 3. Advertisements for Zelnorm® or articles discussing Zelnorm® which you reviewed before and during the time you took Zelnorm®. Yes ___ No ___

4. The packaging, including the bottle, blister packs, box and label, for Zelnorm® and any remaining medication (plaintiffs must retain the originals of the items requested). Yes ___ No ___
5. Product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Zelnorm®. Yes ___ No ___
6. Documents on which you relied in deciding to use Zelnorm®. Yes ___ No ___
7. Documents that mention Zelnorm®, or any alleged health risks or hazards related to Zelnorm®, that were collected by you at any time (not from your attorney). Yes ___ No ___
8. Statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation. Yes ___ No ___
9. Documents that were provided to you by any Novartis entity. Yes ___ No ___
10. Documents constituting any communications or correspondence between you and any representative of any Novartis entity. Yes ___ No ___
11. Documents concerning any medications you have used or ingested for constipation, abdominal pain, CIC, IBS or IBS-C, other than Zelnorm®. Yes ___ No ___
12. Photographs, drawings, journals, slides, videos, DVDs or any other media relating to your alleged injury or condition or your life since then. Yes ___ No ___
13. If you claim you have suffered a loss of wages or earnings capacity, your federal tax returns for each of the last five (5) years. Yes ___ No ___
14. If you claim you have suffered a loss of wages or earnings capacity, all employment records in your possession, including employment applications, performance evaluations, paychecks and pay stubs. Yes ___ No ___
15. If you claim a loss from any type of expenses, copies of all bills, receipts or other documents showing the expense. Yes ___ No ___
16. Medical bills or other documents that would show the amounts anyone has paid for medical care that you believe is related to your injuries and damages claimed in this case. Yes ___ No ___
17. Premium notices or other documents that would show the amounts anyone paid to secure any of the health or disability insurance that has paid benefits to you in connection with the injuries and damages claimed in this case. Yes ___ No ___

18. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding. Yes ___ No ___
19. Copies of all pleadings, including but not limited to complaints, answers, answers to interrogatories, deposition notices, transcripts of depositions, settlement papers, releases, stipulations of dismissal and covenants not to sue, in any action for personal injuries by or on behalf of you at any time during your life. Yes ___ No ___
20. Journals, diaries, notes, letters, e-mails or other documents written by you or received by you which refer to your health or well-being, any injuries or illnesses, Zelnorm®, or the risks or benefits of Zelnorm®. Yes ___ No ___
21. Print-outs of internet postings made by you which relate to your health or well-being, any injuries or illnesses, Zelnorm®, or the risks or benefits of Zelnorm®. Yes ___ No ___
22. Documents you or anyone acting for you, including your attorneys, obtained from any local, state or federal government office or agency about Zelnorm®. This would include documents obtained through a FOIA request. Yes ___ No ___

ACKNOWLEDGEMENT

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information, and belief and that I have supplied all the documents requested in Part XIII of this Plaintiff's Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have signed, witnessed, and supplied the authorizations attached to this Verification.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

Date: _____ Signature: _____

	BER Docket #	Plaintiff's Name
1	L-7267-08	SULLIVAN, Nancy & Burt
2	L-7269-08	JAMES, Linda & Stanley
3	L-7271-08	MOUNT, James
4	L-7275-08	STEPHENS, Carolyn
5	L-7278-08	DISSELL, Martha
6	L-7281-08	CHEVALIER, Dyanne
7	L-7282-08	SLAYTON, Beverly
8	L-7283-08	AUERBACH, Haydee & Glenn
9	L-7284-08	DOBBINS, Michael
10	L-7285-08	RAYMOND, Michael
11	L-7286-08	COLQUITT, Rickee (O/B Est of Peggy Weaver)
12	L-7287-08	DODDS, Thomas (O/B Est of Kathryn Dodds)
13	L-7288-08	ICE, Susan (O/B Est of Frank Ice)
14	L-7289-08	WINGATE, Jamie L.
15	L-7290-08	JACKSON, Dianne
16	L-7291-08	KENNEDY, Sandra (O/B Est of Charles Kennedy)
17	L-7292-08	SEALY, Kathy
18	L-7293-08	YOHE, Pamela & Raymond
19	L-7332-08	BRIGGS, Mildred
20	L-7333-08	OSBORNE, Barbara
21	L-7335-08	HAWKINS, Audrey
22	L-7389-08	TONCHES, Beverly
23	L-7390-08	TEASDALE, Brenda
24	L-7573-08	COMER, Helen & Arthur
25	L-7574-08	SERAFINO, Barbara & Frank
26	L-7786-08	NOVY, Catherine & Robert
27	L-7787-08	OLSEN, Robert & Karen Lee
28	L-8326-08	GOOW, Sara
29	L-8834-08	PERSCHEL, Mary
30	L-8838-08	EBY, Janet & Douglas
31	L-8840-08	SEMAN, Harriet & Steven
32	L-8991-08	DAVIS, Donnie & Barbara
33	L-9600-08	GRESHAM, Helen & Arthur

34	L-9601-08	KOSMIDES, Kathryn
35	L-9604-08	DAVIS, Bobby
36	L-685-09	OVERTON, Diana
37	L-1204-09	EDWARDS, Hattie (O/B Estate of Hattie Gilmore
38	L-1834-09	Grove, David
39	L-1831-09	Jackoby, Kathy & Edward
40	L-1832-09	Mikhail, Rosa
41	L-2310-09	Asturi, Constance
42	L-2464-09	Johnson, Sharon
43	L-2467-09	Russell, Doris A.
44	L-2466-09	Lee, Mark
45	L-2861-09	Zerbey, Roxanne
46	L-2867-09	Reeves, Betsy
47	L-2878-09	Russell, Cheryl
48	L-2886-09	Cox, Kathy
49	L-2890-09	Martin, Loretta
50	L-2894-09	Czaplicki, Mary
51	L-2897-09	Reid, Paula
52	L-2898-09	Parks, Robin
53	L-2756-09	Reynolds, Catherine (o/b/o Estate of Janet Hines
54	L-2767-09	Petriello, Andrew & Petriello, Dorothea
55	L-2781-09	Haddock, Horrace C., & Haddock, Margaret
56	L-2792-09	Peek, Ada & Peek, David
57	L-2802-09	Konrad, Linda & Bickerstaff, Douglas
58	L-2813-09	Andry, Debra J.
59	L-2818-09	Mills, Thelma & Mills, James
60	L-2836-09	Truel, Karen Kay
61	L-2839-09	Reach, Jacob (o/b/o Estate of Eddie Reach)
62	L-2851-09	Zeanah, Marianne
63	L-2852-09	Davis, Brenda
64	L-2901-09	Coffman, Andrew & Coffman, Vivian
65	L-2904-09	Crisp, Thomas Elloitte
66	L-2905-09	Davis, Charlotte M.
67	L-2907-09	Davis, Irene C. & Davis, Thomas E.
68	L-2908-09	Kilpatrick, Wilma Marsha

69	L-2909-09	Mcelhannon, Mary & Mcelhannon, Jack
70	L-2910-09	Mullings, Tomlin A.
71	L-2911-09	Tyler, Jessye C.
72	L-2912-09	Cook, Carolyn S.
73	L-2914-09	Knoll, Barond J.
74	L-2915-09	Miles, Joyce Ann
75	L-2916-09	Crabtree, Bernita
76	L-2918-09	Stevenson, Judith L.
77	L-2919-09	Weaver, Bernice L.
78	L-2920-09	Craig, John M.
79	L-2921-09	Young, Edward Lee
80	L-2922-09	Wall, Barbara A.
81	L-2923-09	Barbee-Miles, Yvetta L
82	L-2924-09	Centers, Susan M.
83	L-2926-09	Hurst, Christopher & Hurst, Marilyn
84	L-2927-09	Ingram, George Ann
85	L-2928-09	Evans, Annette & Evans, Johnathan
86	L-2929-09	Moses, Barbara A. & Moses, John C.
87	L-2935-09	Jones, Rhonda & Jones, Sammy
88	L-2936-09	Williams, Roberta Fay
89	L-2937-09	Lizana, Kathy & Lizana Ronnie
90	L-2939-09	Vasquez, Beverly
91	L-2941-09	Veron, Betty & Veron, Jack
92	L-2943-09	Mcallister, Sandra
93	L-2945-09	Grant, Catherine Jean
94	L-2947-09	Hardin, Tresa V
95	L-2949-09	Bohnert, Margaret M.
96	L-2950-09	Bennett, Guy T.
97	L-2952-09	Bitzer, Diana F.
98	L-2953-09	Glaze, Bonnie
99	L-2956-09	Prickett, Janet
100	L-2958-09	Rephan, Carolyn Sue
101	L-2969-09	Penn, Luana J.
102	L-2974-09	Bernard, Mary L. (individually and o/b/o James W. Bernard
103	L-2978-09	Kelly, Barbara & Kelly, Duane

104	L-2980-09	Hillman, Beth (individually and o/b/o Estate of Mary Hillman)
105	L-2982-09	Williams, Cheryl L. & Williams, Robert
106	L-2983-09	Davis, George M. (Individually and o/b/o Estate of George S. Davis)
107	L-2985-09	Newell, Pamela & Newell, Cecil
108	L-2986-09	Freed, Sharon & Freed, Allen
109	L-2992-09	Henderson, Walter
110	L-2993-09	Nielson Jr, Scott K & Nielson, Sharon A.
111	L-2994-09	Monroe, Easter M.
112	L-2995-09	Heasley, Lillian
113	L-2996-09	Coll, Amy
114	L-2997-09	Eichelberger, Joan
115	L-2998-09	Carpenter, Paula
116	L-2999-09	Taylor, Carol
117	L-3001-09	Jackson, Patricia
118	L-3002-09	Paterson, Gail
119	L-3003-09	James, Karen
120	L-3005-09	Wachendorf, Jeffrey
121	L-3006-09	Pazdell, Marilyn
122	L-3007-09	Messer, Marilyn
123	L-3009-09	Herron, Joyce
124	L-3010-09	Schlagel, Evelyn
125	L-3012-09	Jaumot, Leslie (individually and as representative of the estate of josephine reed)