

UNOFFICIAL COPY

EXHIBIT A

Loan#: 8008613369 LPS#: 2102136 Bin #: 091203_8



UNIT 1863-3E, 1863 MICHIGAN CITY ROAD, CALUMET CITY, ILLINOIS, AS
DELINEATED ON SURVEY RECORDED ON 18TH DAY OF SEPTEMBER, 1974 AS
DOCUMENT NUMBER 22851983 OF LOTS 1 THROUGH 7 (BOTH INCLUSIVE) IN BLOCK
1, IN PULLMAN'S SUBDIVISION, BEING A SUBDIVISION OF PART OF THE WEST 1/3 OF
THE EAST 1/2 OF THE SOUTHWEST 1/4 SECTION 12 TOWNSHIP 36 NORTH, RANGE 14,
EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING SOUTH OF THE CENTERLINE OF
MICHIGAN CITY ROAD ACCORDING TO THE PLAT THEREOF RECORDED ON
AUGUST 3, 1925, AS DOCUMENT NO. 8994419, IN COOK COUNTY, ILLINOIS, TOGETHER
WITH AN UNDIVIDED 5.68731% INTEREST IN SAID PARCEL (EXCEPTING FROM SAID
PARCEL ALL THE PROPERTY AND SPACE COMPRISING ALL THE UNITS THEREOF AS
DEFINED AND SET FORTH IN SAID DECLARATION AND SURVEY).

Property of Cook County Clerk's Office

UNOFFICIAL COPY

INDIANA STATE DEPARTMENT OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE / COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

CERTIFICATE OF DEATH

Mar 23, 1998 Date Issued *Franklin D. Premuda* Hammond Health Commissioner

Local No. 242

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

| | | | | |
|--|---|---|---|---|
| 1 DECEASED—NAME (First, Middle, Last) BARBARA D. CANNON | | 2 SEX FEMALE | 3a TIME OF DEATH 11:37 PM | 3b DATE OF DEATH (Month, Day, Yr.) MARCH 17, 1998 |
| 4 #SOCIAL SECURITY NUMBER 351-46-9645 | 5a AGE—Last Birthday (Years) 47 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Mo, Day, Yr.) MAY 18, 1950 |
| 7 BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS | 8a. WAS DECEDENT A U.S. VETERAN? NO | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? -- | 9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | |

DECEDENT

| | | |
|--|---|--|
| 9b FACILITY NAME (If not institution, give street and number) ST. MARGARET-MERCY HEALTHCARE CENTER | 9c CITY, TOWN, OR LOCATION OF DEATH HAMMOND | 9d COUNTY OF DEATH LAKE |
| 10. MARITAL STATUS (Specify) MARRIED | 11. SURVIVING SPOUSE (If wife, give maiden name) THOMAS J. CANNON | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) CASH ACCOUNTING |
| | | 12b KIND OF BUSINESS/INDUSTRY BANK |

PARENTS

| | | | |
|--|---|---|--|
| 13a RESIDENCE—STATE ILLINOIS | 13b COUNTY COOK | 13c CITY, TOWN, OR LOCATION CALUMET CITY | 13d STREET AND NUMBER 1863 MICHIGAN CITY ROAD |
| 13e ZIP CODE 60409 | 13f. IN U.S. CITY LIMITS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 14 CITIZEN OF WHAT COUNTRY? U.S.A. | 15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) |
| | | 16 RACE—American Indian, Black, White, etc. (Specify) WHITE | 17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 + 1) |

INFORMANT

| | |
|---|---|
| 18. FATHER'S NAME (First, Middle, Last) JACK KODMAN | 19 MOTHER'S NAME (First, Middle, Maiden Surname) BERNICE KENNEDY |
| 20a INFORMANT'S NAME (Type/Print) THOMAS J. CANNON | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1836 MICHIGAN CITY RD., CALUMET CITY, IL 60409 |
| 20c Relationship HUSBAN | |

DISPOSITION

| | | |
|---|--|--|
| 21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) MARCH 20, 1998 HOLY CROSS CEMETERY | 21c LOCATION—City or Town, State CALUMET CITY, ILLINOIS |
| 22a EMBALMER'S NAME LEO V. HENNESSY | 22b EMBALMER'S LICENSE NO. IL 031-010388 | 23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes |

CAUSE OF DEATH

| | | |
|---|--|---|
| 24a SIGNATURE OF FUNERAL DIRECTOR <i>Stephen C. G...</i> | 24b LICENSE NUMBER (of license) 29300133 | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME #287 MCCOY FUNERAL CHAPEL 5713 HOHMAN AVE. HAMMOND, IN FOR HENNESSY-NOWAK FUNER. HOME 400 PULASKI RD. CALUMET CITY, IL |
| 26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, 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. Dissection of the thoracic aorta DUE TO (OR AS A CONSEQUENCE OF) b. Right lung hemothorax DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last | | |
| PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I | | |
| 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) Yes | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes |

CERTIFIER

| | | | |
|---|--|---------------------------------------|---|
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated <input type="checkbox"/> HEALTH OFFICER 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) as stated <input checked="" type="checkbox"/> Deputy 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 as stated | 29b SIGNATURE AND TITLE OF CERTIFIER <i>Franklin D. Premuda</i> | 29c MEDICAL LICENSE NO. N/A | 29d DATE SIGNED (Month, Day, Year) March 23, 1998 |
|---|--|---------------------------------------|---|

HEALTH OFFICER

| | | |
|--|--|---|
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307 | 31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Premuda M.D.</i> | 32 DATE FILED (Month, Day, Year) March 23, 1998 |
|--|--|---|

| | | | | |
|--|---------------------------------------|--|---------------------------------|----------------------------------|
| 33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide | 34a DATE OF INJURY (Month, Day, Year) | 34b TIME OF INJURY | 34c INJURY AT WORK? (Yes or no) | 34d DESCRIBE HOW INJURY OCCURRED |
| 34g DATE PRONOUNCED DEAD (Month, Day, Year) March 17, 1998 | | 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. No | | |