0413304141
Doc#: 0413304141
Eugene "Gene" Moore Fee: $82.00
Cook County Recorder of Deeds
Date: 05/12/2004 11:15 AM Pg: 1 of 6

AFFIDAVIT OF HEIRSHIP

I, MICHAEL SWANSON OF CROWN POINT INDIANA, DO HEREBY DECLARE THAT My mother Audrey J. Swanson whom deceased on June 28, 1996 was married to my father Monroe H. Swanson whom also deceased on November 7th 1998.

That the decedents were husband and wife at the time of acquiring title to land, and they remained so until decedent's death. This marriage born five children namely Carol Freeman of West Boylston Ma, Kimberly Novak of Lowell Indiana, Renee Taylor of Old Fort North Carolina, Faye Sasuta of Crete Illinois and Michael Swanson of Crown Point Indiana. No other children were born of Audrey J. Swanson and Monroe H. Swanson and no other children were adopted by the two parties.

32907 5 1/4

LEGAL DESCRIPTION: THE EAST 19 FEET OF LOT 92 IN SUBDIVISION OF LOT 63 IN SCHOOL TRUSTEES SUBDIVISION OF SECTION 16, TOWNSHIP 37 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

Address: 206 W. 111th St. in Chicago, Illinois.
Pin # 25-16-428-039

Michael Swanson

State of Illinois

County of Cook

I, the undersigned, a Notary Public in and for said county and state, do hereby certify that Michael Swanson

Personally appeared before me and is (are) known or proved to me to be the person (s) who, being informed of the contents of the foregoing instrument, have executed same and acknowledged said instrument to be _____ free and voluntary act and deed and that _____ executed said instrument for the purposes and uses therein set forth.

Witness my hand and official seal this 9 day of April, 2004

My commission expires:

Francesca E Siegert
Notary Public

"OFFICIAL SEAL"
Francesca E. Siegert
Notary Public, State of Illinois
My Commission Exp. 10/21/2007

* **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.

Local No. 2216-96

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
AUDREY	SWANSON	FEMALE	1:30 A M	JUNE 28,1996

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr)	7. BIRTHPLACE (City and State or Foreign Country)
338-22-9259	65			Oct.15,1930	CHICAGO, ILLINOIS

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
NO	N/A	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. ANTHONY MEDICAL CENTER	CROWN POINT	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
MARRIED	MONROE H. SWANSON	BEAUTICIAN	SELF EMPLOYED

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	CROWN POINT	790 W. JOLIET

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46307	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	WHITE	Elementary/Secondary (0-12): 12	College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
BERNARD BUNYEA	MOLLY SHAPIRO

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
MONROE H. SWANSON	790 W.JOLIET,CROWN POINT,IN 46307	HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	JUNE 30,1996 NORTHWEST IND. CREMATION SERVICE	CROWN POINT INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
N/A	N/A	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Russell A. Kuftoff	29300105	Burns Funeral Home,10101 Broadway Crown Point,IN 46307 FDH83002445

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

CAUSE OF DEATH

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Bronchogenic Carcinoma
DUE TO (OR AS A CONSEQUENCE OF)
b.
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

OCT 12 1999

Alexander D. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	NO	NO	N/A

CERTIFIER

29a. CERTIFIER (Check only one)
[ ] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated
[ ] 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
[ ] 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
	01030518	JULY 3, 1996

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. Srisuwanan Soon Sompop, 8315 Virginia St., Suite J, Merrillville, Indiana

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) July 3, 1996

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

*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.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 246898 State No. .....

269843

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Monroe	H.	Swanson	Male	10:31AM	November 7, 1998

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
398-18-0551	73			JUL 2, 1925	Ogema, Wi.

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
Yes	1945	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Anthony Medical Center	Crown Point	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Widowed	NONE	Employer	Town of Lowell

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Crown Point	790 West Joliet St.

13e. ZIP CODE	13f. INSIDE CITY LIMITS?	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46307	[X] No [ ] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	White	8	

PARENTS

18. FATHER'S NAME (First, Middle, Last)		19. MOTHER'S NAME (First, Middle, Maiden Surname)	
Arthur	Swanson	Alma	Johnson

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Michael Swanson	3903 W.109thAve, Crown Point, IN.46307	Son

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	NOV 10, 1998 Chapel Lawn Memorial Gardens	Schererville, IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
Leonard Gregorczyk	FD08800305	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (or Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Leonard Gregorczyk	FD08800305	FH83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

CAUSE OF DEATH

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.

		Approximate Interval: Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. DIVERTICULITIS	
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF)	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF)	
	d.	

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No

CERTIFIER

29a. CERTIFIER (Check only one)

[X] CERTIFYING PHYSICIAN. To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.

[ ] 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.

[ ] 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
	01043633	11/9/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Tom Galouzis M.D., 1600 Southlake Pky.Ave, Hobart, IN.46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) November 9, 1998

33. MANNER OF DEATH

[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide

34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	(Yes or no)	INJURY OCCURRED

34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

STATEMENT OF INFORMATION

STEWART TITLE OF ILLINOIS	Order #:

Interrogatories Re: Estate of, deceased.

Name of affiant: Michael Swanson	Address of affiant: 3903 W. 109th Crown Pt. Indiana
Relationship of affiant to deceased: Son	Occupation of the deceased: Plant Engineer.

Residences of deceased for the ten years preceding date of death:

From (date)	To (date)	Street Number	City	State
4-10-77	6-28-96	790 W. Joliet	Crown Pt.	Ind

	YES	NO
Is the estate of the decedent being probated?	☐	☑
If yes, state the case number, county and state: _____		
Have the administration proceedings been completed?	☐	☐
Did the decedent leave a will?	☐	☑
If yes, has it been admitted to probate?	☐	☐
If no, has it been filed with the circuit court in the unproven will box?	☐	☐

What was the total value of the estate of the decedent, including the property described in the above title commitment, as well as all personal property and other real estate in Illinois or elsewhere in the U.S., proceeds of the insurance on the life of the decedent, cash, securities, deposits and the interest of the decedent in real or personal property, if any, held in joint tenancy?

$ 10,000.00

	YES	NO
Is the estate of sufficient size to be subject to federal estate tax?	☐	☐
Have all state and federal taxes due and owing by the decedent or his or her estate been fully paid and discharged?	☑	☐

	YES	NO

STATEMENT OF INFORMATION

Have all expenses of the last illness and burial of the deceased, doctor's, hospital, and undertaker's bills been paid in full? ☒ ☐

Is the estate liable to our subject to a claim on the part of anyone for personal or nursing services rendered or room and board furnished to the decedent? ☐ ☒
If yes, please describe to whom and for how much on the reverse side.

NOTE: Paid receipts for these items should be provided.

	YES	NO
Have all debts of the deceased, including partnership obligations, if any, and claims against the estate had been fully paid?	☒	☐

If no, describe all unpaid items in detail on reverse side.

	YES	NO
Is the decedent's estate liable on any lease, contracts, mortgage, judgement, deficiency decree or other obligations?	☐	☒

If yes, describe fully on reverse side.

Affiant states that the foregoing answers to interrogatories are true and makes this affidavit and answ
interrogatories to induce Stewart Title Company of Illinois to issue its commitment and its title insura
the above-referenced order number free and clear of claims, administration expenses, taxes and other
any, relating to the estate of said decedent.

x _____
(signed)

STATE OF ILLINOIS
)SS
COUNTY OF Cook

"OFFICIAL SEAL"
Francesca E. Siegert
Notary Public, State of Illinois
My Commission Exp. 10/21/2007

THE SAID Unsigned
THIS 9 DAY OF April

SUBSCRIBED AND SWORN TO BEFORE ME BY
19 2004

Francesca E Siegert
NOTARY PUBLIC

PRESENTED TO STEWART TITLE COMPANY OF ILLINOIS
BY: _____
ADDRESS: _____