STATE OF ILLINOIS)
) SS.
COUNTY OF C O O K)

0413445077

Doc#: 0413445077
Eugene "Gene" Moore Fee: $30.50
Cook County Recorder of Deeds
Date: 05/13/2004 10:15 AM Pg: 1 of 4

DECEASED JOINT TENANCY AFFIDAVIT

1) **ALMA PRATER**, being duly sworn on oath states, that she resides at 946 N. St. Louis, in the City of Chicago, State of Illinois.

2) That she was acquainted with Ruby S. Slaughter, and Charlesetta S. Smith both now deceased who, at the time of their deaths were two of the owners of the land at 946 N. St. Louis, Chicago, in Cook County, Illinois, described as:

Lot 460 in Dickey's Third Addition to Chicago in the Southeast 1/4 of Section 2, Township 39 North, Range 13 East of the Third principal Meridian, in Cook County, Illinois.

PREIN 16-02-416-025-000

3) The deceased Ruby S. Slaughter died May 2, 1995, as evidenced by a copy of her death certificate attached hereto. The deceased Charlesetta S. Smith died July 21, 1998 as evidenced by a copy of her death certificate also attached hereto.

FURTHER AFFIANT SAYETH NOT.

Alma Prater

Subscribed and Sworn to before me
this 29 day of April, 2004

NOTARY PUBLIC

OFFICIAL SEAL
PEARETHA FLOYD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/26/06

PREPARED BY AND PLEASE MAIL TO:
Devereux Bowly, Attorney at Law
Legal Assistance Foundation of Chicago
3333 West Arthington
Chicago, IL 60624
(773) 321-7910
Attorney No. 91010

N:\BOWLY\AFF\PRATHER,DECEASED JOINT TENANCY AFFD.

STATE OF ILLINOIS)
County of Cook)

DAVID ORR, County Clerk

AUG 15 2003

I, David Orr, County Clerk of the County of Cook, in the State aforesaid, and Keeper of the Records and Files of said County do hereby certify that the attached is a true and correct copy of the original Record on file, all of which appears from the records and files in my office.

IN WITNESS THEREOF, I have hereunto set my hand and affixed the Seal of the County of Cook, at my office in the city of Chicago, in said County.

David Orr
COUNTY CLERK

DECEDENT'S BIRTH NO.

REGISTRATION DISTRICT NO 16.10

REGISTERED NUMBER

STATE OF ILLINOIS

MEDICAL CERTIFICATE OF DEATH

STATE FILE NUMBER 608447

Type or Print in PERMANENT INK. See Funeral Directors, Hospital, or Physicians Handbook for INSTRUCTIONS

Field	Entry
1. DECEASED-NAME (FIRST, MIDDLE, LAST)	RUBY SLAUGHTER
2. SEX	FEMALE
3. DATE OF DEATH (MONTH, DAY, YEAR)	MAY 2nd, 1995
4. COUNTY OF DEATH	COOK
5a. AGE-LAST BIRTHDAY (YRS)	74
5b. UNDER 1 YEAR (MOS / DAYS)	
5c. UNDER 1 DAY (HOURS / MIN)	
5d. DATE OF BIRTH (MONTH DAY YEAR)	AUGUST 17, 1920
6a. CITY, TOWN, TWP, OR ROAD DISTRICT NUMBER	CHICAGO
6b. HOSPITAL OR OTHER INSTITUTION-NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER)	SACRED HEART HOSPITAL
6c. IF HOSP. OR INST. INDICATE DOA, OP/EMER. RM, INPATIENT (SPECIFY)	IN-PATIENT
7. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY)	KANSAS
8a. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY)	WIDOWED
8b. NAME OF SURVIVING SPOUSE (MAIDEN NAME, IF WIFE)	NONE
9. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO)	NO
10. SOCIAL SECURITY NUMBER	317-20-8857
11a. USUAL OCCUPATION	RETIRED
11b. KIND OF BUSINESS OR INDUSTRY	
12. EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED) Elementary/Secondary (0-12) College (1-4 or 5+)	12
13a. RESIDENCE (STREET AND NUMBER)	946 N. ST. LOUIS
13b. CITY, TOWN, TWP, OR ROAD DISTRICT NO	CHICAGO
13c. INSIDE CITY (YES/NO)	YES
13d. COUNTY	COOK
13e. STATE	ILLINOIS
13f. ZIP CODE	60651
14a. RACE (WHITE, BLACK, AMERICAN INDIAN, ETC.) (SPECIFY)	BLACK
14b. OF HISPANIC ORIGIN? (SPECIFY NO OR YES-IF YES, SPECIFY CUBAN, MEXICAN, PUERTO RICAN, etc.)	NO
15. FATHER-NAME (FIRST, MIDDLE, LAST)	CHARLEY STRINGER
16. MOTHER-NAME (FIRST, MIDDLE, MAIDEN LAST)	SUSIE BANKS
17a. INFORMANT'S NAME (TYPE/PRINT)	FLORENCE [illegible] R. [illegible]
17b. RELATIONSHIP	RECORDS
17c. MAILING ADDRESS (STREET AND NO OR R.F.D., CITY OR TOWN, STATE, ZIP)	3240 W. FRANKLIN BLVD. CHICAGO, IL 60624

18. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, 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) Bronchial Esophageal Aspiration

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.
DUE TO, OR AS A CONSEQUENCE OF:
(b) Chronic Obstructive Pulmonary Disease
DUE TO, OR AS A CONSEQUENCE OF:
(c) Coronary Artery Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I

19a. AUTOPSY (YES/NO): NO
19b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (YES/NO)

20a. DATE OF OPERATION, IF ANY
20b. MAJOR FINDINGS OF OPERATION
20c. IF FEMALE, WAS THERE A PREGNANCY IN PAST THREE MONTHS? YES ☐ NO ☐

21a. (MONTH, DAY, YEAR) [illegible] -95
21b. WAS CORONER OR MEDICAL EXAMINER NOTIFIED? (YES/NO): NO
21c. HOUR OF DEATH: 9:15 AM

[illegible] AT THE TIME, DATE, AND PLACE AND DUE TO THE CAUSE(S) STATED
[signature illegible]
22b. DATE SIGNED (MONTH, DAY, YEAR): MAY 2nd, 1995
[illegible] Franklin Blvd Chicago IL 60624
(TYPE/PRINT)
22d. ILLINOIS LICENSE NUMBER: 036-054622

NOTE: IF AN INJURY WAS INVOLVED IN THIS DEATH THE CORONER OR MEDICAL EXAMINER MUST BE NOTIFIED.

[illegible] ROSEEN
24c. LOCATION (CITY OR TOWN, STATE): Hobart, IN.
24d. DATE (MONTH, DAY, YEAR): 5-6-1995

(STREET AND NUMBER OR R.F.D., CITY OR TOWN, STATE, ZIP) [illegible] INC. 9900 S. THROOP CHICAGO ILL. 60643

25c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER: 034009009

25b. DATE FILED BY LOCAL REGISTRAR (MONTH, DAY, YEAR): MAY 9 1995

PRINTED BY AUTHORITY OF THE STATE OF ILLINOIS

TAX 630-5863901 ACE TERM

* 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.

5CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 98-0513 State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Charlesetta Smith
2. SEX	Female
3a. TIME OF DEATH	6:04 A M
3b. DATE OF DEATH (Month, Day, Yr)	July 21, 1998
4. *SOCIAL SECURITY NUMBER	317-20-8852
5a. AGE—Last Birthday (Years)	71
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	November 21, 1926
7. BIRTHPLACE (City and State or Foreign Country)	Coffeyville, Kansas
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	1774 Noble Street
9c. CITY, TOWN, OR LOCATION OF DEATH	Gary
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Widowed
11. SURVIVING SPOUSE (If wife, give maiden name)	N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Day Care Provider
12b. KIND OF BUSINESS/INDUSTRY	Self-employed
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Gary
13d. STREET AND NUMBER	1774 Noble Street
13e. ZIP CODE	46404
13f. INSIDE CITY LIMITS	☐ No ☐ Yes
13g. ON A FARM?	xxx No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XXX No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12th
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Charles L. Springer
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Susie Banks

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Dijuana Smith
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1774 Noble Street Gary, Indiana 46404
20c. Relationship	Daughter

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	XXX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	July 27, 1998 Evergreen Cemetery
21c. LOCATION—City or Town, State	Hobart, Indiana
22a. EMBALMER'S NAME	Roosevelt Allen Sr
22b. EMBALMER'S LICENSE NO.	#01051696
23. WAS DEATH REPORTED TO CORONER?	XXX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	#08700646
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	83007704 Guy & Allen Funeral Directors, Inc 2959 W. 11th Avenue Gary, Indiana 464

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Metastatic Carcinosarcoma of Uterus	8 Months
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Field	Entry
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)	No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	----------

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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	B Fuller, MD
29c. MEDICAL LICENSE NO.	01034701
29d. DATE SIGNED (Month, Day, Year)	7/28/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Barbara L. Fuller, M.D. 9305 So. Calumet Ave Ste A1 Munster, IN 463

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature] MD MPH
32. DATE FILED (Month, Day, Year)	JUL 29 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	
34c. INJURY AT WORK? (Yes or no)	
34d. DESCRIBE HOW 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	