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JOINT TENANCY AFFIDAVIT

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)



Doc#: 0420811190
Eugene "Gene" Moore Fee: \$28.00
Cook County Recorder of Deeds
Date: 07/26/2004 03:42 PM Pg: 1 of 3

KAREN J. UEBLER,
hereby referred to as the affiant, states under
oath that the affiant resides at
8633 Hohman Avenue
Munster, IN. 46321
In the City of Munster,
State of Indiana;
that the affiant was acquainted with
ALICE M. PERWANGER,
the decedent; at the time of death, the
decedent was one of the owners of property,
by virtue of a properly recorded joint
tenancy deed, said property located in
Cook County, State of
Illinois, and legally
described as follows:

Lot Twenty-three (23) in Freitag's Oak Grove Addition to the Village of West Hammond, Illinois, a subdivision of part of the Southeast quarter (1/4) of the Northwest fractional quarter (1/4) and the Northeast quarter (1/4) of the Southwest fractional quarter (1/4) of Section 8, Town 36 North, Range 15, East of the Third Principal Meridian, according to Plat recorder in the Recorder's Office of Cook County, Illinois, May 25, 1896, in Book 71 of Plats PAGE 6, AS Document Number 2393552.

30-08-306-003

The decedent had no interest in any business or partnership, nor held any power of appointment at death, nor created any remainder interests in property by transfer with retention of a life interest therein or the creation of interests to take effect in possession or enjoyment after death;

The decedent died on July 9, 2002, leaving no/a last will and testament;

The total value of decedent's estate, including the taxable interest in the above property was \$ _____, and that the value of the above property individually was \$ _____.

3/11

The State and Estate/Inheritance Tax and the Federal Estate Tax, if any, that was due from the decedent's estate, has been paid in full;

The affiant makes this affidavit to induce Attorneys' Title Guaranty Fund, Inc. (ATG) to issue its policy of title insurance on the above described property.

ATGF, INC.

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JOINT TENANCY AFFIDAVIT (continued)

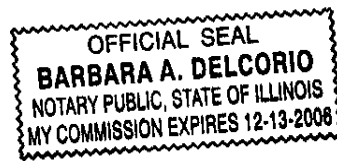
The affiant hereby covenants and agrees, individually, and for the affiants, heirs, personal representatives or assignees, to forever fully indemnify, protect, defend and hold ATG harmless and to reimburse ATG for all loss, costs, damages, suits, attorney's fees and expenses of every kind and nature that ATG may suffer, expend or incur by reason of the issuance of said policy free and clear of the following objections:

1. Claims against the estate of Alice M. Berwangel, the decedent;
2. State Estate/Inheritance Tax and Federal Estate Tax that may be charged against the estate of said decedent;
3. Legacies, if any, created by the will of said decedent;
4. Rights of contribution.

Karen J. Uebler (Seal)
 KAREN J. UEBLER (Seal)

Subscribed and sworn to before me this

9 day of July, 2004
(Month) (Year)
Barbara A. Delcorio
(Notary Public)



Note: If the decedent left a will, it will be necessary that the original or certified copy thereof be presented to ATG for inspection. A death certificate, together with evidence of payment of death taxes, if any, should accompany this affidavit.

This instrument prepared by:

DARRYL R. LEM
(Name)
850 Burnham Avenue
(Address)
Calumet City, IL. 60409
(City, State, Zip)

Return to:

DARRYL R. LEM
(Name)
850 Burnham Avenue
(Address)
Calumet City, IL. 60409
(City, State, Zip)

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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

* 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. 1113-02

State No. _____

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

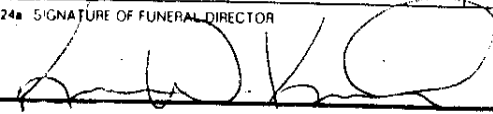

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED NAME (First Middle Last) Alice M. Berwanger		2 SEX Female		3a TIME OF DEATH 7:30 P M		3b DATE OF DEATH (Month Day, Yr) July 9, 2002	
4 *SOCIAL SECURITY NUMBER 323-31-0292		5a AGE—Last Birthday (Years) 90		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6a WAS DECEDENT A U.S. VETERAN? No		6b YEAR LAST SERVED IN U.S. ARMED FORCES? -----		6 DATE OF BIRTH (Mo, Day, Yr) April 19, 1912		7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana	
8a HOSPITAL <input type="checkbox"/> Inpatient		8b ER/Outpatient <input type="checkbox"/>		8c DOA <input type="checkbox"/>		8d OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)	
9a FACILITY NAME (If not institution, give street and number) 8643 Hohman Ave.				9c CITY, TOWN OR LOCATION OF DEATH Munster		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Widowed		11 SURVIVING SPOUSE (If wife, give maiden name) None		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cornetmaker		12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Illinois		13b COUNTY Cook		13c CITY, TOWN OR LOCATION Calumet City		13d STREET AND NUMBER 445 Garfield	
13a ZIP CODE 60409		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		17 College (11.4 or 5 +)			
18 FATHER'S NAME (First Middle Last) George Peters				19 MOTHER'S NAME (First Middle Maiden Surname) Comelia Benschop			
20a INFORMANT'S NAME (Type/Print) Karen Uebler		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8633 Hohman Ave. Munster, Indiana 46321				20c Relationship Daughter	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment		<input checked="" type="checkbox"/> Burial <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) July 16, 2002 St. Joseph Cemetery	
21c LOCATION—City or Town, State Hammond, Indiana		22a EMBALMER'S NAME John Noble		22b EMBALMER'S LICENSE NO. 9000031		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) 1021590		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home 3004968 8415 Calumet Ave. Munster, Indiana 46321			
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)		metastatic liver carcinoma				Approximate Interval Between Onset and Death	
Conditions if any which gave rise to the immediate cause stating the underlying cause last		a DUE TO (OR AS A CONSEQUENCE OF)					
		b DUE TO (OR AS A CONSEQUENCE OF)					
		c DUE TO (OR AS A CONSEQUENCE OF)					
		d DUE TO (OR AS A CONSEQUENCE OF)					
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) No	
29a CERTIFIER (Check only one) <input checked="" 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 type="checkbox"/> 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 P. Neale MD		29c MEDICAL LICENSE NO. 02002162 A		29d DATE SIGNED (Month Day, Year) July 10-2			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Peter Neale 16240 Louis Ave. South Holland, Illinois 60473							
31 HEALTH OFFICER'S SIGNATURE 						32 DATE FILED (Month Day, Year) July 12, 2002	
33 MANNER OF DEATH <input 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		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.					