

# UNOFFICIAL COPY

STATE OF ILLINOIS )  
 ) SS:  
COUNTY OF COOK )



Doc#: 0430334028  
Eugene "Gene" Moore Fee: \$50.50  
Cook County Recorder of Deeds  
Date: 10/29/2004 10:46 AM Pg: 1 of 3

## AFFIDAVIT

WILLIAM HODGES of 6830 Lode Drive #2A, Worth, Illinois, being first duly sworn, deposes and says that he is the son of WILLIAM HODGES and GLORIA HODGES who are the owners of the following described property, to wit:

Lot 26 in Block 4 of McChesney's Resubdivision of the North 1/2 of Blocks 1 to 7 in McChesney's Hyde Park Homestead Subdivision of the South 1/2 of the South 1/2 of the Northeast 1/4 of Section 22, Township 38 North, Range 14, East of the Third Principal Meridian, in Cook County, Illinois.

Permanent Index Number 20-22-228-032-0000  
Commonly known as 6628 South Champlain- Chicago, Illinois

AFFIANT states that WILLIAM HODGES died intestate on 12/24/83; that he was married only once to GLORIA HODGES; that GLORIA HODGES died intestate on November 24, 1990; that she was married only once to WILLIAM HODGES; that of this marriage three children were born and no children were adopted:

WILLIAM HODGES, son  
Lilia Hodges, daughter  
DIANA L. Craft, daughter

who are of legal age and mentally competent;

AFFIANT states that at the time of their deaths, the value of the estates of WILLIAM HODGES and GLORIA HODGES did not exceed \$500,000.00.

FURTHER AFFIANT SAYETH NOT.

William Hodges 20 Oct 04  
William Hodges

Subscribed and sworn to before me  
this 25 day of October, 2004.

Judy A. Johnson  
Notary Public





CERTIFICATE OF DEATH

UNOFFICIAL COPY

1. NAME OF DECEASED (Print Name) Gloria L. Hodges		2. DATE OF DEATH 11/24/90		3. SEX Fe	4. DATE OF BIRTH 11/7/25	5a. AGE - Last Birth-day (yrs.) 65	5d. UNDER 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hours _____ Minutes _____	STATE USE ONLY #1729	
6. SOCIAL SEC. NO. 356 20 2553		7a. PLACE OF DEATH HOSPITAL: <input checked="" type="checkbox"/> INPATIENT <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> NURSING HOME <input type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (Specify)		7b. FACILITY NAME (If not institution, give street and no.) Robert Wood Johnson Medical Center		7c. CITY/TOWN OR LOCATION New Brunswick		7d. COUNTY Middlesex
8a. RESIDENCE - (State) New Jer	8b. COUNTY Union	8c. CITY OR TOWN Plainfield		8d. STREET AND NUMBER 1265 Oxford Avenue		8e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	8f. ZIP CODE 07060			
9. BIRTHPLACE (City & State, or Foreign Country) Illinois		10a. DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10b. IF YES, WAR DATES (From/To): - -		11. MARITAL STATUS <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED				
12. SURVIVING SPOUSE (If Wife, Maiden Name) -----		13. USUAL OCCUPATION (Kind of work done most of life, even if retired) Clerical Work				14. KIND OF BUSINESS OR INDUSTRY State Government				
15. NAME AND ADDRESS OF LAST EMPLOYER Department of Motor Vehicles, Chicago, Illinois										
16. RACE 1 <input type="checkbox"/> WHITE 2 <input checked="" type="checkbox"/> BLACK		3 <input type="checkbox"/> AMER. INDIAN 4 <input type="checkbox"/> OTHER (Specify):		17. OF HISPANIC ORIGIN? IF YES, SPECIFY: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> MEXICAN 3 <input type="checkbox"/> CUBAN 5 <input type="checkbox"/> OTHER (Specify):		2 <input type="checkbox"/> PUERTO RICAN 4 <input type="checkbox"/> CENT./SO. AMERICA		18. DECEDENT'S EDUCATION Highest Grade Completed 12
19. NAME OF FATHER (First, Middle, Last) Henry Vessell			20. MAIDEN NAME OF MOTHER (First, Middle, Last) Queen E. Roberts							
21a. NAME OF INFORMANT Diana Craft				21b. RELATIONSHIP Daughter		22a. DISPOSITION <input type="checkbox"/> BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> OTHER (Specify):				
22b. NAME OF CEMETERY OR CREMATORY Rosehill Crematory						22c. CITY OR TOWN Linden		22d. STATE New Jer		
23a. NAME AND ADDRESS OF FUNERAL HOME Judkins Colonial Home, 428 West Fourth Street, Plainfield, New Jersey 07061										
23b. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				23c. N.J. LICENSE NO. 2242		24a. SIGNATURE OF LOCAL REGISTRAR <i>[Signature]</i>		24b. DATE RECEIVED 11/26/90		
25a. TIME OF DEATH 00:53 A.M.		25b. DATE AND HOUR ANNOUNCED DEAD DATE: 11-24-90				HOUR: 00:53 A.M.		25c. DATE SIGNED 11-24-90		
25d. Complete items 25c-d only when certifying physician is not available at time of death to certify cause of death.				25e. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT TIME, DATE, AND PLACE INDICATED.				SIGNATURE OF PRONOUNCER (If different than certifier) <i>[Signature]</i>		
26. PART I: IMMEDIATE CAUSE (Final disease or condition resulting in death). Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.		IMMEDIATE CAUSE (Enter the diseases, injuries 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.) a. <i>Cardiac arrhythmia, Hypotension</i> b. <i>? Sepsis, Dehydration, Cachexia</i> c. <i>Hypoglycemia, Hepatomegaly ? Etiology</i> d. <i>End Stage renal disease - Hemodialysis dependent.</i>						INTERVAL BETWEEN ONSET AND DEATH		
PART II: Other significant conditions - contributing to death but not related to underlying cause in PART I. <i>Bil pleural effusion, Hypertensive glomerulonephrosis</i>										
27. IF FEMALE, WAS SHE PREGNANT AT DEATH, OR ANY TIME 90 DAYS PRIOR TO DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								28. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
29. DEATH DUE TO: <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		<input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> COULD NOT BE DETERMINED		30a. DATE OF INJURY		30b. TIME OF INJURY M _____		30c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		30d. DESCRIBE HOW INJURY OCCURRED
30e. PLACE <input type="checkbox"/> STREET <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE BUILDING <input type="checkbox"/> FARM <input type="checkbox"/> OTHER (Specify):				30f. CITY AND COUNTY				30h. STATE		
30f. LOCATION OF INJURY (Number and Street)										
30g. CITY AND COUNTY										
30h. STATE										
31a. NAME AND ADDRESS OF CERTIFIER MEHDI H. NAQUE M.D. 1574 Route 130 No., No. Brunswick, NJ								31b. CERTIFYING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> PRONOUNCER AND CERTIFIER		
31b. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED DUE TO CAUSES LISTED ABOVE. SIGNATURE OF CERTIFIER <i>[Signature]</i>								31c. DATE SIGNED 11-24-90		

Items 1 and 2 to be typed by Funeral Director

To be printed by Physician

DATE OF DEATH  
11-24-90 00:53 AM

PHYSICIAN - Please Print:  
NAME OF DECEASED AS KNOWN BY ATTENDING PHYSICIAN  
Gloria Hodges

STATE USE ONLY  
IND/OCC  
CAUSE  
PLACE OF ACC  
CROSS CLASS

Fee: \$4.00  
DEC 14 1990  
Gloria O'Hara  
Registrar of Vital Statistics  
DO NOT ACCEPT THIS TRANSCRIPT UNLESS THE RAISED SEAL OF THE HEALTH DEPARTMENT IS AFFIXED HEREON.

HEALTH DEPARTMENT  
NEW BRUNSWICK, N.J.  
Under my hand and Health Department seal I certify that this is a true photostatic reproduction from an image of the original record.