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Doc#: 0531842054 Fee: $36.00
Eugene "Gene" Moore RHSP Fee:$10.00
Cook County Recorder of Deeds
Date: 11/14/2005 10:04 AM Pg: 1 of 7

Warranty Deed

ILLINOIS

Above Space for Recorder's Use Only

THE GRANTORS JUANITA THREATTE AND STARLING JOHNASON of the City of Omar, County of Logan, State of West Virginia for and in consideration of TEN and 00/100 DOLLARS, and other good and valuable consideration in hand paid, CONVEY and WARRANT to GEORGE P. VLASIS II 10412 Linus Lane, Oak Lawn Illinois 60453*(Name and Address of Grantee-s)*, ; the following described Real Estate situated in the County Of Cook in the State of Illinois to wit: ***(See Page 2 for Legal Description)***, hereby releasing and waiving all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois.

SUBJECT TO: General taxes for 2004 and subsequent years; Covenants, conditions and restrictions of record, if any;
Permanent Real Estate Index Number: 20-32-212-018-0000
Address of Real Estate: 8000 Sangamon, Chicago, Illinois 60620

The date of this deed of conveyance is October 14, 2005

(SEAL) JUANITA THREATTE	*(SEAL)* STARLING JOHNASON

State of Illinois, County of Cook ss. I, the undersigned, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that JUANITA THREATTE AND STARLING JOHNASON personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person, and acknowledged that she signed, sealed and delivered the said instrument as her free and voluntary act, for the uses and purposes therein set forth, including the release and waiver of the right of homestead.

by Brian Smith Pursuant to Power of Attorneys Recorded

(Impress Seal Here)
(My Commission Expires________)

Given under my hand and official seal

Notary Public

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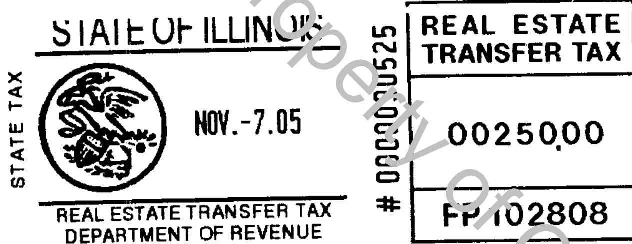
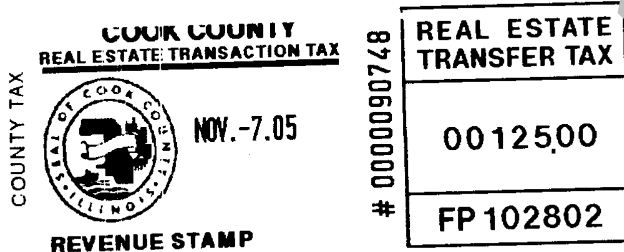
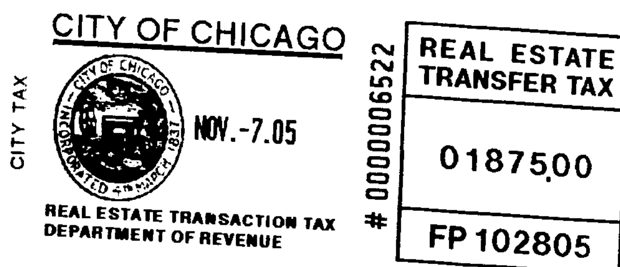
LEGAL DESCRIPTION

For the premises commonly known as: 8000 Sangamon, Chicago, Illinois 60620
PIN: 20-32-212-018-0000

LOT 1 IN BLOCK 5 IN CHESTER HIGHLANDS SECOND ADDITION TO AUBURN PARK, BEING A SUBDIVISION OF THE EAST 7/8 OF THE SOUTH ½ OF THE NORTH ¼ OF THE NORTHEAST ¼ OF SECTION 32, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.







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This instrument was prepared by:	Send subsequent tax bills to:	Recorder-mail recorded document to:
Brian A. Smith 5323 West 95th Street Oak Lawn, Illinois 60453	George Vlasis II 5323 West 95th Street Oak Lawn, Illinois 60453	George Vlasis II 5323 West 95th Street Oak Lawn, Illinois 60453

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AFFIDAVIT OF HEIRSHIP

JUANITA THREATTE, under oath states as follows:

1. John C. Trice died on July 13, 2005 in the city of Logan, county of Logan, State of West Virginia.

2. The affiant was the stepdaughter of the deceased at the time of his death.

3. John C. Trice was married to Lottie M. Trice once and only to Lottie M. Trice.

4. John C. Trice had no children born to or adopted by him.

5. John C. Trice had no siblings.

6. John C. Trice had two stepchildren as follows:

   A. **JUANITA THREATTE**, born June 20, 1946, an adult and competent and;

   B. **STARLING JOHNSON**, born July 27, 1949, an adult and competent

7. Based upon the foregoing, the heirs of John C. Trice are as follows:

   A. **JUANITA THREATTE**, born June 20, 1946, an adult and competent and;

   B. **STARLING JOHNSON**, born July 27, 1949, and adult and competent

Property of Cook County Clerk's Office

Juanita Threatte

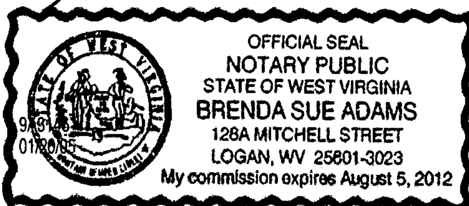
JUANITA THREATTE

SUBSCRIBED and SWORN to

before me this 5th day of October, 2005.

Brenda Sue Adams

NOTARY PUBLIC



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WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIANS / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
ROOM 165, 350 CAPITOL STREET, CHARLESTON, WV 25301

011563

STATE FILE NUMBER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEDENT'S NAME (First, Middle, Last): John C Trice
2 SEX: M
3 DATE OF DEATH (Month, Day, Year): 7-13-2005
4 SOCIAL SECURITY NUMBER: 319-03-0349
5a AGE-Last Birthday (Years): 88
5b UNDER 1 YEAR (Months, Days)
5c UNDER 1 DAY (Hours, Minutes)
6 DATE OF BIRTH (Month, Day, Year): 7-29-16
7 BIRTHPLACE (City and State or Foreign Country): Atlanta Georgia
8 WAS DECEDENT EVER IN US ARMED FORCES? (Yes or no): yes
9a PLACE OF DEATH (Check only one; see instructions on other side): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☑ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): Logan Regional Medical Center
9c CITY, TOWN, OR LOCATION OF DEATH: Logan
9d COUNTY OF DEATH: Logan
10 MARITAL STATUS-Married, Never Married, Widowed, Divorced (Specify): Widowed
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.): Butcher
12b KIND OF BUSINESS/INDUSTRY:
13a RESIDENCE-STATE: WV
13b COUNTY: Logan
13c CITY, TOWN, OR LOCATION: Omar
13d STREET AND NUMBER:
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f ZIP CODE: 25638
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☑ No ☐ Yes Specify:
15 RACE—American Indian, Black, White, etc. (Specify): Black
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) 16A: 8th; College (1-4 or 5+) 16B:

PARENTS

17 FATHER'S NAME (First, Middle, Last): John Trice
18 MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Trice

INFORMANT

19a INFORMANT'S NAME (Type/Print): Guanita Threatte
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 471 Omar, W.V.

DISPOSITION

20a METHOD OF DISPOSITION: ☑ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Forest Lawn
20c LOCATION—City or Town, State: Pecks Mill W.V.
21 SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: [signature]
22 NAME AND ADDRESS OF FACILITY: Pond Funeral Home Box 21 Logan W.V.

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-b only when certifying physician is not available at time of death to certify cause of death
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: [signature] DO
23b DATE SIGNED (Month, Day, Year): 7-13-05

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH
24 TIME OF DEATH: 0635 A
25 DATE PRONOUNCED DEAD (Month, Day, Year): July 13 2005
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No

CAUSE OF DEATH

27 PART I. 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. | Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Cardiovascular Dis[illegible]
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: CVA, Cardiomyopathy, A-fib
28a WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

29 MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
30a DATE OF INJURY (Month, Day, Year): 7-13-05
30b TIME OF INJURY: 0635 M
30c INJURY AT WORK? (Yes or No): NO
30d DESCRIBE HOW INJURY OCCURRED: Natural
30e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): Nursing Home
30f LOCATION (Street and Number or Rural Route Number, City or Town, State): 1000 W. Park Ave. Logan WV

CERTIFIER

31a CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☑ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER/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.
31b SIGNATURE AND TITLE OF CERTIFIER: [signature] DO
31c DATE SIGNED (Month, Day, Year): 7-13-05
32 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): J M. Miller, DO. Logan, WV

REGISTRAR

33 REGISTRAR'S SIGNATURE: Ginger Hite
34 DATE FILED (Month, Day, Year): 7/26/2005

NAME OF DECEDENT ____ For use by physician or institution

Form VS-002 (Rev. 6/92)

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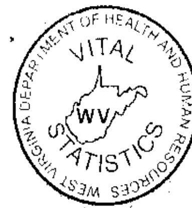
STATE OF WEST VIRGINIA



This is to certify that this document is a true and accurate reproduction of an official record, or the facts abstracted from an official record, on file with:

Vital Statistics
Bureau for Public Health
West Virginia Department of Health and Human Resources
Charleston, West Virginia.

Gary L. Thompson
State Registrar

Date Certified: JUL 27 2005

The certified copy or information appears on the reverse side on multicolor surface. Document contains heat-sensitive stamp and watermark.

Do not accept without verifying watermark and heat-sensitive stamp.

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It is a crime punishable by fine and imprisonment to counterfeit or alter this certificate or to use the vital statistics record of another person for deceptive purposes.

Property of Cook County Clerk's Office

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WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIANS / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
ROOM 165, 350 CAPITOL STREET, CHARLESTON, WV 25301

007283

STATE FILE NUMBER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last): Lottie M. Trice
2. SEX: F
3. DATE OF DEATH (Month, Day, Year): 5-10-2003
4. SOCIAL SECURITY NUMBER: 236-46-6502
5a. AGE-Last Birthday (Years): 74
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): 7-15-28
7. BIRTHPLACE (City and State or Foreign Country): OMAR, WV.
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or no): NO
9a. PLACE OF DEATH (Check only one; see instructions on other side): HOSPITAL: ☑ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): LOGAN General Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: LOGAN
9d. COUNTY OF DEATH: LOGAN
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John C. Trice
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): House Wife
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE—STATE: W.V.
13b. COUNTY: LOGAN
13c. CITY, TOWN, OR LOCATION: OMAR
13d. STREET AND NUMBER:
13e. INSIDE CITY LIMITS? (Yes or no): yes
13f. ZIP CODE: 25638
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☑ No ☐ Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): BLACK
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) 16A; College (1-4 or 5+) 16B

PARENTS

17. FATHER'S NAME (First, Middle, Last): MASCO Powell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Powell

INFORMANT

19a. INFORMANT'S NAME (Type/Print): QUANITA Threatte
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): OMAR, W.V.

DISPOSITION

20a. METHOD OF DISPOSITION: ☐ Burial ☑ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Cook's Crematory
20c. LOCATION—City or Town, State: Nitro, W.V. 25143
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Lacy L. Smith
22. NAME AND ADDRESS OF FACILITY: Pond Funeral Home Logan, WV

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-b only when certifying physician is not available at time of death to certify cause of death.
23a. To the best of my knowledge, death occurred at the time, date and place stated. Signature and Title: William McHaris DO
23b. DATE SIGNED (Month, Day, Year): 5-10-03

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 1535 M
25. DATE PRONOUNCED DEAD (Month, Day, Year): 5-10-03
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH

27. PART I. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ~~Meta~~ Terminal Cancer Colon with mets
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF): Chr C [illegible]
c. DUE TO (OR AS A CONSEQUENCE OF): HTN
d. DUE TO (OR AS A CONSEQUENCE OF): Non [illegible]

C18.9

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.

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

29. MANNER OF DEATH: ☑ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
30a. DATE OF INJURY (Month, Day, Year)
30b. TIME OF INJURY: M
30c. INJURY AT WORK? (Yes or No)
30d. DESCRIBE HOW INJURY OCCURRED
30e. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (Specify)
30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFIER

31a. CERTIFIER (Check only one)
☑ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER/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.

31b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
31c. DATE SIGNED (Month, Day, Year): 5/10/03
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): S. Rao, MD. Charleston, WV

REGISTRAR

33. REGISTRAR'S SIGNATURE: Ginger Hite
34. DATE FILED (Month, Day, Year): 5/16/2003

NAME OF DECEDENT — For use by physician or institution

02

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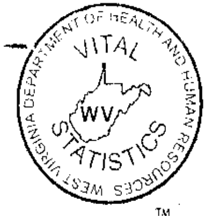
A0500162

STATE OF WEST VIRGINIA



This is to certify that this document is a true and accurate reproduction of an official record, or the facts abstracted from an official record, on file with:

Vital Statistics
Bureau for Public Health
West Virginia Department of Health and Human Resources
Charleston, West Virginia.

Gary L. Thompson
State Registrar

Date Certified: AUG 29 2005

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