

# UNOFFICIAL COPY



EUGENE "GENE" MOORE  
RECORDER OF DEEDS/REGISTRAR OF TITLE  
COOK COUNTY, ILLINOIS



Doc#: 0720647105 Fee: \$26.50  
Eugene "Gene" Moore RHSP Fee: \$10.00  
Cook County Recorder of Deeds  
Date: 07/25/2007 10:53 AM Pg: 1 of 2

## DECEASED JOINT TENANCY AFFIDAVIT

STATE OF ILLINOIS

COUNTY OF COOK

BERNICE C. JACKSON BEING DULY SWORN STATES THAT SHE  
RESIDES AT 13700 EAGLE NEST DRIVE IN THE CITY OF CRETE, ILLINOIS.  
THAT SHE WAS ACQUAINTED WITH CHARLES JACKSON THE DECEASED, WHO AT  
THE TIME OF HIS DEATH, WAS ONE OF THE OWNERS OF THE LAND IN COOK COUNTY,  
ILLINOIS, DESCRIBED AS FOLLOWS: LOT 3 (EXCEPTING THEREFROM THE NORTHWESTERLY 25.00  
FEET THEREOF) IN BLOCK 12 IN GOLDEN GATE SUBDIVISION, BEING A SUBDIVISION OF PART OF THE EAST  
1/2 OF THE NORTHWEST 1/4 OF SECTION 34, TOWNSHIP 37 NORTH, RANGE 14, EAST OF THE  
THIRD PRINCIPAL MERIDIAN IN COOK COUNTY, IL PIN: 25-34-115-D20.  
COMMONLY KNOWN AS 13314 S. RIVERDALE CHICAGO, IL 60827  
THAT THE DECEASED DIED MARCH 3, 1989, AS EVIDENCED BY A ORIGINAL CERTIFIED  
COPY OF THE DEATH CERTIFICATE OF THE DECEASED ATTACHED HERETO.

THAT THE DECEASED DIED:

- LEAVING NO LAST WILL & TESTAMENT.
- LEAVING A LAST WILL & TESTAMENT, A COPY OF WHICH IS ATTACHED HERETO. THE ORIGINAL OF THE UNPROVEN WILL SHOULD BE FILED WITH THE CLERK OF THE CIRCUIT COURT OF \_\_\_\_\_ COUNTY, ILLINOIS.
- LEAVING A LAST WILL & TESTAMENT WHICH WAS FILED IN THE UNPROVEN WILL BOX OF THE PROBATE DIVISION OF THE CIRCUIT COURT OF \_\_\_\_\_ COUNTY, ILLINOIS ABOUT \_\_\_\_\_.

AT THE TOTAL VALUE OF THE ESTATE OF THE DECEASED, INCLUDING BOTH REAL AND PERSONAL PROPERTY OWNED BY THE DECEASED EITHER INDIVIDUALLY OR IN JOINT TENANCY AT THE TIME OF THE DECEASED, DOES NOT EXCEED THE SUM OF FIFTY THOUSAND DOLLARS.

DESCRIBED AND SWORN TO BEFORE ME BY SAID

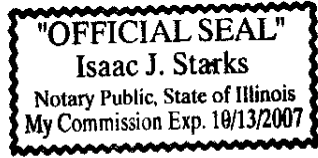
BERNICE C. JACKSON

THIS 23<sup>RD</sup> DAY OF JULY A.D. 2007

Isaac J. Starks  
NOTARY PUBLIC

Bernice C. Jackson  
AFFIANT'S SIGNATURE

THIS WAS PREPARED BY  
ISAAC J. STARKS  
5704 WOODGATE DR  
MATTESON, IL 60443  
708-720-0082



UNOFFICIAL COPY

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

MAR 0 8 1989  
Date Issued  
Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 175

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

1. DECEASED—NAME FIRST: Charles MIDDLE: LAST: Jackson			2. SEX Male		3. DATE OF DEATH (Mo. Day, Yr.) March 3, 1989	
4. SOCIAL SECURITY NUMBER 344-22-8647		5a. AGE—Last Birthday (Years) 59	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Month, Day, Year) March 2, 1930	7. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois
8. YEAR LAST SERVED IN U.S. ARMED FORCES? WWII 1947		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
9b. FACILITY NAME (If not institution, give street and number) ST Margret Hosp.			9c. CITY, TOWN, OR LOCATION OF DEATH Hammond		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS—Married Never Married, Widowed, Divorced (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Bernice Cato		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life) Stationary Eng.		12b. KIND OF BUSINESS/INDUSTRY City of Chicago
13a. RESIDENCE—STATE Illinois		13b. COUNTY COOK	13c. CITY, TOWN, OR LOCATION Chicago		13d. STREET AND NUMBER 13314 S. Riverdale	
13e. INSIDE CITY LIMITS? (Yes or no) Yes	13f. FARM No	13g. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - if yes, specify Cuban, Mexican, Puerto Rican, etc.) No	15. RACE—American Indian, Black, White, etc. (Specify) Blk	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
17. FATHER'S NAME (First, Middle, Last) John Jackson			18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ross Jackson			
19a. INFORMANT'S NAME (Type/Print) Bernice Jackson			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13314 S. Riverdale Chicago, IL		19c. Relationship Wife	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 9, 1989 Cedar Park		20c. LOCATION—City or Town, State Chicago, Ill	
21a. SIGNATURE OF FUNERAL DIRECTOR Paul Anthony Robinson			21b. LICENSE NUMBER (of Licensee) 1017284	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ENNOIS & R OBINSON Mem Chnl 1900 W. 15th Ave Gary, IN 300249		
23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <		23b. LICENSE NUMBER	23c. DATE SIGNED (Month, Day, Year)		23d. DATE SIGNED (Month, Day, Year)	
24. TIME OF DEATH 7:23 p. M		25. DATE PRONOUNCED DEAD (Month, Day, Year) March 3, 1989		26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) NO		
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. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): c. Renal failure DUE TO (OR AS A CONSEQUENCE OF): d. Sepsis 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)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> 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. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying 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. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER C. Gomez				29c. LICENSE NUMBER 22750	29d. DATE SIGNED (Month, Day, Year) March 7, 1989	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) C. Gomez, M.D. P.O.Box 665, Hammond, Indiana 46325						
31. HEALTH OFFICER'S SIGNATURE Franklin J. Remuda M.D.					32. DATE FILED (Month, Day, Year) MAR 0 8 1989	
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	
34a. 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)			