

UNOFFICIAL COPY



Doc#: 0800205165 Fee: \$30.00
Eugene "Gene" Moore RHSP Fee: \$10.00
Cook County Recorder of Deeds
Date: 01/02/2008 12:35 PM Pg: 1 of 4

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

IN RE:

AGNES SOLICH

DECEASED

AFFIDAVIT OF HEIRSHIP

DEBORAH CHMIELEWSKI, being first duly sworn on oath, deposes and states as follows:

1. The Decedent, AGNES SOLICH, died testate at Hammond, Indiana July 5, 2007 at the age of 83 years. A copy of the Certificate of Death is attached as Exhibit A. A copy of decedent's Last Will and Testament is attached as Exhibit B. 4c

2. Affiant is of legal age, residing at 1242 Knighthood, Dyer, IN 46311 and is a daughter of the Decedent.

3. Decedent was married once and only once to MICHAEL SOLICH, JR. who predeceased Decedent dying July 12, 1991. Copy of the Certificate of Death is attached as Exhibit C.

4. Four children were born to Decedent and MICHAEL SOLICH, JR. as a result of their marriage; namely, KATHLEEN ZALBEN, daughter; DEBORAH CHMIELEWSKI, daughter; PAMELA CASE, daughter; and DARLENE HANSEN, daughter.

5. No other children were born to decedent nor did she adopt any children.

6. Based upon the foregoing, Decedent, AGNES SOLICH, left as her heirs at law the following, all of whom survived Decedent: KATHLEEN ZALBEN, daughter; DEBORAH CHMIELEWSKI, daughter; PAMELA CASE, daughter; and DARLENE HANSEN, daughter, all of whom are of

670298700189

Property of Cook County Clerk's Office

Trust Fund, Inc

UNOFFICIAL COPY

legal age and under no disability.

7. At the time of he death, Decedent was the surviving joint tenant of MICHAEL SOLICH, JR. and held legal title to the following real estate:

Lot 34 in Block l in Torrence Avenue Addition to Burnham, a subdivision of the South West Quarter of the South West Quarter of Section 6, Township 36 North, Range 15 East of the Third Principal Meridian, in Cook County, Illinois.

Address: 14418 Saginaw, Burnham, IL 60633

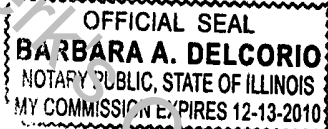
Permanent Index Number: 30-06-307-030-0000

Further Affiant sayeth not.


DEBORAH CHMIELEWSKI

SUBSCRIBED & SWORN to before me this 11th day of
December, 2007.


NOTARY PUBLIC



This instrument prepared by
& mail to:

ROBERT C. COLLINS, JR.
ATTORNEY AT LAW
850 Burnham Ave.
Calumet City, IL 60409
(708) 862-5800

* ATTENTION ESTATE: The Social Security # 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. 418

UNOFFICIAL COPY

INDIANA STATE DEPARTMENT OF HEALTH

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

CERTIFICATE OF DEATH

July 11, 2007
Date Issued
Hammond Health Commissioner

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

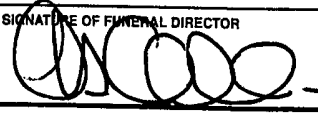
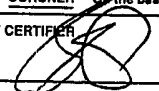
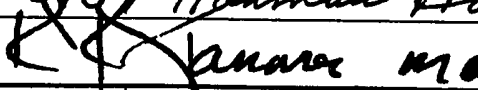
DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

1. DECEASED—NAME (First, Middle, Last) Agnes Solich				2. SEX Female		3a. TIME OF DEATH 11:30A M		3b. DATE OF DEATH (Month, Day, Year) July 5, 2007	
4. *SOCIAL SECURITY NUMBER 305-20-4685		5a. AGE—Last Birthday (Years) 83	5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) Dec. 8, 1923		7. BIRTHPLACE (City and State or Foreign Country) Youngtown, Ohio
8a. WAS DECEDENT A U.S. VETERAN? yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) St. Margaret Mercy Hospital North Campus Hammond					9c. CITY, TOWN, OR LOCATION OF DEATH Lake			9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) None		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 Own Home		
13a. RESIDENCE—STATE IL.		13b. COUNTY Cook		13c. CITY, TOWN, OR LOCATION Burnham			13d. STREET AND NUMBER 14418 Saginaw		
13e. ZIP CODE 60401		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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 12	
18. FATHER'S NAME (First, Middle, Last) John Byich					19. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Radulovich				
20a. INFORMANT'S NAME (Type/Print) Pamela Case				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 2 Wintergreen Circle Southwick, MA, 01077			20c. Relationship daught		
21a. 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)			21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) July 9, 2007 Calumet Park Cemetery			21c. LOCATION—City or Town, State Merrillville, In.			
22a. EMBALMER'S NAME: Henry Blake			22b. EMBALMER'S LICENSE NO. 0109406		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR 			24b. LICENSE NUMBER (of licensee) 20700033		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 19400005 LaHayne FH for Rosemoor FH 6955 Southeastern-17943 S. Torrer Hammond, In. 46324-Lansing, IL 60443				
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) a. <u>Sepsis</u> 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): Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last									
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 					29c. MEDICAL LICENSE NO. 01052692		29d. DATE SIGNED (Month, Day, Year) 7/9/07		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type/Print) DR. Beauvegard 457 Hammond Hammond In 46320									
31. HEALTH OFFICER'S SIGNATURE 							32. DATE FILED (Month, Day, Year) July 11, 2007		
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.						

INDIANA STATE BOARD OF HEALTH UNOFFICIAL COPY

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

CERTIFICATE OF DEATH

July 11, 2007
Date Issued

[Signature]
Hammond Health Commissioner

Local No. 539

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) MICHAEL SOLICH Jr.			2. SEX MALE		3a. TIME OF DEATH 1:20 a.m.		3b. DATE OF DEATH (Month, Day, Yr.) JULY 12, 1991			
4. SOCIAL SECURITY NUMBER 359-16-1254		5a. AGE—Last Birthday (Years) 65	5b. UNDER 1 YEAR Months: _____ Days: _____		5c. UNDER 1 DAY Hours: _____ Minutes: _____		6. DATE OF BIRTH (Mo, Day, Yr.) October 19, 1925			
7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana		8a. WAS DECEDENT A U.S. VETERAN? Yes								
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence								
9a. FACILITY NAME (If not institution, give street and number) St. Margaret Hospital				9c. CITY, TOWN, OR LOCATION OF DEATH Hammond			9d. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Agnes Bych		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crane Operator			12b. KIND OF BUSINESS/INDUSTRY Steel Mill			
13a. RESIDENCE—STATE Illinois		13b. COUNTY Cook		13c. CITY, TOWN, OR LOCATION Burnham			13d. STREET AND NUMBER 14418 S. Saginaw			
13e. ZIP CODE 60633		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Yrs College (1-4 or 5+) _____				18. FATHER'S NAME (First, Middle, Last) Michael Solich Sr.					19. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes N/A	
20a. INFORMANT'S NAME (Type/Print) Agnes Solich				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14418 S. Saginaw, Burnham, Ill. 60633				20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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 15, 1991 Calumet Park Cemetery				21c. LOCATION—City or Town, State Merrillville, Ind.			
22a. EMBALMER'S NAME James Porras			22b. EMBALMER'S LICENSE NO. 1045964		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>			24b. LICENSE NUMBER (of License) 1045184		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3002819 5840 Hohman ave (For Compare F H Hammond, Inc. Chicago, Ill)					
26 PART I. Enter the disease, 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)		a. Carcinoma of the lung DUE TO (OR AS A CONSEQUENCE OF)						Approximate Interval Between Onset and Death		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		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 <i>Don Dumont</i>						29c. MEDICAL LICENSE NO. 33451		29d. DATE SIGNED (Month, Day, Year) July 12/91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. DON DUMONT, 761 45TH AVENUE, MUNSTER IN 46321										
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Pemuda M.D.</i>							32. DATE FILED (Month, Day, Year) July 15, 1991			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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.							

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER ONLY