

# UNOFFICIAL COPY

## AFFIDAVIT OF HEIRSHIP

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



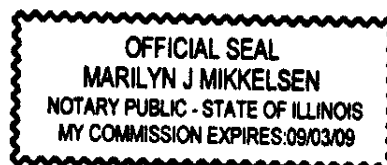
Doc#: 0822108127 Fee: \$40.00  
Eugene "Gene" Moore RHSP Fee: \$10.00  
Cook County Recorder of Deeds  
Date: 08/08/2008 12:36 PM Pg: 1 of 3

1. That his name is Kenneth Gill. He resides at 14342 S. Drexel, Dolton, Illinois.
2. He is the son of Leon Gill, deceased.
3. That Leon Gill was married 2 times. The first marriage was to Barbara Gill. That marriage ended in divorce. One child was born to Leon Gill and Barbara Gill namely, Kenneth Gill.
4. Leon Gill remarried. The marriage was to Barbara Gill. The remarriage again ended in divorce. No other children were born to or adopted by Leon Gill and Barbara Gill.
5. That all of the death related expenses of Leon Gill including, but not limited to, hospital bills, doctor bills and funeral bills, have been paid.
6. That by virtue of the above and foregoing, the only heir at law is Kenneth Gill, his son, who is adult, competent and living.

  
KENNETH GILL

SUBSCRIBED AND SWORN to  
Before me this 24 day of July, 2008.

  
NOTARY PUBLIC



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# UNOFFICIAL COPY

LOT 26 AND THE SOUTH 20 FEET OF LOT 27 IN BLOCK 16, LOT 27 OF SOUTHFIELD, BEING A SUBDIVISION OF BLOCKS 17, 18, 19, 22, 23, 24, 26, 27, 28, 29, 30, 31, AND 32 IN JANE STINSON'S SUBDIVISION OF THE WEST ½ OF THE SOUTHWEST ¼ OF SECTION 25, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN.

7845 S. CORNELL, CHICAGO, IL

P.I.N. 20-25-325-012

Property of Cook County Clerk's Office

# UNOFFICIAL COPY

## STATE OF ILLINOIS AMENDED CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. <b>16-10</b>	LOCAL FILE NUMBER <b>609592</b>	STATE FILE NUMBER <b>154 July 08</b>				
1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) <b>Leon Gill</b>		2. SEX <b>Male</b>	3. DATE OF DEATH (Month/Day/Year) (Spell Month) <b>July 10, 2008</b>			
4. COUNTY OF DEATH <b>Cook</b>	5a. AGE AT LAST BIRTHDAY (Years) <b>79</b>	5b. UNDER 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hours _____ Minutes _____	6. DATE OF BIRTH (Month/Day/Year) <b>December 7, 1928</b>		
7a. CITY OR TOWN <b>Chicago</b>		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) <b>Trinity Hospital</b>				
7c. PLACE OF DEATH (Check only one: see instructions) IF DEATH OCCURRED IN A HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing Home/Long-term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify): _____						
8. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, IL</b>	9. SOCIAL SECURITY NUMBER <b>329-20-6468</b>	10. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married but separated <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		11. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage) <b>None</b>	12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
13a. RESIDENCE (Street and Number) <b>7845 S. Cornell Ave</b>		13b. APT. NO.	13c. CITY OR TOWN <b>Chicago</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
13e. COUNTY <b>Cook</b>	13f. STATE <b>IL</b>	13g. ZIP CODE <b>60649</b>	14. FATHER'S NAME (First, Middle, Last) <b>Charlie Gill</b>		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) <b>Willie Hunter</b>	
16a. INFORMANT'S NAME <b>Kenneth Gill</b>		16b. RELATIONSHIP <b>Son</b>	16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) <b>14342 Drexel Dolton, IL 60419</b>			
17. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify): _____		18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) <b>Oakland Memory Lane Cemetery</b>		19. LOCATION - CITY, TOWN AND STATE <b>Dolton, Illinois</b>	20. DATE OF DISPOSITION (Month/Day/Year) <b>July 21, 2008</b>	
21a. FUNERAL HOME NAME <b>Cremation Society of Illinois</b>		21b. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER <b>034-011165</b> CW		
21d. STREET AND NUMBER <b>1374 E 53RD Street</b>		21e. CITY OR TOWN <b>Chicago</b>		21f. STATE <b>Illinois</b>		21g. ZIP <b>60615</b>
22. LOCAL REGISTRAR'S SIGNATURE <i>[Signature]</i>		23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) <b>JUL 18 2008</b>				
CAUSE OF DEATH (See instructions and examples) 24. PART I. Enter the chain of events - diseases, injuries or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): _____ Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST b. _____ Due to (or as a consequence of): _____ c. _____ Due to (or as a consequence of): _____ PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I. <b>HYPERTENSIVE Cardiovascular Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ _____ _____	
27. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		28. IF FEMALE: <input type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Pregnant within one year of death but time unknown <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past 12 months		25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation		26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		29. MANNER OF DEATH		
30. DATE OF INJURY (Month/Day/Year)		31. TIME OF INJURY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)		33. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
34. LOCATION OF INJURY - Street and Number _____ Apartment Number _____ City or Town _____ State _____ ZIP Code _____						
35. DESCRIBE HOW INJURY OCCURRED: _____						
36. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify) _____						
37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year) <b>July 10 2008</b>		40. TIME OF DEATH <b>8:34</b> <input type="checkbox"/> A.M. <input checked="" type="checkbox"/> P.M.
41. CERTIFIER (Check only one): <input type="checkbox"/> Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> 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 stated.						
42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) <b>TERA A. JONES, M.D. 2121 W. HARRISON CHICAGO ILLINOIS 60612</b>					43. PHYSICIAN'S LICENSE NUMBER	
44. TITLE OF CERTIFIER <b>THE MEDICAL EXAMINER</b>		45. DATE CERTIFIED (Month/Day/Year)		46. SIGNATURE OF CERTIFIER <i>[Signature]</i>		

DEPARTMENT OF PUBLIC HEALTH  
CITY OF CHICAGO

THIS CERTIFICATE COPY WOULD BE VOID IF ANY ALTERATION OR ERASURE IS MADE.

*[Signature]*

STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC HEALTH  
CITY OF CHICAGO  
JUL 18 2008