

# UNOFFICIAL COPY

## DECEASED TENANTS BY THE ENTIRETY AFFIDAVIT

State of Illinois        )  
                                      )        SS.  
County of Cook        )

**Joanne M. Schonauer**, hereinafter called Affiant being duly sworn states that she resides at 696 Golfview, Buffalo Grove, IL 60089. That Affiant was married to Thomas J. Schonauer, hereinafter referred to as Deceased, and at the time of Deceased's death. That the Affiant and Deceased owned the land as **Tenants by the Entirety** in Cook County, Illinois, described as:

**Commonly known as:**                        **696 Golfview, Buffalo Grove, IL 60089**

**Property Index Number:**                **03-05-413-037**

**Legal Description:**

**Lot 126 in Arlington addition to Buffalo Grove, a subdivision in Section 4 and 5, Township 42 North, Range 12 East of the Third Principal Meridian, in Cook County, Illinois.**

That the Deceased died on August 3 2008, as evidenced by a copy of Deceased's death certificate attached hereto.

That the Deceased, at the time of his death, held the above-described property as **TENANTS BY THE ENTIRETY** along with his wife, the Affiant.

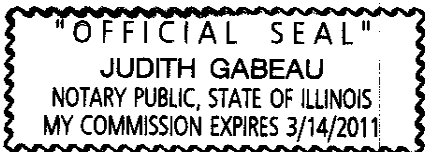
That as the surviving spouse, Affiant is now the sole owner of the above-described property.

Affiant makes this affidavit for the purpose of any individual or corporation who may be harmed by the Affiant's lack of veracity.

Subscribed and sworn before me this 27th day of September, 2008.

Judith Gabeau  
Notary Public




Joanne M. Schonauer  
Affiant's Signature



Doc#: 0833829061 Fee: \$58.00  
Eugene "Gene" Moore RHSP Fee: \$10.00  
Cook County Recorder of Deeds  
Date: 12/03/2008 03:24 PM Pg: 1 of 2

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## STATE OF ILLINOIS CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. <b>16.0</b>		STATE FILE NUMBER	
LOCAL FILE NUMBER			
1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last) <b>Thomas Joseph Schonauer</b>		2. SEX <b>Male</b>	3. DATE OF DEATH (Month/Day/Year) (Spell Month) <b>August 3, 2008</b>
4. COUNTY OF DEATH <b>Cook</b>	5a. AGE AT LAST BIRTHDAY (Years) <b>58</b>	5b. UNDER 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hours _____ Minutes _____
7a. CITY OR TOWN <b>Arlington Hts.</b>		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) <b>Northwest Community Healthcare</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>Devils Lake, ND</b>	9. SOCIAL SECURITY NUMBER <b>502-56-7632</b>	10. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married but separated <input type="checkbox"/> Widowed <input 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>Joanne Ebertz</b>
12. EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
13a. RESIDENCE (Street and Number) <b>696 Golfview Terrace</b>		13b. APT. NO.	13c. CITY OR TOWN <b>Buffalo Grove</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>60089</b>	14. FATHER'S NAME (First, Middle, Last) <b>Claude Schonauer</b>
		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) <b>Eve Rerich</b>	
16a. INFORMANT'S NAME <b>Joanne Schonauer</b>		16b. RELATIONSHIP <b>Spouse</b>	16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) <b>696 Golfview Terrace Buffalo Grove, IL 60089</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>Lakewood Crematory</b>	19. LOCATION - CITY, TOWN AND STATE <b>Lake Bluff, IL</b>
		20. DATE OF DISPOSITION (Month/Day/Year) <b>August 6, 2008</b>	
21a. FUNERAL HOME NAME <b>Kolssak Funeral Home</b>		21b. FUNERAL DIRECTOR'S SIGNATURE 	
		21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER <b>034-015553</b>	
LOCAL REGISTRAR'S SIGNATURE 		23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) <b>AUG 05 2008</b>	
<b>CAUSE OF DEATH (See instructions and examples)</b>			
24. PART I. Enter the <i>chain of events</i> - 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.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Acute + chronic congestive heart failure</b> Due to (or as a consequence of): _____			<b>1-2 days</b> <b>one year</b>
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. <b>Esophageal cancer</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.			
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	
		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	
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 checked="" 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 (we) (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>August 3, 2008</b>
		40. TIME OF DEATH <b>3:00</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 checked="" 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>James J. Jant MD 333 N. Michigan Chicago 60607</b>		43. PHYSICIAN'S LICENSE NUMBER <b>36-052465</b>	
44. TITLE OF CERTIFIER <b>MD</b>		45. DATE CERTIFIED (Month/Day/Year) <b>8-4-08</b>	46. SIGNATURE OF CERTIFIER 

This is to certify that this is a true and correct copy of the official death record filed with the Illinois Department of Public Health.

STATE OF ILLINOIS  
County of Cook

DAVID ORR, County Clerk

AUG 05 2008

I, David Orr, County Clerk of the County of Cook, in the State aforesaid, and Keeper of the Records and Files of said County do hereby certify that the attached is a true and correct copy of the original Record on file, all of which appears from the records and files in my office.

IN WITNESS THEREOF, I have hereunto set my hand and affixed the Seal of the County of Cook, at my office in the city of Chicago, in said County.

  
COUNTY CLERK