

UNOFFICIAL COPY

and any amendments thereto, of 15721 Brassie Ct., Orland Park, Illinois, as to an undivided 50% interest;

3. That DELORES M. WHEELER was the Trustmaker and Co-Trustee of the DELORES M. WHEELER LIVING TRUST dated February 4, 1992;
4. That the date of death of DELORES M. WHEELER was January 16, 2009;
5. That the successor trustees of the DELORES M. WHEELER LIVING TRUST are ROBERT D. WHEELER, RONALD BURNSON and BRIAN R. WHEELER .
6. That ROBERT D. WHEELER was the husband of DELORES M. WHEELER;
7. That RONALD BURNSON was the son-in-law of DELORES M. WHEELER;
8. That BRIAN R. WHEELER was the son of DELORES M. WHEELER;
9. That the DELORES M. WHEELER LIVING TRUST dated February 4, 1992 provides for a marital trust and family trust allocation upon the death of the Trustmaker;
10. That the 50% interest of the DELORES M. WHEELER LIVING TRUST in the aforementioned real estate is allocated to this family trust.
11. That according to Article Seventeen, Section 3. of the aforementioned trust, the successor Trustee has the following powers with regard to the real estate:

t. Real Estate Powers

My Trustee may purchase, sell, transfer, exchange or otherwise acquire or dispose of any real estate.

My Trustee may make leases and grant options to lease for any term, even though the term may extend beyond the termination of any trust created under this agreement.

My Trustee may grant or release easements and other interests with respect to real estate, enter into party wall agreements, execute estoppel certificates, and develop and subdivide any real estate.

My Trustee may dedicate parks, streets, and alleys or vacate any street or alley, and may construct, repair, alter, remodel, demolish, or abandon improvements.

My Trustee may elect to insure, as it deems advisable, all actions contemplated by this subsection.

My Trustee may take any other action reasonably necessary for the preservation of real estate and fixtures comprising a part of the trust property or the income therefrom.

v. Sale, Lease, and Other Dispositive Powers

My Trustee may sell, lease, transfer, exchange, grant options with respect to, or otherwise dispose of the trust property.

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My Trustee may deal with the trust property at such time or times, for such purposes, for such considerations and upon such terms, credits, and conditions, and for such periods of time, whether ending before or after the term of any trust created under this agreement, as it deems advisable.

My Trustee may make such contracts, deeds, leases, and any other instruments it deems proper under the immediate circumstances, and may deal with the trust property in all other ways in which a natural person could deal with his or her property.

Date: Feb 17, 2009

Robert D. Wheeler
ROBERT D. WHEELER

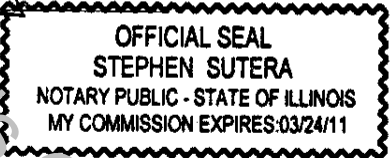
State of Illinois
County of Cowl, ss.

I, the undersigned, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that **ROBERT D. WHEELER**, 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 he signed, sealed and delivered the said instrument as his free and voluntary act, for the uses and purposes therein set forth, including the release and waiver of the right of homestead.

Given under my hand and official seal, this 19 day of FEB, 2009.

Commission expires 3/24, 2011

Stephen Sutera
NOTARY PUBLIC



PREPARED BY AND MAIL TO:

Stephen Sutera
4927 West 95th Street
Oak Lawn IL 60453-2503
(708)857-7255

STATE OF ILLINOIS CERTIFICATE OF DEATH

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REGISTRATION DISTRICT NO. 16.0		LOCAL FILE NUMBER		STATE FILE NUMBER	
1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) DELORES M WHEELER			2. SEX Female		3. DATE OF DEATH (Month/Day/Year) (Spell Month) January 16, 2009
4. COUNTY OF DEATH Cook		5a. AGE AT LAST BIRTHDAY (Years) 80	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Month/Day/Year) October 18, 1928
7a. CITY OR TOWN Windeale LYONS TOWNSHIP			7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) RML Specialty Hospital		
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) Chicago, IL		9. SOCIAL SECURITY NUMBER 339-22-5428		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) Robert D. Wheeler		12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
13a. RESIDENCE (Street and Number) 15721 Brassie Ct.		13b. APT. NO.	13c. CITY OR TOWN Orland Park		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13e. COUNTY Cook	13f. STATE IL	13g. ZIP CODE 60462	14. FATHER'S NAME (First, Middle, Last) Fred Conrad		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Doris Greitzer
16a. INFORMANT'S NAME Robert D. Wheeler		16b. RELATIONSHIP Husband		16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 15721 Brassie Ct., Orland Park, IL 60462	
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) Good Shepherd Cemetery		19. LOCATION - CITY, TOWN AND STATE Orland Park, IL	20. DATE OF DISPOSITION (Month/Day/Year) January 20, 2009
21a. FUNERAL HOME NAME McKenzie Funeral Home, Ltd., 15618 S. Cicero Ave., Oak Forest, Illinois 60452		STREET AND NUMBER		CITY OR TOWN	STATE
21b. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas J. Dipola</i>		21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-010222			
22. LOCAL REGISTRAR'S SIGNATURE <i>David Orr</i>		23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) JAN 20 2009			
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.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure 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. bladder CA, S3B0, neptery, Biskwa					25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No
28. IF FEMALE: <input checked="" type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death		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 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. (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) 1/16/09		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year) 1/16/09	
40. TIME OF DEATH 03:57		41. CERTIFIER (Check only one): <input checked="" 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) Nishi Sabgal 520 E Ogden Suite C, Windeale, IL 60520					43. PHYSICIAN'S LICENSE NUMBER 036-096911
44. TITLE OF CERTIFIER MD		45. DATE CERTIFIED (Month/Day/Year) 1/16/09		46. SIGNATURE OF CERTIFIER <i>[Signature]</i>	

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

JAN 20 2009

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.

David Orr

COUNTY CLERK