

UNOFFICIAL COPY

DECLASED JOINT TENANCY AFFIDAVIT

State of Illinois)
) ss.
County of Cook)

BARRY R. DIEDEN, being duly sworn states that she resides at 5048 N. Tripp Ave., Chicago, IL 60630

That she was acquainted with MARIA E. DIEDEN, who, at the time of her death, was the owner of the land in Cook County, Illinois, described as:

LOT 24 IN DR. PRICE'S RIVER PARK SUBDIVISION OF THE WEST 3/4 OF THE NORTHWEST 1/4 OF THE SOUTHEAST 1/4 OF SECTION 10, TOWNSHIP 40 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

3-19-407-024-0000

That the deceased died July 15, 2008, as evidenced by a copy of death certificate of the deceased attached hereto.

That the deceased died

Leaving no Last Will and Testament

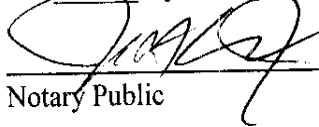
Leaving a Last Will and Testament a copy of which is attached hereto. The original of the unproven will should be filed with the Clerk of the Probate Division of the Circuit Court of _____ County, Illinois.

Leaving a Last Will and Testament which was filed in the Unproven Will Box of the Probate Division of the Circuit Court of _____ County, Illinois, about _____.

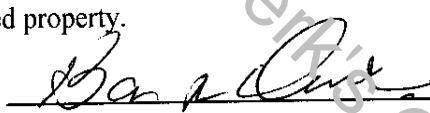
That the total value of the estate of the deceased, including both real and personal property owned by the deceased either individually or in joint tenancy at the time of the death of the deceased, does not exceed the sum of \$ _____ dollars.

Affiant makes this affidavit for the purpose of inducing the Title Insurance Company to issue its Title Insurance Policy, describing the above mentioned property.

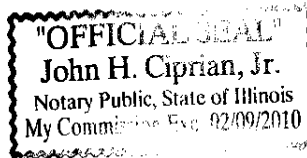
Subscribed and Sworn to before me
this 3rd day of September, 2009



Notary Public



BARRY E. DIEDEN



Doc#: 0924655074 Fee: \$58.00
Eugene "Gene" Moore RHSP Fee: \$10.00
Cook County Recorder of Deeds
Date: 09/03/2009 04:03 PM Pg: 1 of 2

CERTIFICATE OF VITAL RECORDS

UNOFFICIAL COPY

STATE OF ILLINOIS CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. <u>16. 36</u>		STATE FILE NUMBER	
LOCAL FILE NUMBER <u>2-19-90</u>		STATE FILE NUMBER	
1. DECEASED'S LEGAL NAME (Include Suffix, First, Middle, Last) <u>MARIA HERNANDEZ DIEDEN</u>		2. SEX <u>Female</u>	3. DATE OF DEATH (Month/Day/Year) (Spell Month) <u>July 15, 2008</u>
4. COUNTY OF DEATH <u>Cook</u>	5a. AGE AT LAST BIRTHDAY (Years) <u>60</u>	5b. UNDEF. 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hours _____ Minutes _____
7a. CITY OR TOWN <u>Skokie</u>		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) <u>Midwest Palliative Hospice Care Center</u>	
7c. PLACE OF DEATH (Check only one; see instructions)			
IF DEATH OCCURRED IN A HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room Outpatient <input type="checkbox"/> Dead on Arrival			
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input checked="" 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) <u>Chicago, Illinois</u>	9. SOCIAL SECURITY NUMBER <u>[REDACTED]-5395</u>	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) <u>Barry Dieden</u>
12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
13a. RESIDENCE (Street and Number) <u>5048 N. Tripp</u>		13b. APT. NO. <u>Chicago</u>	13c. CITY OR TOWN <u>Chicago</u>
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
13e. COUNTY <u>Cook</u>	13f. STATE <u>IL</u>	13g. ZIP CODE <u>60630</u>	14. FATHER'S NAME (First, Middle, Last) <u>George Toledo</u>
15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) <u>Maria Hernandez Toledo</u>			
16a. INFORMANT'S NAME <u>Barry Dieden</u>		16b. RELATIONSHIP <u>Husband</u>	16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) <u>5048 N. Tripp, Chicago, IL 60630</u>
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) <u>Glen Oaks</u>	19. LOCATION - CITY, TOWN AND STATE <u>Hillside, Illinois</u>
20. DATE OF DISPOSITION (Month/Day/Year) <u>July 18, 2008</u>			
21a. FUNERAL HOME NAME STREET AND NUMBER CITY OR TOWN STATE ZIP <u>Malec & Sons Funeral Home 6000 N. Milwaukee Avenue Chicago, Illinois 60646</u>			
21b. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley A. Stinich</u>		21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER <u>034-011619</u>	
22. LOCAL REGISTRAR'S SIGNATURE <u>[Signature]</u>		23. DATE FILED WITH LOCAL DEPARTMENT OF PUBLIC HEALTH (Year) <u>JUL 18 2008</u>	
CAUSE OF DEATH (See instructions and examples) 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 ventral 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) → <u>Gastric Malignancy</u> Due to (or as a consequence of) _____			<u>unknown</u>
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 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		28. IF FEMALE: <input checked="" 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 <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify): _____
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, RECORD: <input type="checkbox"/> Driver/operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Could not be determined <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 <u>7-15-08</u>		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	39. DATE PRONOUNCED (Month/Day/Year) <u>July 15, 2008</u>
40. TIME OF DEATH <u>6:50</u> <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.			
41. CERTIFIER (Check only one): <input checked="" type="checkbox"/> Physician in charge of patient's care (To be checked, my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Physician in charge of patient's care at time of death (To be checked, in 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 (To be checked, 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) <u>Nancy C. Malley MD, 2055 Claire Ct., Glenview, IL 60025</u>			43. PHYSICIAN'S LICENSE NUMBER <u>036099073</u>
44. TITLE OF CERTIFIER <u>M.D.</u>	45. DATE CERTIFIED (Month/Day/Year) <u>July 15, 2008</u>	46. SIGNATURE OF CERTIFIER <u>Nancy C. Malley MD</u>	

Illinois Department of Public Health - Division of Vital Records
VR200 (Rev. 1/08)

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.

JUL 18 2008

Lowell Hunkleberry