



Doc#: 1102133024 Fee: \$86.00
Eugene "Gene" Moore RHSP Fee: \$10.00
Cook County Recorder of Deeds
Date: 01/21/2011 09:26 AM Pg: 1 of 4

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

IN RE THE ESTATE OF)
)
NORMAN A. ROSS,)
)
Deceased)

AFFIDAVIT OF HEIRSHIP

- LINDA M. JOHNSTONE, daughter of the decedent, states that she has personal knowledge of the decedent and if called to would testify to the following:
- That NORMAN A. ROSS died on May 3, 2010 and at the time of his death he was a widower, having been married to Dorothy L. Ross on May 8, 1954 and who predeceased him on October 30, 1997.
- There were five (5) children born to decedent Norman A. Ross and his wife, Dorothy L. Ross, namely; PAMELA A. PAPP, DARLENE E. ROSS, LINDA M. JOHNSTONE, DONNA M. ROSS and DIANE L. ROSS.
- Decedent's children are all surviving, competent adult children with no disabilities and no other children were born to or adopted by Decedent or his wife.
- That all of decedent's funeral expenses have been paid. That there are no outstanding taxes due on decedent's estate and no unpaid medical bills pending.
- AFFIANT FURTHER SAYETH NOT.

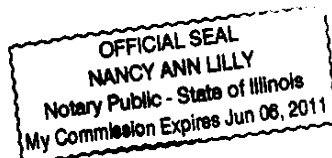
Linda M. Johnstone
LINDA M. JOHNSTONE *2/3*

Subscribed & sworn to before me Dec. 28, 2010

FIDELITY NATIONAL TITLE

012013518

Nancy Ann Lilly
Notary Public



THOMAS A. TOOLIS of
Jahnke, Sullivan & Toolis, LLC
Attorney for the Estate
9031 W. 151st St., Suite 203
Orland Park, Illinois 60462
(708)349-9333

BOX 15

DONE AT CUSTOMER'S REQUEST

S *[initials]*
P *[initials]*
S *[initials]*
SC *[initials]*
INT *[initials]*

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STATE OF ILLINOIS
MEDICAL CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEASED'S BIRTH NO.

REGISTRATION DISTRICT NO. 16.31

REGISTERED NUMBER 492

Type or Print in PREPARATION BOOK See Funeral Directors, Hospital, or Physicians Handbook for INSTRUCTIONS

DECEASED-NAME FIRST MIDDLE LAST DOROTHY L ROSS SEX Female DATE OF DEATH (MONTH, DAY, YEAR) 3 October 30, 1997

COUNTY OF DEATH Cook HOSPITAL OR OTHER INSTITUTION-NAME (IF NOT MEMBER, GIVE STREET AND NUMBER) St. Francis Hospital

CITY, TOWN, TWP. OR ROAD DISTRICT NUMBER Blue Island

BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY) Chicago, IL

MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) Married

RESIDENCE (STREET AND NUMBER) 6321 S. Long

STATE Illinois

FATHER-NAME FIRST MIDDLE LAST Leo Dietz

MOTHER-NAME FIRST MIDDLE LAST Lillian Ericson

RELATIONSHIP 17b. Husband

ADDRESS (STREET AND NO. OR R.F.D., CITY OR TOWN, STATE, ZIP) 6321 S. Long, Chicago, IL 60638

CONDITIONS, IF ANY WHICH GIVE RISE TO IMMEDIATE CAUSE (a) AND LATENT CAUSE (b) STATED IN THE UNDERLYING CAUSE LAST. (c)

DATE OF OPERATION, IF ANY 20a. 10-25-97

NAME AND ADDRESS OF CERTIFIER 22a. Dr. Redington 2310 York St. Blue Island IL 60404

I HEREBY CERTIFY THAT THE foregoing is a true and correct copy of the DEATH RECORD for the decedent named at ITEM 1 and that this record was established and filed in my office in accordance with the provisions of the Illinois Statutes relating to the REGISTRATION OF BIRTHS, STILLBIRTHS AND DEATHS.

DATE NOV 03 1997 SIGNED [Signature] OFFICIAL TITLE, LOCAL REGISTRAR

BLUE ISLAND, ILLINOIS

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CERTIFICATION OF VITAL RECORD

REGISTRATION DISTRICT NO. <u>16-34</u>		STATE OF ILLINOIS CERTIFICATE OF DEATH				STATE FILE NUMBER
LOCAL FILE NUMBER						
1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First Middle Last) Norman A Ross			2. SEX Male	3. DATE OF DEATH (Month Day Year) (Spell Month) May 3, 2010		
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) September 14, 1929		
7a. CITY OR TOWN Harvey		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in error, give street and number) Ingalls Memorial 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) (Spell) Stonelake, WI	9. SOCIAL SECURITY NUMBER	10. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married but separated <input checked="" 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)		12. EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13a. RESIDENCE (Street and Number) 6321 Long Avenue		13b. APT. NO.	13c. CITY OR TOWN Chicago		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
13e. COUNTY Cook	13f. STATE IL	13g. ZIP CODE 60628	14. FATHER'S NAME (First, Middle, Last) Emil Ross		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Matilda Unavailable	
16a. INFORMANT'S NAME Pamela Pappas		16b. RELATIONSHIP Daughter		16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 2428 Lake Vista Ct., Cassesberry, FL 32707		
17. METHOD OF DISPOSITION: <input 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) St. Mary Cemetery		19. LOCATION - CITY, TOWN AND STATE Evergreen Park IL		20. DATE OF DISPOSITION (Month/Day/Year) May 7, 2010
21a. FUNERAL HOME NAME Blake-Lamb Funerl Home		STREET AND NUMBER 4727 W. 103rd Street		CITY OR TOWN Oak Lawn	STATE Illinois	ZIP 60453
21b. FUNERAL DIRECTOR'S SIGNATURE <i>Robert H. Giff</i>				21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-012014		
22. LOCAL REGISTRAR'S SIGNATURE <i>Nancy L. Clark</i>				23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) MAY 05 2010		
CAUSE OF DEATH (See instructions and examples)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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. Acute myocardial infarction 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. C-difficil colitis Due to (or as a consequence of):						
c. Abdominal Aortic Aneurysm 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. COPD / CA of prostate / Amyloidosis / prostatic adenocarcinoma						
25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. WILL AUTOPSY FINDINGS BE USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
27. DID TOBACCO USE CONTRIBUTE TO DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		28. IF FEMALE: <input type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Pregnant at 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. (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON 4/13/10		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year) May 3, 2010		40. TIME OF DEATH 5:48 P.M. <input type="checkbox"/> P.M.
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) Vivek Kaistha M.D.: 16650 S. Harlem Avenue Tinley Park, IL 60477					43. PHYSICIAN'S LICENSE NUMBER 036-088189	
44. TITLE OF CERTIFIER M. D.		45. DATE CERTIFIED (Month/Day/Year) 5/3/10		46. SIGNATURE OF CERTIFIER <i>Vivek Kaistha</i>		

(Based on the 2003 U.S. Standard Certificate) Illinois Department of Public Health - Division of Vital Records VR2000 (Rev. 1/08)

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FIDELITY NATIONAL TITLE INSURANCE COMPANY

9031 W. 151ST STREET #110, ORLAND PARK, ILLINOIS 60462

PHONE: (708) 873-5200
FAX: (708) 873-5206

ORDER NUMBER: 2010 012013512 OCF
STREET ADDRESS: 6321 S. LONG AVE.

CITY: CHICAGO
TAX NUMBER: 19-21-102-027-0000

COUNTY: COOK COUNTY

LEGAL DESCRIPTION:

THE SOUTH 6 FEET 8 INCHES OF LOT 2 AND THE NORTH 9 FEET 4 INCHES OF LOT 3 IN BLOCK 1 IN SECOND SOUTH LONG AVENUE SUBDIVISION BEING PART OF THE NORTHEAST 1/4 OF THE NORTHWEST 1/4 OF SECTION 21, TOWNSHIP 38 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDINT TO THE PLAT THEREOF REGISTERED AS DOCUMENT 959025.