

UNOFFICIAL COPY

JOINT TENANCY AFFIDAVIT

(continued)

Subscribed and sworn to before me this

21 day of September, 2011
(Month) (Year)

Rebecca M Rusch
(Notary Public)



My commission expires: _____

Note: If the decedent left a will, a certified copy thereof must be presented to ATG for inspection, along with a certified copy of the death certificate and evidence of payment of death taxes, if any.

This instrument prepared by: LAURENCE J. HAYES Return to:

LAURENCE J. HAYES
1085 CEDAR CREEK
LAKE ZURICH, IL
60047

Property of Cook County Clerk's Office

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REGISTRATION DISTRICT NO. 16.0		STATE OF ILLINOIS CERTIFICATE OF DEATH		STATE FILE NUMBER	
LOCAL FILE NUMBER		1. DECEDENT'S U.S. AL. NAME (Include AKA's if any) (First, Middle, Last) Regina T. Hayes		2. SEX Female	3. DATE OF DEATH (Month/Day/Year) (Spell Month) March 3, 2009
4. COUNTY OF DEATH Cook	5a. AGE AT LAST BIRTHDAY (Years) 81	5b. UNDER 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hour _____ Minute _____	6. DATE OF BIRTH (Month/Day/Year) August 10, 1927	
7a. CITY OR TOWN Des Plaines		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) 1450 Phoenix Drive			
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 HOSPITAL <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long-Term care facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify): _____		
8. BIRTHPLACE (City and State or Foreign Country) Chicago, IL	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 SPOUSES NAME (If wife, give full name prior to first marriage) 12. EVER IN THE US ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13a. RESIDENCE (Street and Number) 1450 Phoenix Drive		13b. APT. NO. -	13c. CITY OR TOWN Des Plaines		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13e. COUNTY Cook	13f. STATE IL	13g. ZIP CODE 60016	14. FATHER'S NAME (First, Middle, Last) John Caulfield		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Margaret Noonan
16a. INFORMANT'S NAME Laurence Hayes		16b. RELATIONSHIP Son	16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 1085 Cedar Creek Lake Zurich, IL 60047		
17. METHOD OF DISPOSITION: <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Other (Specify): _____		18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) All Saints Cemetery		19. LOCATION - CITY, TOWN AND STATE Des Plaines, IL 60016	20. DATE OF DISPOSITION (Month/Day/Year) March 6, 2009
21a. FUNERAL HOME NAME Friedrichs Funeral Home, Inc.		21b. STREET NUMBER 320 West Central Road		21c. CITY OR TOWN Mount Prospect	21d. STATE Illinois
21e. ZIP 60056		21f. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Friedrichs</i>		21g. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-014719	
22. LOCAL REGISTRAR'S SIGNATURE <i>David Orr</i>		23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) MAR 05 2009			
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 cause 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 multiple causes if necessary.					months
IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic carcinoma of the stomach 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 which 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.					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					28. 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 the past 12 months <input type="checkbox"/> Not 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. (DO NOT) ATTEND THE DECEASED (Month/Day/Year) 2/16/09		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year) March 3, 2009	
40. TIME OF DEATH 12:15 <input type="checkbox"/> A.M. <input checked="" 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) 880 W CENTRAL AVE 60005		43. PHYSICIAN'S LICENSE NUMBER 3643487		44. TITLE OF CERTIFIER M.D.	
45. DATE CERTIFIED (Month/Day/Year) 3/4/09		46. SIGNATURE OF CERTIFIER <i>David Orr</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

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

MAR 05 2009