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Therefore, pursuant to the surviving joint tenancy of Alice Patterson and the sole heirship of Karen Patterson, ownership of said real property described above is in Karen Patterson.

Affiant makes this affidavit for the purpose of clearing title to the above property.

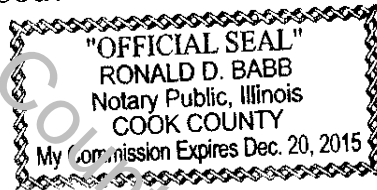
Further affiant sayeth not.

Karen L. Patterson (Seal)
Karen Patterson, affiant

Sate of Illinois)
County of Cook) ss.

On this 10th day of June, 2013, Karen Patterson, personally known to me, appeared before me and signed the above affidavit as her free and lawful act, for the purposes stated.

Ronald D. Babb
Notary Public



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CERTIFICATION OF VITAL RECORDS

HARVEY, ILLINOIS DISTRICT 16.34

STATE OF ILLINOIS

STATE FILE NUMBER

MEDICAL CERTIFICATE OF DEATH

Form containing fields for Decedent's Birth No., Registration District No., Deceased Name (MELVIN A PATTERSON), Date of Death (3 OCTOBER 6, 2002), Date of Birth (5d JANUARY 7, 1935), Cause of Death (Sepsis, Liver Cirrhosis, ICHSS), Informant's Name (KAREN PATTERSON), and Disposition (HICKEY MEMORIAL CHAPEL).

PRINTED BY AUTHORITY OF THE STATE OF ILLINOIS

CERTIFIED COPY OF VITAL RECORDS

I HEREBY CERTIFY THAT THE FOREGOING is a true and correct copy of the DEATH record for the individual named therein 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.

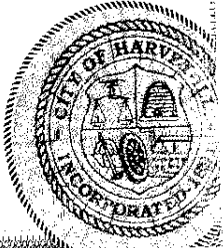
DATE ISSUED

ISSUED AT:

OCT 8 2002 CITY OF HARVEY 15320 SO. BROADWAY AVE. ILLINOIS 60426

Signature of Gwendolyn L. Davis, Local Registrar

This copy not valid unless prepared on engraved border displaying seal and signature of Local Registrar



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STATE OF ILLINOIS CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 1634	STATE FILE NUMBER	
LOCAL FILE NUMBER	2. SEX Female	3. DATE OF DEATH (Month/Day/Year) (Spell Month) April 30, 2008
1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) Alice Patterson		
4. COUNTY OF DEATH Cook	5a. AGE AT LAST BIRTHDAY (Years) 73	5b. UNDER 1 YEAR Months _____ Days _____
7a. CITY OR TOWN Harvey		5c. UNDER 1 DAY Hours _____ Minutes _____
6. DATE OF BIRTH (Month/Day/Year) March 14, 1935		
7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, 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 Country) Harvey, Illinois	9. SOCIAL SECURITY NUMBER [REDACTED] 1	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) None		12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
13a. RESIDENCE (Street and Number) 3638 Sunset Ave.	13b. APT. NO.	13c. CITY OR TOWN Markham
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Anna Tymoc
13a. COUNTY Cook	13f. STATE IL	13g. ZIP CODE 60428
14. FATHER'S NAME (First, Middle, Last) John Komafel		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Anna Tymoc
16a. INFORMANT'S NAME Karen L. Patterson		16b. RELATIONSHIP Daughter
15c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 3638 Sunset Ave. Markham, Illinois 60428		17. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Burial <input type="checkbox"/> Other (Specify): _____
18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) Forest Crematory		19. LOCATION - CITY, TOWN AND STATE Romeoville, Illinois
20. DATE OF DISPOSITION (Month/Day/Year) MAY 3, 2008		21a. FUNERAL HOME NAME Illinois Cremation Direct
21b. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-011165
22. LOCAL REGISTRAR'S SIGNATURE <i>Nancy L. Clark</i>		23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) MAY 05 2008
CAUSE OF DEATH (See instructions and examples) 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. <u>Lung Cancer</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</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		
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.		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 checked="" 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 <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"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined <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 (DID) (DID NOT) ATTEND THE DECEASED AND LAST SAW HIM/HER ALIVE ON <u>02/14/08</u>		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
39. DATE PRONOUNCED (Month/Day/Year) 04/30/08		40. TIME OF DEATH OR: 40 <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) Mark Kozloff 71 W 156th St Suite 401 Harvey IL 60426		43. PHYSICIAN'S LICENSE NUMBER IL 0362047581
44. TITLE OF CERTIFIER MD	45. DATE CERTIFIED (Month/Day/Year) 05/02/08	46. SIGNATURE OF CERTIFIER <i>[Signature]</i>

Based on the 2003 U.S. Standard Certificate) 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.

MAY 05 2008

Nancy L. Clark