

**ORIGINAL**

# UNOFFICIAL COPY

This Instrument Prepared By:  
Barry C. Bergstrom & Associates, Ltd.  
3330 - 181st Place  
Lansing, IL 60438



Doc#: 1325344099 Fee: \$42.00  
RHSP Fee: \$9.00 RPRF Fee: \$1.00  
Karen A. Yarbrough  
Cook County Recorder of Deeds  
Date: 09/10/2013 03:41 PM Pg: 1 of 3

**MAIL TO:**  
Barry C. Bergstrom & Assoc.  
3330 181st Place, Ste. 104  
Lansing, Illinois 60438

Property of Cook County Clerk's Office

**DECEASED JOINT TENANCY AFFIDAVIT**

STATE OF ILLINOIS )  
                              )SS  
COUNTY OF COOK )

The Affiant, ROSEMARY E. ENGLUND, being duly sworn states that the Affiant resides at 17515 William Street, Lansing, Illinois 60438.

That ROSEMARY E. ENGLUND was acquainted with KURT J. ENGLUND, the deceased, who, at the time of his death was one of the owners of the land in Cook County, Illinois hereinafter legally described:

**LEGAL DESCRIPTION**

LOT TWENTY-THREE (23) (EXCEPT THE SOUTH TWENTY-FOUR (24) FEET) AND THE SOUTH THIRTY-FOUR (34) FEET OF LOT TWENTY-FOUR (24) IN BLOCK TWO (2) IN RIVERVIEW MANOR BEING A SUBDIVISION OF THE NORTH 17.2004 ACRES OF THE SOUTH 28.6724 ACRES OF THE EAST QUARTER (E1/4) OF THE SOUTH WEST QUARTER (SW1/4) OF SECTION TWENTY-NINE (29) TOWNSHIP THIRTY-SIX (36) NORTH, RANGE FIFTEEN (15) EAST OF THE THIRD PRINCIPAL MERIDIAN IN COOK COUNTY, ILLINOIS. ✓

ADDRESS OF PROPERTY: 17515 WILLIAM STREET, LANSING, ILLINOIS 60438 ✓

PIN: 30-29-311-037-0000 ✓

That the Decedent died February 17, 1998, as evidenced by a copy of death certificate of the deceased attached hereto.

That the deceased died:

/X/ Leaving no Last Will and Testament.

3 yes  
3 3  
3 NO  
4 NO  
1 Cyes  
1 yes  
1 NTD ✓


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- // Leaving a Last Will and testament a copy of which is attached hereto. The original of the Will was filed with the Clerk of the Probate Division of the Circuit Court of Cook County, Illinois and admitted to Probate on July 30, 2013.
- // Leaving a Last Will and Testament which was filed in the Unproved Will Box of the Probate Division of the Circuit Court of Cook County, Illinois on or about July 30, 2013.


That the total value of the estate of the Decedent, including both real and personal property owned by the Decedent either individually or in joint tenancy at the time of the death of the Decedent, does not exceed the sum of \$625,000.00.

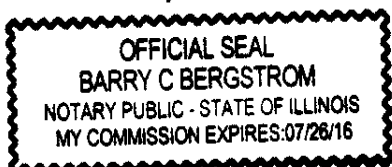
Affiant makes this Affidavit for the purpose of inducing any title company to issue its title insurance policy, describing the real estate referred to above.

Dated: July 30, 2013

  
ROSEMARY E. ENGLUND

Subscribed and sworn to before me  
by the said ROSEMARY E. ENGLUND, this 30th  
day of July, 2013.

  
BARRY C. BERGSTROM, Notary Public



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ATTENTION ESTATE: The Social Security # being requested by this state agency in order to issue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

## INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0368-98

### CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

256858  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>Kurt J. Englund</b>				2. SEX <b>Male</b>	3a. TIME OF DEATH <b>1255A M</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>February 17, 1998</b>
4. *SOCIAL SECURITY NUMBER <b>[REDACTED]-5430</b>		5a. AGE—Last Birthday (Years) <b>62</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>Dec. 6, 1935</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, IL</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>Never</b>	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) <b>The Community Hospital</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Rosemary Hayes</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Comptroller</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Manufacturing</b>
13a. RESIDENCE—STATE <b>Illinois</b>		13b. COUNTY <b>Cook</b>	13c. CITY, TOWN OR LOCATION <b>Lansing</b>		13d. STREET AND NUMBER <b>17515 William St.</b>	
13e. ZIP CODE <b>60438</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>						
18. FATHER'S NAME (First, Middle, Last) <b>John C. Englund</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Birgit Orman</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Rosemary Englund</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17515 William Lansing, IL 60438</b>		20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>February 19, 1998 Skyline Memorial Park</b>		21c. LOCATION—City or Town, State <b>Monee, Illinois</b>	
22a. EMBALMER'S NAME <b>Daniel Holste</b>			22b. EMBALMER'S LICENSE NO. <b>IL 034-014638</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i> THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE STATE OF ILLINOIS DEPARTMENT OF HEALTH WITH THE LAST OFFICIAL			24b. LICENSE NUMBER (of Lic. No.) <b>FDO 1000857</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>LaHayne FH83002885 5746 Hohman Hammond, IN for Schroeder-Lauer 3227 Ridge Rd. Lansing, IL 60438</b>	
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>FEB 19 1998</b> <b>Diagnosed Cardiomypathy</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): <b>Alexander S. Williams MD</b> CONDITIONS CONTRIBUTING TO THE IMMEDIATE CAUSE, stating the leading cause last DUE TO (OR AS A CONSEQUENCE OF): <b>d</b> Approximate Interval Between Onset and Death <b>1 week</b>						
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>Hypertension</b>						
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>						
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>						
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER 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) as stated. <input type="checkbox"/> 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 as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>					29c. MEDICAL LICENSE NO. <b>036066062</b>	29d. DATE SIGNED (Month, Day, Year) <b>2-18-98</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Bruce Parisi, M.D. 1851 Sibley Blvd. Calumet City, IL 60409</b>						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) <b>February 19, 1998</b>
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED	
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER