

UNOFFICIAL COPY

Doc#: 1431749073 Fee: \$64.00
RHSP Fee: \$9.00 RPRF Fee: \$1.00
Karen A. Yarbrough
Cook County Recorder of Deeds
Date: 11/13/2014 01:12 PM Pg: 1 of 3



DECEASED JOINT TENANCY AFFIDAVIT

STATE OF ILLINOIS) SS.
COUNTY OF COOK)

KATHERINE GERHARDT, being duly sworn states that she resides 435 Alles St., Unit 304, Des Plaines, Illinois

That she was acquainted with JACOB GERHARDT, deceased who, at the time of his death, was one of the owners of the land in Cook County, Illinois described as:

SEE ATTACHED LEGAL DESCRIPTION

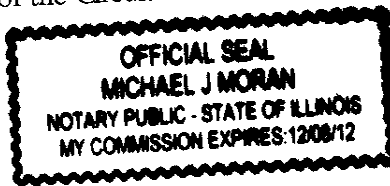
That the deceased died October 5, 2008, as evidenced by a certified copy of death certificate of the deceased attached hereto.

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 is filed with the Clerk of the Probate Division of the Circuit Court of Cook 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 Cook County, Illinois about 12/19/08



Subscribed and sworn to before me
this 8 day of APRIL, 2009.

Michael J Moran
Notary Public

Katherine Gerhardt
KATHERINE GERHARDT

UNOFFICIAL COPY

LEGAL DESCRIPTION

For the premises commonly known as 435 Alles Street, Unit 304, Des Plaines, IL 60016

PARCEL 1: UNIT 304 IN THE AVALON CONDOMINIUMS AS DELINEATED ON A SURVEY ATTACHED AS EXHIBIT "C" TO THE DECLARATION OF CONDOMINIUM RECORDED MAY 4, 2005, AS DOCUMENT NUMBER 0512445019, AND AS AMENDED FROM TIME TO TIME WITH ITS UNDIVIDED PERCENTAGE INTEREST IN THE COMMON ELEMENTS.

PARCEL 2: THE EXCLUSIVE RIGHT OF USE OF LIMITED COMMON ELEMENTS KNOWN AS GARAGE SPACE G-15 AND STORAGE SPACE S-15.

Prepared by and mailed to:
Michael J. Moran & Associates, P.C.
121 S. Wilke Road, Suite 201
Arlington Heights, IL 60005

UNOFFICIAL COPY

STATE OF ILLINOIS CERTIFICATE OF DEATH

STATE FILE NUMBER

REGISTRATION DISTRICT NO. 16.0		LOCAL FILE NUMBER		2. SEX Male	3. DATE OF DEATH (Month/Day/Year) (Spell Month) October 05, 2008
1. DECEDENT'S LEGAL NAME (include AKAs if any) (First, Middle, Last) Jacob Gerhardt					
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) December 19, 1927
7a. CITY OR TOWN Park Ridge, IL		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) Advocate Lutheran General Hospital, 1775 Dempster Street, Park Ridge IL 60068			
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"/> Died 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) LIEBLING, ROMANIA		9. SOCIAL SECURITY NUMBER -0192		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) KATHERINE SCHAEFER		12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
13a. RESIDENCE (Street and Number) 435 ALLES STREET		13b. APT. NO. 304	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) JAKOB GERHARDT	
15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) MARIA MOTZ		16. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 435 ALLES ST., DES PLAINES, IL 60016			
16a. INFORMANT'S NAME KATHERINE GERHARDT		16b. RELATIONSHIP WIFE		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) MEMORY GARDENS CEMETERY		19. LOCATION - CITY, TOWN AND STATE ARLINGTON HTS., ILLINOIS			
20. DATE OF DISPOSITION (Month/Day/Year) OCTOBER 8, 2008		21a. FUNERAL HOME NAME OEHLER FUNERAL HOME			
21b. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Heinz, Jr.</i>		21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-010505		22. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) OCT 06 2008	
23. LOCAL REGISTRAR'S SIGNATURE <i>[Signature]</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months			
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. METASTATIC LIVER CANCER Due to (or as a consequence of): 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		26. WERE AUTOPSY FINDINGS 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"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		28. IF FEMALE: <input type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Pregnant within one year of death but time unknown <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Unknown if pregnant within the past 12 months <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) Street: ZIP Code:	
33. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		34. LOCATION OF INJURY Street and Number			
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 10/4/08		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year) 10/05/08	
40. TIME OF DEATH 12:40 <input checked="" 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 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) SUSAN S. BROWN, MD 8915 GOLF RD NILES IL 60714		43. PHYSICIAN'S LICENSE NUMBER 036078967		44. DATE CERTIFIED (Month/Day/Year) 10/5/08	
44. TITLE OF CERTIFIER MD		45. SIGNATURE OF CERTIFIER <i>[Signature]</i>			

OCT 06 2008

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.

[Signature]
COUNTY CLERK