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Karen A. Yarbrough
Cook County Recorder of Deeds
Date: 03/06/2015 11:14 AM Pg: 1 of 2

DECEASED JOINT TENANCY AFFIDAVIT

STATE OF ILLINOIS

COUNTY OF COOK

JOHN AUGUST WEILER, being duly sworn, states that he resides at 2002 Euclid Avenue, Chicago Heights, Illinois 60411. The he was acquainted with BARBARA ANN PAUL, the deceased, who at the time of her death, was one of the owners of the land in Cook County, Illinois, described as follows:

LOTS THIRTEEN (13) AND FOURTEEN (14) IN BLOCK TWO HUNDRED NINETEEN (219) IN CHICAGO HEIGHTS IN SECTION TWENTY-NINE (29), TOWNSHIP THIRTY-FIVE (35) NORTH, RANGE FOURTEEN (14) EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.


STREET ADDRESS: 2002 Euclid Avenue, Chicago Heights, Illinois 60411

PERMANENT REAL ESTATE TAX IDENTIFICATION NUMBERS: 32-29-104-008-0000 and 32-29-104-009-0000

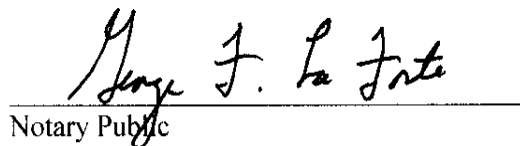
That the deceased died August 23, 2009, as evidence by the copy of the death certificate of the deceased attached hereto.

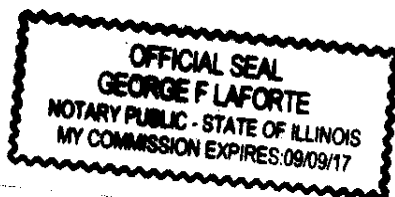
That the deceased died leaving no last will and testament.

That the total value of the estate of the deceased, including both real and personal property owned by the deceased, either individually or in joint tenancy at the time of her death, does not exceed taxable estate values.


Affiant's Signature – John August Weiler

Subscribed and sworn to before me by said John August Weiler this 3rd day of March, 2015.


Notary Public



This instrument prepared by:

George F. LaForte
Attorney at Law
3612 W. Lincoln Highway, Suite 23
Olympia Fields, Illinois 60461
708-747-1770

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STATE OF ILLINOIS CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 16.32		LOCAL FILE NUMBER 568		377 AUGUST 2009		STATE FILE NUMBER	
1. DECEASED'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) BARBARA PAUL A.				2. SEX FEMALE		3. DATE OF DEATH (Month/Day/Year) (Spell Month) AUGUST 23, 2009	
4. COUNTY OF DEATH COOK		5a. AGE AT LAST BIRTHDAY (Years) 69		5b. UNDER 1 YEAR Months _____ Days _____		5c. UNDER 1 DAY Hours _____ Minutes _____	
6. DATE OF BIRTH (Month/Day/Year) July 7, 1940		7a. CITY OR TOWN Chicago Heights		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) St. James Hospital			
7c. PLACE OF DEATH (Check only one: see instructions)							
IF DEATH OCCURRED IN A HOSPITAL <input type="checkbox"/> Inpatient <input checked="" 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) Chicago Hts., IL		9. SOCIAL SECURITY NUMBER 355 32 0698		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) John Weiler	
12. EVER IN U.S. ARMED FORCES: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13a. RESIDENCE (Street and Number) 2002 Euclid Ave		13b. APT. NO.		13c. CITY OR TOWN Chicago Heights	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13e. COUNTY Cook		13f. STATE IL		13g. ZIP CODE 60411	
14. FATHER'S NAME (First, Middle, Last) Gilbert Paul				15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Eleanor Jenne			
16a. INFORMANT'S NAME John Weiler		16b. RELATIONSHIP Husband		16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 2002 Euclid Ave Chicago Hts., IL 60411			
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) Homewood Memorial Gardens		19. LOCATION - CITY, TOWN AND STATE Homewood, IL		20. DATE OF DISPOSITION (Month/Day/Year) August 31, 2009	
21a. FUNERAL HOME NAME Steger Memorial Chapel		STREET AND NUMBER 3045 Chicago Rd		CITY OR TOWN Steger		STATE IL	
21b. FUNERAL DIRECTOR'S SIGNATURE Don Egeler		21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-015590		22. LOCAL REGISTRAR'S SIGNATURE <i>Cheryl M. Steger</i>			
23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) August 28, 2009		<p>CAUSE OF DEATH (See instructions and examples)</p> <p>24. PART I. Enter the <i>chain of events</i> - 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.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): _____</p> <p>Sequentially list conditions, if any, leading to the cause listed on line a. b. _____ Due to (or as a consequence of): _____</p> <p>Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST c. _____ Due to (or as a consequence of): _____</p>					
PART II. Enter other <i>significant conditions contributing to death</i> 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 type="checkbox"/> No <input checked="" type="checkbox"/> Unknown						28. IF FEMALE: <input checked="" type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Pregnant at time of 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						26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	
38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year) August 23, 2009		40. TIME OF DEATH 3:50 <input type="checkbox"/> A.M. <input checked="" type="checkbox"/> P.M.		41. CERTIFIER (Check only one): <input 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 checked="" 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) Dr. Ponni Arunkumar, MD 2121 W. HARRISON ST., CHICAGO, ILLINOIS 60612-3705						43. PHYSICIAN'S LICENSE NUMBER	
44. TITLE OF CERTIFIER THE MEDICAL EXAMINER		45. DATE CERTIFIED (Month/Day/Year) August 25, 2009		46. SIGNATURE OF CERTIFIER <i>Ponni Arunkumar, MD</i>			

Based on the 2003 U.S. Standard Certificate)

Illinois Department of Public Health - Division of Vital Records

VR200 (Rev. 1/08)