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JOINT TENANCY AFFIDAVIT (continued)

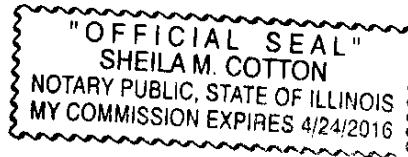
The affiant hereby covenants and agrees, individually, and for the affiants, heirs, personal representatives or assignees, to forever fully indemnify, protect, defend and hold ATG harmless and to reimburse ATG for all loss, costs, damages, suits, attorney's fees and expenses of every kind and nature that ATG may suffer, expend or incur by reason of the issuance of said policy free and clear of the following objections:

1. Claims against the estate of INVAIS OVERA, the decedent;
2. State Estate/Inheritance Tax and Federal Estate Tax that may be charged against the estate of said decedent;
3. Legacies, if any, created by the will of said decedent;
4. Rights of contribution.

[Signature] (Seal)
 _____ (Seal)

Subscribed and sworn to before me this

30 day of June, 2015
 _____ (Month) _____ (Year)
[Signature]
 _____ (Notary Public)



Note: If the decedent left a will, it will be necessary that the original or certified copy thereof be presented to ATG for inspection. A death certificate, together with evidence of payment of death taxes, if any, should accompany this affidavit.

This instrument prepared by:

Return to:

Law Offices of
 David R. Schluster, Ltd.
 401 W. Irving Park Rd.
 Itasca, IL 60143
 (630) 285-5300

 (City, State, Zip)

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STATE OF ILLINOIS CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 16.0 LOCAL FILE NUMBER STATE FILE NUMBER 1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) INGRID OHERN 2. SEX FEMALE 3. DATE OF DEATH (Month/Day/Year) (Spell Month) FEBRUARY 14, 2009 4. COUNTY OF DEATH COOK 5a. AGE AT LAST BIRTHDAY (Years) 54 5b. UNDER 1 YEAR Months Days 5c. UNDER 1 DAY Hours Minutes 6. DATE OF BIRTH (Month/Day/Year) February 3, 1955 7a. CITY OR TOWN ELK GROVE VILLAGE 7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) ALEXIAN BROTHERS MEDICAL CENTER 7c. PLACE OF DEATH (Check only one: see instructions) IF DEATH OCCURRED IN A HOSPITAL [X] Inpatient [] Emergency Room/Outpatient [] Dead on Arrival IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL [] Hospice facility [] Nursing Home/Long-term care facility [] Decedent's home [] Other (Specify): 8. BIRTHPLACE (City and State or Foreign Country) Germany 9. SOCIAL SECURITY NUMBER 10. MARITAL STATUS AT TIME OF DEATH [X] Married [] Married but separated [] Widowed [] Divorced [] Never Married [] Unknown 11. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage) George O'Hern 12. EVER IN U.S. ARMED FORCES? [] Yes [X] No 13a. RESIDENCE (Street and Number) 80 Clearmont Drive 13b. APT. NO. 13c. CITY OR TOWN Elk Grove Village 13d. INSIDE CITY LIMITS? [X] Yes [] No 13e. COUNTY Cook 13f. STATE IL 13g. ZIP CODE 60007 14. FATHER'S NAME (First, Middle, Last) Joseph Gruner 15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Hermine Jilly 16a. INFORMANT'S NAME George O'Hern 16b. RELATIONSHIP Husband 16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 80 Clearmont Dr. Elk Grove Village, IL 60007 17. METHOD OF DISPOSITION: [] Burial [X] Cremation [] Donation [] Entombment [] Other (Specify): 18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) Twin Pines Crematory 19. LOCATION - CITY, TOWN AND STATE Dundee, Illinois 20. DATE OF DISPOSITION (Month/Day/Year) February 18, 2009 21a. FUNERAL HOME NAME Grove Memorial Chapel STREET AND NUMBER 1199 S Arlington Hts Road CITY OR TOWN Elk Grove Village STATE IL ZIP 60007 21b. FUNERAL DIRECTOR'S SIGNATURE David Dravecky 21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034.016303 22. LOCAL REGISTRAR'S SIGNATURE 23. DATE FILED WITH LOCAL HEALTH DEPARTMENT (Month/Day/Year) FEB 17 2009 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 disorder, 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 detail and lines if necessary. IMMEDIATE CAUSE (Final disease or condition resulting in death) -> a. Brain Dead 2° to Severe AVM rupture Due to (or as a consequence of): b. intracranial hemorrhage non-traumatic Due to (or as a consequence of): c. multiorgan failure - I/S/B cardiac arrest Due to (or as a consequence of): APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH COPY 27. DID TOBACCO USE CONTRIBUTE TO DEATH? [] Yes [X] Probably [] No [] Unknown 28. IF FEMALE: [X] Not pregnant within past 12 months [] Pregnant at time of death [] Not pregnant, but pregnant within 42 days of death [] Pregnant within one year of death but time unknown [] Not pregnant, but pregnant 43 days to 1 year before death [] Unknown if pregnant within the past 12 months 29. MANNER OF DEATH [X] Natural [] Suicide [] Could not be determined [] Accident [] Homicide [] Pending investigation 30. DATE OF INJURY (Month/Day/Year) 31. TIME OF INJURY [] A.M. [] P.M. 32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area) 33. INJURY AT WORK? [] Yes [] 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: [] Driver/Operator [] Passenger [] Pedestrian [] Other (Specify) 37. (DID/DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON 02/14/09 38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? [] Yes [X] No 39. DATE PRONOUNCED (Month/Day/Year) 2-14-2009 40. TIME OF DEATH 4:00 [] A.M. [X] P.M. 41. CERTIFIER (Check only one): [X] Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated. [] 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. [] 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 (Form 28) OLEA NAJAR-MARZOUKI / 1838 ... 43. PHYSICIAN'S LICENSE NUMBER 036 113676 44. TITLE OF CERTIFIER M.D. 45. DATE CERTIFIED (Month/Day/Year) 02/16/09 46. SIGNATURE OF CERTIFIER

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

Illinois Department of Public Health - Division of Vital Records

VR200 (Rev. 1/08)