

UNOFFICIAL COPY

JOINT TENANCY AFFIDAVIT (continued)

Kimberly White

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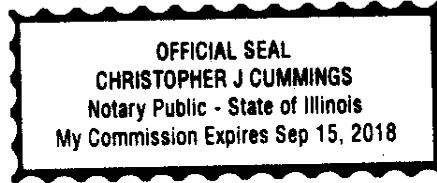
Subscribed and sworn to before me this

30th day of June, 2015
(Month) (Year)

Christopher J. Cummings

(Notary Public)

My commission expires: 9-15-2018



Note: If the decedent left a will, a certified copy thereof must be presented to ATG for inspection, along with a certified copy of the death certificate and evidence of payment of death taxes, if any.

This instrument prepared by:
Christopher J. Cummings
Christopher J. Cummings, P.C.
2024 Hickory Road, Suite 205
Homewood, IL 60430,

Return to:
Christopher J. Cummings
Christopher J. Cummings, P.C.
2024 Hickory Road, Suite 205
Homewood, IL 60430,

Property of Cook County Clerk's Office

UNOFFICIAL COPY

REGISTRATION DISTRICT NO. 99.0		STATE OF ILLINOIS CERTIFICATE OF DEATH		STATE FILE NUMBER	
1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) Anthony Joseph Nadratowicz			2. SEX Male	3. DATE OF DEATH (Month/Day/Year) (Spell Month) May 17, 2008	
4. COUNTY OF DEATH Will		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) July 29, 1927
7a. CITY OR TOWN Crete			7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in other, give street and number) St. James Manor and Villa		
7c. PLACE OF DEATH (Check only one; see instructions) IF DEATH OCCURRED IN A HOSPITAL <input 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 checked="" 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, Illinois	9. SOCIAL SECURITY NUMBER [REDACTED]	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) Dora Compton	12. EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13a. RESIDENCE (Street and Number) 2203 221st St.		13b. APT. NO.	13c. CITY OR TOWN Sauk Village	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
13e. COUNTY Cook	13f. STATE Illinois	13g. ZIP CODE 60411	14. FATHER'S NAME (First, Middle, Last) Anthony Nadratowicz		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Mary Blazusiek
16a. DECEASED'S NAME Dora Nadratowicz		16b. RELATIONSHIP Wife	16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 2203 221st St. Sauk Village, Illinois 60411		
17. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Ination <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify): _____		18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) Lowell Memorial Cemetery	18. LOCATION - CITY, TOWN AND STATE Lowell, Indiana	20. DATE OF DISPOSITION (Month/Day/Year) May 20, 2008	
21a. FUNERAL HOME NAME Hack Funeral Home		STREET AND NUMBER 753 Hodges Street	CITY OR TOWN Lowell, In.	STATE Indiana	ZIP 46041
21b. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Zelko</i>			21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-008334		
22. LOCAL REGISTRAR'S SIGNATURE <i>James E. Zelko</i>			23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) MAY 20 2008		
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.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>pneumonia</u> Due to (or as a consequence of):					
Sequently 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. <u>Dementia</u> Due to (or as a consequence of):					
c. <u>Coronary Artery Disease</u> 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 type="checkbox"/> No <input type="checkbox"/> Unknown					28. IF FEMALE: <input 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
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)	
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): _____
37.1 (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON 5/15/08		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year) 5-17-08	
40. TIME OF DEATH 7:52 P.M. <input 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) Savio Manatt 30 East 15th St. Chicago Hts., Illinois 60411				43. PHYSICIAN'S LICENSE NUMBER 036-069553	
44. TITLE OF CERTIFIER attending Physician		45. DATE CERTIFIED (Month/Day/Year) 5-19-08		46. SIGNATURE OF CERTIFIER <i>Savio Manatt</i>	

(Based on the 2005 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.

James E. Zelko
James E. Zelko
Executive Director
Local Registrar
Will County Health Department
DATE ISSUED: MAY 20 2008