

SPECIAL NOTICE:

This form is NOT required by law for the Cook County Recorder of Deeds (CCRD). CCRD employees CANNOT assist with the preparation of this, or ANY LEGAL FORM.

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Doc# 1721913036 Fee \$42.00

RHSP FEE:\$9.00 RPRF FEE: \$1.00

KAREN A. YARBROUGH

COOK COUNTY RECORDER OF DEEDS

DATE: 08/07/2017 11:59 AM PG: 1 OF 3

PREPARED BY:

Lakeisha Murdaugh

634 Yates Ave

Calumet City, IL 60409

SURVIVING TENANT AFFIDAVIT

I, Lakeisha Murdaugh, the surviving tenant of the tenancy created by the deed with the document number: 90316348 do hereby declare under oath that the tenant Gail Williams died on 1/12/1999 as evidenced by the attached certified copy of her/his death certificate (see attached).

I also declare that the aforementioned joint tenant was an owner of property with the following details:

LEGAL DESCRIPTION

Lot F in Block 23 in @ FRANK CROSS Sec Attached

PROPERTY IDENTIFICATION NUMBER (PIN):

29 - 12 - 427 - 012 - 0000

COMMONLY KNOWN ADDRESS:

NOTARY & AFFIANT SIGNATURE SECTION BELOW

Subscribed & Sworn to me by:

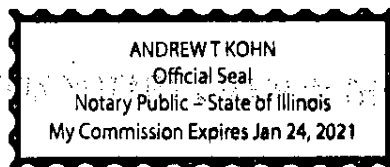
Affiant Signature: [Handwritten Signature]

Affiant Signature:

Lakeisha Murdaugh

On the Following Date:

8/7/2017



Book

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LOT 1 IN BLOCK 23 IN G. FRANK CROISSANT'S SHADOW LAWN, BEING A SUBDIVISION OF THAT PART OF THE WEST 1/2 OF THE SOUTH EAST 1/4 AND THE EAST 1/3 OF THE EAST 1/2 OF THE SOUTHWEST 1/4 OF SECTION 12, TOWNSHIP 36 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN LYING NORTH OF THE CENTER LINE OF MICHIGAN CITY ROAD IN COOK COUNTY, ILLINOIS.

PERMANENT INDEX NO. 29-12-427-012

Commonly known as: 634 S. Yates Calumet City, Illinois

HERE

Property of Cook County Clerk's Office

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

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Tracking No. 130062

Local No. 109 CERTIFICATE OF DEATH State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19.3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) Gail Williams		2. SEX Female		3. TIME OF DEATH 7:35 P M		3b. DATE OF DEATH (Month, Day, Year) January 12, 1999	
4. SOCIAL SECURITY NUMBER 112-52-8157		5a. AGE - Last Birthday (Years) 42		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) August 6, 1956		7. BIRTHPLACE (City and State or Foreign Country) West Point, MS					
8a. WAS DECEDENT A U.S. VETERAN? NO		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NO		9. PLACE OF DEATH (Check only one - See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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) St. Margaret Mercy Hospital North				9c. CITY, TOWN OR LOCATION OF DEATH Hammond		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Single		11. SURVIVING SPOUSE (If wife, give maiden name) None		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Teacher		12b. KIND OF BUSINESS/INDUSTRY School	
13a. RESIDENCE - STATE Illinois		13b. COUNTY Cook		13c. CITY, TOWN OR LOCATION Calumet City		13d. STREET AND NUMBER 337 Hoxie	
13e. ZIP CODE 60409		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
16. FATHER'S NAME (First, Middle, Last) Armie Spiller		17. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Murry					
18. RACE - American Indian, Black, White, etc. (Specify) Black		19. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		20. College (1-4 or 5+) 5			
20a. INFORMANT'S NAME (Type/Print) Jason Williams				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 337 Hoxie, Calumet City, IL 60409		20c. Relationship Son	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) January 19, 1999 Oakland Memory Lanes Cemetery		21c. LOCATION - City or Town, State Dolton, IL			
22a. EMBALMER'S NAME Spencer Leak Sr.		22b. EMBALMER'S LICENSE NO. IL 031-007489		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b. LICENSE NUMBER 1045184		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish FH #3002819, 5840 Hohman Hammond, IN 46320. (For Leak & Son FH Chicago, IL 60619 - Signature Only)			
26. PART I - Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Vascular collapse. DUE TO (OR AS A CONSEQUENCE OF) Due to arteriosclerotic heart and vascular disease. DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a. WAS WAX OR POLYCAUSTIC AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO		28b. WAS WAX OR POLYCAUSTIC AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO	
29a. CERTIFIER (Check only one) <input 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 checked="" type="checkbox"/> DEPUTY 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>Saul Blasto</i>		29c. MEDICAL LICENSE NO. N/A		29d. DATE SIGNED (Month, Day, Year) February 8, 1999	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Paul Castro, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307		31. HEALTH OFFICER'S SIGNATURE <i>Franklin Sremuda M.D.</i>		32. DATE FILED (Month, Day, Year) February 9, 1999			
33. MANNER OF DEATH <input checked="" 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) January 12, 1999		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					

THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT  
JUL 21 2017

NOT VALID UNLESS

RAISED SEAL AFFIXED