

4721-10989

# UNOFFICIAL COPY



Doc#: 2226612214 Fee: \$98.00  
Karen A. Yarbrough  
Cook County Clerk  
Date: 09/23/2022 02:09 PM Pg: 1 of 3

## ATTORNEYS' TITLE GUARANTY FUND, INC.

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### JOINT TENANCY AFFIDAVIT

STATE OF IL  
COUNTY OF Cook } SS

Mary Jane Farrell hereby referred to as the affiant, states under oath that the affiant resides at 10857 S Avenue F, in the City of Chicago, State of IL; that the affiant was acquainted with John S. Farrell, the decedent; at the time of death, the decedent was one of the owners of property, by virtue of a properly recorded joint tenancy deed, said property located in Cook County, State of IL, and legally described as follows

Lot 19 (except the North 25 feet thereof) and Lot 20 in F.J. Lewis' South Eastern Development, being a Subdivision in the West Half and in the Northeast Quarter of Section 17, and the Southeast Quarter of Section 18, Township 37 North, Range 15, East of the Third Principal Meridian, in Cook County, Illinois.

10857 S. AVENUE F  
CHICAGO, IL 60617  
26-17-210 S 043-0000

The decedent had no interest in any business or partnership, nor held any power of appointment at death, nor created any remainder interests in property by transfer with retention of a life interest therein or the creation of interests to take effect in possession or enjoyment after death;

The decedent died on February 25, 2009, leaving no/a last will and testament;

The total value of decedent's estate, including the taxable interest in the above property was \$ 1,000.00, and the value of the above property individually was \$ 99,000.00;

The State and Estate/Inheritance Tax and the Federal Estate Tax, if any, that was due from the decedent's estate, has been paid in full;

The affiant makes this affidavit to induce Attorneys' Title Guaranty Fund, Inc., (ATG®) to issue its policy of title insurance on the above described property.

# UNOFFICIAL COPY

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:

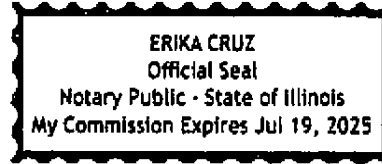
1. Claims against the estate of John S. Farrell, the decedent;
2. State Estate/Inheritance Tax and Federal Estate Tax that may be charged against the estate of said decedent;
3. Legacies, if any, created by the will of said decedent;
4. Rights of contribution.

Mary Jane Farrell (Seal)  
 \_\_\_\_\_ (Seal)

Subscribed and sworn to before me this

11th day of September, 2022  
Day Month Year

Erika Cruz  
 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:

Robson & Lopez LLC  
121 S Western Ave, Unit 1  
Name  
Chicago IL 60612  
Address  
 \_\_\_\_\_  
City, State, Zip

Return to:

Robson & Lopez LLC  
121 S Western Ave, Unit 1  
Name  
Chicago, IL 60612  
Address  
 \_\_\_\_\_  
City, State, Zip

# UNOFFICIAL COPY

# EXHIBIT

10

REGISTRATION DISTRICT NO. <b>16.10</b>		STATE OF ILLINOIS CERTIFICATE OF DEATH				STATE FILE NUMBER	
LOCAL FILE NUMBER		1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) <b>John S. Farrell Sr.</b>		2. SEX <b>Male</b>		3. DATE OF DEATH (Month/Day/Year) (Spell Month) <b>February 25, 2009</b>	
4. BIRTHPLACE (City and State or Foreign Country) <b>Cook</b>		5a. AGE AT LAST BIRTHDAY (Years) <b>65</b>		5b. UNDER 1 YEAR Months _____ Days _____		5c. UNDER 1 DAY Hours _____ Minutes _____	
6. DATE OF BIRTH (Month/Day/Year) <b>May 11, 1943</b>		7a. CITY OR TOWN <b>Chicago</b>		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) <b>10857 Avenue F</b>			
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 type="checkbox"/> Nursing Home/Long-term care facility <input checked="" type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify): _____							
8. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, IL</b>		9. SOCIAL SECURITY NUMBER		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) <b>Mary Jane Clark</b>	
12. EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13a. RESIDENCE (Street and Number) <b>10857 Avenue F</b>		13b. APT. NO.		13c. CITY OR TOWN <b>Chicago</b>	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13e. COUNTY <b>Cook</b>		13f. STATE <b>IL</b>		13g. ZIP CODE <b>60617</b>	
14. FATHER'S NAME (First, Middle, Last) <b>James W. Farrell</b>		15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) <b>Margaret Cosgrove</b>					
16a. INFORMANT'S NAME <b>Mary Jane Farrell</b>		16b. RELATIONSHIP <b>Wife</b>		16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) <b>10857 Ave. F; Chicago, IL 60617</b>			
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) <b>Holy Cross Cemetery</b>		19. LOCATION - CITY, TOWN AND STATE <b>Calumet City, IL</b>		20. DATE OF DISPOSITION (Month/Day/Year) <b>March 2, 2009</b>	
21a. FUNERAL HOME NAME <b>Elmwood Chapel</b>		21b. STREET AND NUMBER <b>11200 S. Ewing Avenue</b>		21c. CITY OR TOWN <b>Chicago</b>		21d. STATE <b>Illinois</b>	
21e. ZIP <b>60617</b>		21f. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Bepkowsky</i>		21g. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER <b>034-012040</b>			
22. LOCAL REGISTRAR'S SIGNATURE <i>Larry Hoover</i>		23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) <b>FEB 27 2009</b>					
24. PART I. CAUSE OF DEATH (See instructions and examples) 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. <b>Atherosclerotic Heart Disease</b> Due to (or as a consequence of): _____ Sequentially 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. _____ 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. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown							25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. IF FEMALE: <input 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							26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. 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							
28. DATE OF INJURY (Month/Day/Year)		29. TIME OF INJURY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		30. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)		31. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
32. LOCATION OF INJURY Street and Number, Apartment Number, City or Town, State, ZIP Code							
33. DESCRIBE HOW INJURY OCCURRED:							34. IF TRANSPORTATION IN INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify): _____
35. I (DID/DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON		36. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		37. DATE PRONOUNCED (Month/Day/Year) <b>February 25, 2009</b>		38. TIME OF DEATH <b>6:30</b> <input type="checkbox"/> A.M. <input checked="" type="checkbox"/> P.M.	
39. 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.							
40. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) <b>Stephanie Marshall, D.O., 24 Joliet St.; Dyer, Indiana 46311</b>							41. PHYSICIAN'S LICENSE NUMBER <b>02001947A</b>
42. TITLE OF CERTIFIER <b>D.O.</b>		43. DATE CERTIFIED (Month/Day/Year) <b>February 26, 2009</b>		44. SIGNATURE OF CERTIFIER <i>Stephanie Marshall</i>			
THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL DEATH RECORD FILED IN THE OFFICE OF THE CLERK OF THE CITY OF CHICAGO, DEPARTMENT OF PUBLIC HEALTH.							

(Based on the 2008 U.S. Standard Certificate)

Illinois Department of Public Health - Division of Vital Records

VR200 (Rev. 1/08)

DEPARTMENT OF PUBLIC HEALTH  
CITY OF CHICAGO

THIS CERTIFICATE COPY SHALL BE  
EMPOWERED SEAL IS AFFIXED OTHER  
REGISTRAR'S SIGNATURE

*Stephanie Marshall MD*

1. TERRY MASON, M.D., LOCAL  
REGISTRAR OF VITAL STATISTICS OF  
CHICAGO IS THE KEEPER OF  
THE RECORDS OF BIRTH, STILLBIRTHS  
AND DEATHS FOR THE CITY OF CHICAGO  
BY WRITE UP OF THE LAWS OF THE STATE  
OF ILLINOIS AND THE ORDINANCES OF  
THE CITY OF CHICAGO. THAT THE  
ACCOMPANYING CERTIFICATE ON THIS  
SHEET IS A TRUE COPY OF A RECORD  
KEPT BY ME IN OBEYANCE OF SAID  
LAWS AND ORDINANCES.

STATE OF ILLINOIS  
COUNTY OF COOK  
CITY OF CHICAGO