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DECEASED JOINT TENANCY
AFFIDAVIT

COMMITMENT NO: 951963

DATE: SEPTEMBER 30, 1995

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

DEPT-11 TORRENS \$25.00
T#0013 TRAN 7478 11/13/95 09:13:00
#1216 + CT *-95-780091
COOK COUNTY RECORDER

95780091

Proprietary of Cook County Clerk's Office

GEORGE B. SZAFRANSKI, BEING FIRST DULY SWORN, FOR THE PURPOSE OF INDUCING NATIONS TITLE INSURANCE COMPANY TO ISSUE ITS TITLE INSURANCE POLICY COVERING THE LAND DESCRIBED IN THE ABOVE CAPTIONED COMMITMENT DEPOSES AND SAYS:

1. THAT HE/SHE RESIDES AT: 10657 SOUTH AVENUE O, CHICAGO, ILLINOIS 60617 .
2. THAT HE/SHE WAS ACQUAINTED WITH NORINE D. SZAFRANSKI, WHO DIED ON OCTOBER 22, 1990, AS EVIDENCED BY THE ATTACHED COPY OF THE DEATH CERTIFICATE.
3. THAT SAID DECEDENT WAS ONE OF THE OWNERS OF THE LAND DESCRIBED IN THE ABOVE CAPTIONED COMMITMENT.
4. THAT SAID DECEDENT DIED:
XX LEAVING NO LAST WILL AND TESTAMENT.
LEAVING A LAST WILL AND TESTAMENT.
5. THAT THE TOTAL VALUE OF SAID DECEDENT'S ESTATE FOR ESTATE TAX PURPOSES DOES NOT EXCEED \$ 76,000.00

[Signature]
AFFIANT'S SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS 30TH DAY OF SEPTEMBER, 19 95.

[Signature]
NOTARY PUBLIC

AMERITITLE, INC.
18220 HARWOOD AVENUE
HOMWOOD, IL 60430

OFFICIAL SEAL
ROBIN URBANOWSKI
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 9/14/98

25 00
New

95780091

10788700

Box 64

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Property of Cook County Clerk's Office

LOT FIFTEEN-----15

In D M Cumming's subdivision of Lots 11 to 28 inclusive in Block 49 in Ironworker's Addition being a subdivision of the West Half (½) of the Northwest Quarter (¼) of Section 17 Township 37 North Range 15, East of the Third Principal Meridian in Cook County Illinois.

26-17-100-017

1608155957

Local No. 892

INDIANA STATE BOARD OF HEALTH UNOFFICIAL COPY CERTIFICATE OF DEATH

HAMMOND HEALTH DEPARTMENT,
Franklin S. Dremuda, M.D.
Date Issued: Oct 23, 1990
Hammond Health Commissioner

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED - NAME (Last, Middle, First) Norine D. Szafranski SZAFRANSKI		2 SEX Female	3a TIME OF DEATH 10:59 a.m.	3b DATE OF DEATH (Month, Day, Year) October 22, 1990	
4 SOCIAL SECURITY NUMBER 354-26-9591	5a AGE - Last Birthday (Year) 58	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) AUGUST 6, 1932	
7a WAS DECEDENT A US VETERAN? NO	7b YEAR(LAS) SERVED IN US ARMED FORCES? NONE	8a PLACE OF BIRTH (City and State or Foreign Country) CHICAGO, ILLINOIS			
8b FACILITY NAME (if not institution, give street and number) ST. MARGARET HOSPITAL		8c CITY, TOWN, OR LOCATION OF DEATH HAMMOND	8d COUNTY OF DEATH LAKE		
9a MARITAL STATUS (Specify) MARRIED	9b SURVIVING SPOUSE (If wife, give maiden name) George Szafranski	9c DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		9d KIND OF BUSINESS/INDUSTRY HOME	
10a RESIDENCE - STATE ILLINOIS	10b COUNTY COOK	10c CITY, TOWN OR LOCATION CHICAGO	10d STREET AND NUMBER 10657 AVE O		
11a ZIP CODE 60617	11b INDEX CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	11c CITIZEN OF WHAT COUNTRY? USA	11d WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	11e RACE - American Indian, Black, White, etc (Specify) WHITE	
12a FATHER'S NAME (Full Address, and) ANTHONY LUCIN		12b MOTHER'S NAME (Full Address, Maiden Surname) DIANE LESKUR			
13a DECEASED'S NAME (Type/Year) GEORGE SZAFRANSKI		13b MARITAL ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10657 AVE O, CHICAGO, ILLINOIS 60617	13c Relationship HUSBAND		
14a 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)		14b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) OCTOBER 26, 1990 HOLY CROSS CEMETERY		14c LOCATION - City or Town, State CALUMET CITY, ILL.	
15a EMBALMER'S NAME JAMES PORRAS		15b EMBA. LIC. NO. 1049954	15c WAS DEATH REPORTED TO CORPUS? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
16a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		16b LICENSE NUMBER 1045184	16c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME BURNS-KISH FUNERAL HOME #3002819 5840 HOHMAN AVE (FOR ELMWOOD F H HAMMOND, IND. CHICAGO, ILL)		
17 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter non-specific terms, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		SEPTICAEIMIC SHOCK		FEW DAYS	
DUE TO OR AS A CONSEQUENCE OF		LUPUS ERYTHEMATOSUS		FEW MONTHS	
DUE TO OR AS A CONSEQUENCE OF					
DUE TO OR AS A CONSEQUENCE OF					
18 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
LUPUS ERYTHEMATOSUS LUPUS NEPHRITIS ANEMIA		19 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM (Yes or no) No	20 WAS AN AUTOPSY PERFORMED? (Yes or no) No	21 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
22 CERTIFIER (Check only one) <input checked="" 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 type="checkbox"/> CORONER On the basis of personal 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					
23 SIGNATURE AND TITLE OF CERTIFIER <i>Franklin S. Dremuda, M.D.</i>		24 MEDICAL LICENSE NO 31445	25 DATE SIGNED (Month, Day, Year) October 23, 1990		
26 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 20 (Type/Print) M. Hussain, M.D. 1479 Ring Road, Calumet City, Illinois 60409					
27 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Dremuda, M.D.</i>			28 DATE FILED (Month, Day, Year) Oct. 23, 1990		
29 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		30a DATE OF INJURY (Month, Day, Year)	30b TIME OF INJURY	30c INJURY AT WORK? (Yes or no)	30d DESCRIBE HOW INJURY OCCURRED
		31a PLACE OF INJURY - All home farm, street, factory, office, building, etc (Specify)		31b LOCATION (Street and Number or Rural Route Number, City or Town, State)	
32 DATE PRONOUNCED DEAD (Month, Day, Year)		33 MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc			

DECEDENT

ENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER
BE ONLY

1500091
1000000000

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