

UNOFFICIAL COPY

10:13
27.00
9.33
10:13

9017 MCH
RECORDIN #
MAILINGS #
95901700 #
9017 MCH

95901700

12/19/95

12/19/95

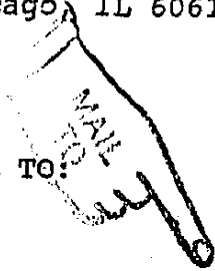
Property of Cook County Clerk's Office

DECEASED JOINT TENANCY AFFIDAVIT

PREPARED BY:
Jamal M. Nor
8532 S. Maryland
Chicago, IL 60619

OSTC 954225

MAIL TO:



CITY SUBURBAN TITLE
SERVICES COMPANY
1000 Skokie Blvd. - Suite 550
Wilmette, Illinois 60091

COOK COUNTY
CLERK
JANICE WHITE
SKOKIE OFFICE

27 50
RW

UNOFFICIAL COPY

Property of Cook County Clerk's Office



UNOFFICIAL COPY

CITY SUBURBAN TITLE

DECEASED JOINT TENANCY AFFIDAVIT

STATE OF ILLINOIS
COUNTY OF Cook

vs.

Order No. 954225

Jamal M. Nor + Emma Jean Nor being duly sworn
states that resides at 85 32 S. Maryland in the City of _____

That she was acquainted with Quella Pachman
deceased who, at the time of _____ death, was one of the owners of the land in _____
County, Illinois, described as:

That the deceased died _____, as evidenced by a
certified copy of death certificate of the deceased attached hereto.

^{B.S.}
That the deceased died:

- Leaving no Last Will & Testament.
- Leaving a Last Will & Testament a copy of which is attached hereto. The original of the unproven will should be filed with the Clerk of the Probate Division of the Circuit Court of _____ County, Illinois.
- Leaving a Last Will & Testament which was filed in the Unproven Will Box of the Probate Division of the Circuit Court of _____ County, Illinois about _____

That the total value of the estate of the deceased, including both real and personal property owned by the deceased either individually or in joint tenancy at the time of the death of the deceased, does not exceed the sum of _____ dollars.

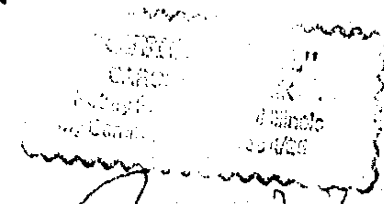
Affiant makes this affidavit for that purpose of inducing the Chicago Title Insurance Company to issue its Title Insurance Policy, describing the above mentioned property.

Subscribed and sworn to before me by the said

this 17 day of Nov, A.D. 1995

Cassiline Segami
Notary Public

95901700



Jamal M. Nor
(affiant's signature)

Emma Jean Nor 11-14-95

UNOFFICIAL COPY

Property of Cook County Clerk's Office

UNOFFICIAL COPY

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|------------------------------|--|---------|--|------|--|---------|--|--------------------|--|-----|--|----|--|------|--|-------|--|------|--|-------|--|-------|--|-------|--|-----------------|--|---------------------------------|--|---|--|--------|--|-----------|--|----------------------|--|--|--|-------------------------|--|---|--|----------|--|----------|--|---------|--|------------------------|--|--|--|------------------------------|--|-----------|--|---------|--|-----------------------|--|-----------------|--|--------|--|------------------------|--|-------|--|-------|--|-----------|--|---------------|--|---------------|--|-------------------|--|-----------|--|----------|--|-----------------|--|-----------------|--|--------------|--|-------|--|--------------------|--|---------|--|-------|--|------------------------------|--|--------------|--|-------------------------|--|--------|--|---------------|--|------------|--|----------------|--|--------------|--|--------------|--|----------|--|------------|--|------------------------|--|------------------------|--|-----------------------------|--|--|--|---------------------------|--|----------|--|----------|--|--|--|---------------|--|---------------|--|------------------------|--|------------|--|-------|--|--|--|-----------------|--|------------------------------|--|-----------------|--|----------------|--|------|--|----------------------------------|--|----------------------------------|--|----------------------------------|--|---------------------------------------|--|------|--|------|--|-----------------------------|--|--|--|--------------------------------|--|----|--|----|--|------|--|---|--|----------------|--|------------------------------|--|------|--|------|--|------|--|------------------------------------|--|--|--|--------------------------|--|----|--|------|--|------|--|
| TYPE OF PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">DECEASED NAME FIRST MIDDLE LAST</td> <td colspan="2">SEX</td> <td colspan="2">DATE OF DEATH (Mo. Day, Yr.)</td> </tr> <tr> <td colspan="2">Quiller</td> <td colspan="2">Male</td> <td colspan="2">10-5-78</td> </tr> <tr> <td colspan="2">R. P. 2354 W. Hale</td> <td colspan="2">Age</td> <td colspan="2">74</td> </tr> <tr> <td colspan="2">Race</td> <td colspan="2">Color</td> <td colspan="2">Hair</td> </tr> <tr> <td colspan="2">Black</td> <td colspan="2">Black</td> <td colspan="2">Brown</td> </tr> <tr> <td colspan="2">County of Death</td> <td colspan="2">City, Town or Location of Death</td> <td colspan="2">Hospital or Other Institution Name (If not in hospital, give street and number)</td> </tr> <tr> <td colspan="2">Miller</td> <td colspan="2">Texarkana</td> <td colspan="2">St. Michael Hospital</td> </tr> <tr> <td colspan="2">State of Birth (If not in U.S.A. name country)</td> <td colspan="2">Citizen or What Country</td> <td colspan="2">Married, Never Married, Widowed, Divorced (Specify)</td> </tr> <tr> <td colspan="2">Arkansas</td> <td colspan="2">U. S. A.</td> <td colspan="2">Widowed</td> </tr> <tr> <td colspan="2">Social Security Number</td> <td colspan="2">Usual Occupation (Give kind of work done during most of working life, even if retired)</td> <td colspan="2">Kind of Business or Industry</td> </tr> <tr> <td colspan="2">43-09-254</td> <td colspan="2">Laborer</td> <td colspan="2">Building Construction</td> </tr> <tr> <td colspan="2">Residence State</td> <td colspan="2">County</td> <td colspan="2">City, Town or Location</td> </tr> <tr> <td colspan="2">Texas</td> <td colspan="2">Eowie</td> <td colspan="2">Texarkana</td> </tr> <tr> <td colspan="2">Father's Name</td> <td colspan="2">Mother's Name</td> <td colspan="2">Street and Number</td> </tr> <tr> <td colspan="2">Patterson</td> <td colspan="2">Parchman</td> <td colspan="2">232 W. 13th St.</td> </tr> <tr> <td colspan="2">Mailing Address</td> <td colspan="2">City or Town</td> <td colspan="2">State</td> </tr> <tr> <td colspan="2">2322 West 13th St.</td> <td colspan="2">Haywood</td> <td colspan="2">Texas</td> </tr> <tr> <td colspan="2">Funeral Care (Type of Death)</td> <td colspan="2">Funeral Home</td> <td colspan="2">Address of Funeral Home</td> </tr> <tr> <td colspan="2">Burial</td> <td colspan="2">Nash Ceretary</td> <td colspan="2">Nash Texas</td> </tr> <tr> <td colspan="2">Date of Burial</td> <td colspan="2">Funeral Home</td> <td colspan="2">City or Town</td> </tr> <tr> <td colspan="2">10-11-78</td> <td colspan="2">Richardson</td> <td colspan="2">Texarkana, Ark. - Tex.</td> </tr> <tr> <td colspan="2">Signature of Physician</td> <td colspan="2">Date Signed (Mo., Day, Yr.)</td> <td colspan="2">Date Received by Registrar (Mo., Day, Yr.)</td> </tr> <tr> <td colspan="2"><i>Jerry Stringfellow</i></td> <td colspan="2">10-13-78</td> <td colspan="2">10-17-78</td> </tr> <tr> <td colspan="2">Name of Attending Physician if Other Than M.D. (Type or Print)</td> <td colspan="2">Time of Death</td> <td colspan="2">Hour of Death</td> </tr> <tr> <td colspan="2">DR. JERRY STRINGFELLOW</td> <td colspan="2">11:20 A.M.</td> <td colspan="2">11:20</td> </tr> <tr> <td colspan="2">Name and Address of Certifier (Physician, Medical Examiner or Coroner) (Type or Print)</td> <td colspan="2">Immediate Cause</td> <td colspan="2">Other Significant Conditions</td> </tr> <tr> <td colspan="2">TEXARKANA, ARK.</td> <td colspan="2">Cardiac Arrest</td> <td colspan="2">None</td> </tr> <tr> <td colspan="2">Cause to, or as a consequence of</td> <td colspan="2">Cause to, or as a consequence of</td> <td colspan="2">Cause to, or as a consequence of</td> </tr> <tr> <td colspan="2">Chronic obstructive Pulmonary Disease</td> <td colspan="2">None</td> <td colspan="2">None</td> </tr> <tr> <td colspan="2">Autopsy (Specify Yes or No)</td> <td colspan="2">Was Case Referred to the Coroner (Specify Yes or No)</td> <td colspan="2">Date of Injury (Mo., Day, Yr.)</td> </tr> <tr> <td colspan="2">No</td> <td colspan="2">No</td> <td colspan="2">None</td> </tr> <tr> <td colspan="2">Acc. Buried How, Under or Pending Inquest (Specify)</td> <td colspan="2">Hour of Injury</td> <td colspan="2">Describe How Injury Occurred</td> </tr> <tr> <td colspan="2">None</td> <td colspan="2">None</td> <td colspan="2">None</td> </tr> <tr> <td colspan="2">Injury at Work (Specify Yes or No)</td> <td colspan="2">Place of Injury (If home, farm, street, factory, office, etc.)</td> <td colspan="2">Street, Cor. or P.O. No.</td> </tr> <tr> <td colspan="2">No</td> <td colspan="2">None</td> <td colspan="2">None</td> </tr> </table> | DECEASED NAME FIRST MIDDLE LAST | | SEX | | DATE OF DEATH (Mo. Day, Yr.) | | Quiller | | Male | | 10-5-78 | | R. P. 2354 W. Hale | | Age | | 74 | | Race | | Color | | Hair | | Black | | Black | | Brown | | County of Death | | City, Town or Location of Death | | Hospital or Other Institution Name (If not in hospital, give street and number) | | Miller | | Texarkana | | St. Michael Hospital | | State of Birth (If not in U.S.A. name country) | | Citizen or What Country | | Married, Never Married, Widowed, Divorced (Specify) | | Arkansas | | U. S. A. | | Widowed | | Social Security Number | | Usual Occupation (Give kind of work done during most of working life, even if retired) | | Kind of Business or Industry | | 43-09-254 | | Laborer | | Building Construction | | Residence State | | County | | City, Town or Location | | Texas | | Eowie | | Texarkana | | Father's Name | | Mother's Name | | Street and Number | | Patterson | | Parchman | | 232 W. 13th St. | | Mailing Address | | City or Town | | State | | 2322 West 13th St. | | Haywood | | Texas | | Funeral Care (Type of Death) | | Funeral Home | | Address of Funeral Home | | Burial | | Nash Ceretary | | Nash Texas | | Date of Burial | | Funeral Home | | City or Town | | 10-11-78 | | Richardson | | Texarkana, Ark. - Tex. | | Signature of Physician | | Date Signed (Mo., Day, Yr.) | | Date Received by Registrar (Mo., Day, Yr.) | | <i>Jerry Stringfellow</i> | | 10-13-78 | | 10-17-78 | | Name of Attending Physician if Other Than M.D. (Type or Print) | | Time of Death | | Hour of Death | | DR. JERRY STRINGFELLOW | | 11:20 A.M. | | 11:20 | | Name and Address of Certifier (Physician, Medical Examiner or Coroner) (Type or Print) | | Immediate Cause | | Other Significant Conditions | | TEXARKANA, ARK. | | Cardiac Arrest | | None | | Cause to, or as a consequence of | | Cause to, or as a consequence of | | Cause to, or as a consequence of | | Chronic obstructive Pulmonary Disease | | None | | None | | Autopsy (Specify Yes or No) | | Was Case Referred to the Coroner (Specify Yes or No) | | Date of Injury (Mo., Day, Yr.) | | No | | No | | None | | Acc. Buried How, Under or Pending Inquest (Specify) | | Hour of Injury | | Describe How Injury Occurred | | None | | None | | None | | Injury at Work (Specify Yes or No) | | Place of Injury (If home, farm, street, factory, office, etc.) | | Street, Cor. or P.O. No. | | No | | None | | None | |
| DECEASED NAME FIRST MIDDLE LAST | | SEX | | DATE OF DEATH (Mo. Day, Yr.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quiller | | Male | | 10-5-78 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| R. P. 2354 W. Hale | | Age | | 74 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Race | | Color | | Hair | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Black | | Black | | Brown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| County of Death | | City, Town or Location of Death | | Hospital or Other Institution Name (If not in hospital, give street and number) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Miller | | Texarkana | | St. Michael Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State of Birth (If not in U.S.A. name country) | | Citizen or What Country | | Married, Never Married, Widowed, Divorced (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arkansas | | U. S. A. | | Widowed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social Security Number | | Usual Occupation (Give kind of work done during most of working life, even if retired) | | Kind of Business or Industry | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 43-09-254 | | Laborer | | Building Construction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Residence State | | County | | City, Town or Location | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Texas | | Eowie | | Texarkana | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father's Name | | Mother's Name | | Street and Number | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patterson | | Parchman | | 232 W. 13th St. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mailing Address | | City or Town | | State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2322 West 13th St. | | Haywood | | Texas | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Care (Type of Death) | | Funeral Home | | Address of Funeral Home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | Nash Ceretary | | Nash Texas | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Burial | | Funeral Home | | City or Town | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10-11-78 | | Richardson | | Texarkana, Ark. - Tex. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of Physician | | Date Signed (Mo., Day, Yr.) | | Date Received by Registrar (Mo., Day, Yr.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Jerry Stringfellow</i> | | 10-13-78 | | 10-17-78 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Attending Physician if Other Than M.D. (Type or Print) | | Time of Death | | Hour of Death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DR. JERRY STRINGFELLOW | | 11:20 A.M. | | 11:20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name and Address of Certifier (Physician, Medical Examiner or Coroner) (Type or Print) | | Immediate Cause | | Other Significant Conditions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TEXARKANA, ARK. | | Cardiac Arrest | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cause to, or as a consequence of | | Cause to, or as a consequence of | | Cause to, or as a consequence of | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic obstructive Pulmonary Disease | | None | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Autopsy (Specify Yes or No) | | Was Case Referred to the Coroner (Specify Yes or No) | | Date of Injury (Mo., Day, Yr.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | No | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Acc. Buried How, Under or Pending Inquest (Specify) | | Hour of Injury | | Describe How Injury Occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| None | | None | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injury at Work (Specify Yes or No) | | Place of Injury (If home, farm, street, factory, office, etc.) | | Street, Cor. or P.O. No. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | None | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

THIS IS A CERTIFIED COPY OF AN ORIGINAL DOCUMENT

THIS IS TO CERTIFY, That the above is an exact reproduction of the original death certificate which is in my possession this date and of which I have the authority to issue under Act 300 of 1975 prior to submitting to the Division of Vital Records for permanent filing. IN TESTIMONY WHEREOF, witness my hand and seal of office at Texarkana, Miller County.

(Do not accept if rephotographed, or if seal cannot be felt. The reproduction of this document is prohibited by law - Arkansas Statute 81-529.)

10-17-78
Date

Thomas P. Welch
 County Registrar

UNOFFICIAL COPY

Property of Cook County Clerk's Office

UNOFFICIAL COPY

LOT 14 IN BLOCK 2 IN WILLIAM ASHTON'S SUBDIVISION IN THE WEST 30 ACRES OF THE SOUTH 60 ACRES OF THE WEST 1/2 OF THE SOUTHWEST 1/4 OF SECTION 35, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

PIN: 20-35-309-036

95901700

UNOFFICIAL COPY

Property of Cook County Clerk's Office