96904605

~~LAND TITLE AMERICA~~
INVESTORS TITLE GUARANTEE
15 SPINNING WHEEL ROAD SUITE 210 HINSDALE IL 60521 (708) 323-9870

DEPT-01 RECORDING $23.50
T#0008 TRAN 3719 11/27/96 11:29:00
#5595 # IR *-96-904605
COOK COUNTY RECORDER
DEPT-10 PENALTY $20.00

DECEASED JOINT TENANT AFFIDAVIT

STATE OF ILLINOIS }
} SS
COUNTY OF COOK }

RE: FILE NO. 60080

BARBARA FINKIEWICZ, NKA, BARBARA COLE, being duly sworn and for the purpose of inducing ~~Land Title America~~ INVESTORS TITLE, Inc. to delete all title exceptions caused by the death of WILLIAM F. FINKIEWICZ, states:

1. That Affiant resides at 18221 WALTER STREET, LANSING, ILLINOIS 60438
2. That Affiant was acquainted with said decedent who died on FEBRUARY 12, 1991 as evidenced by the certified copy of death certificate attached hereto;
3. That said decedent was one of the owners of land: 30-32-301-007
   - ☐ described in the subject file, or;
   - ☒ legally described as follows: Lot 7 in Block 4 in Lansing Central Subdivision, being a subdivision of the Northwest 1/4 of the Southwest 1/4 of fractional Section 32, Township 36 North, Range 15, East of the Third Principal Meridian, except the North 147.5 feet of the East 147.5 feet thereof
4. That said decedent died:
   - ☒ leaving no Last Will and Testament;
   - ☐ leaving a Last Will and Testament, a copy of which is attached hereto;
5. That the total value of the estate of said decedent, including both real and personal property owned by said decedent either individually or in joint tenancy at the date of death, does not exceed $ 70,000

MAIL TO: Barbara Cole
18221 Walter St
Lansing, Ill 60438

23.50
+ 20
43.50

Subscribed and sworn to before me by the said Barbara Cole Affiant this 15th day of November, 1996

X Barbara Cole
(Affiant's Signature)

Elizabeth A. Overstreet
Notary Public

OFFICIAL SEAL
ELIZABETH A OVERSTREET
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 09/15/00

96904605

Form 124

INDIANA STATE BOARD OF HEALTH

Local No. 334-91 CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): William F. Finkiewicz
2. SEX: Male
3a. TIME OF DEATH: 9:35P M
3b. DATE OF DEATH (Month, Day, Yr.): February 12, 1991
4. SOCIAL SECURITY NUMBER: 319-54-7827
5a. AGE—Last Birthday (Years): 33
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): Aug. 23, 1957
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinc
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None
9a. PLACE OF DEATH (Check only one. See instructions.): ☐ HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA ☐ OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Community Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Barbara Crist
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Electronics Technician
12b. KIND OF BUSINESS/INDUSTRY: Motorola Co.
13a. RESIDENCE—STATE: Illinois
13b. COUNTY: Cook
13c. CITY, TOWN, OR LOCATION: Lansing
13d. STREET AND NUMBER: 18221 Walter St.
13e. ZIP CODE: 60438
13f. INSIDE CITY LIMITS? ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): Frank Finkiewicz
19. MOTHER'S NAME (First, Middle, Maiden Surname): Edwina Dombrowski

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Barbara Finkiewicz
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18221 Walter St. Lansing, Ill.
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 16, 1991 Holy Cross Cemetery
21c. LOCATION—City or Town, State: Calumet City, Illinoi
22a. EMBALMER'S NAME: THOMAS J. BURNS
22b. LICENSE NO: 10 45184
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Thomas J. Burns
24b. LICENSE NUMBER (If Licensed): 10 45184
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 3002819 Burns-Kish for Rosemoor F.H. 5840 Hohman Ave. Hammond, Ind.

CAUSE OF DEATH

28. PART I. Enter the diseases, 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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Ischemic heart disease — Unknown

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

CERTIFIER

29a. CERTIFIER (Check only one):
☐ CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☒ 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: Daniel D. Thomas, M.D.
29c. MEDICAL LICENSE NO: 16120
29d. DATE SIGNED (Month, Day, Year): February 15, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 28 (Type/Print): Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams III M.D.
32. DATE FILED (Month, Day, Year): 2/19/91

THIS CERTIFIES THE ABOVE TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPT.

NOV 13 1996

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

CORONER USE ONLY

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): February 12, 1991
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

SBH36-004 State Form 10110 (R2/3-89) DEA CERT PD I

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