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4726/0057 18 001 Page 1 of 4
1999-07-14 10:43:48
Cook County Recorder 51.50
99671025

AFFIDAVIT OF HEIRSHIP

DANIEL C. HALLAHAN, being first duly sworn deposes and states as follows:

1. That he is the son of **CORNELIUS E. HALLAHAN,** who died on January 24, 1999. (copy of death certificate attached hereto.)

2. That the decedent owned the real estate property in joint tenancy with his wife, **BEATRICE C. HALLAHAN,** who died on July 8, 1998, commonly known as 10950 South Avenue M, Chicago, Illinois 60617.

Lot 20, and North ½ of Lot 21, in Block 59 in Ironworker's Addition, a Subdivision of the West ½ of the Northwest ¼ of Section 17, Township 37 North, Range 15, East of the Third Principal Meridian, in Cook County Illinois.

PIN: 26-17-125-073 – 0000, Vol. 500

3. That **CORNELIUS E. HALLAHAN** and **BEATRICE C. HALLAHAN** were married once, to each other and that the following are the children born to the parties, all are adults under no legal disability.

   a. Patricia Hallahan **a/k/a Patricia Notzen**
   b. Daniel C. Hallahan
   c. Thomas Hallahan

4. That no children were adopted by the parties and neither of them had any other children.

5. That both of the decedents' herein died intestate, and the total value of the real estate owned is approximately $87,000.00.

6. That the decedents died intestate and no Federal or State inheritance taxes are due.

7. That based on the foregoing the following are the only heirs of the decedent:

   a. Patricia Hallahan-daughter **a/k/a Patricia Notzen**
   b. Daniel C. Hallahan-son
   c. Thomas Hallahan-son

99671025

DANIEL C. HALLAHAN

SUBSCRIBED and SWORN TO
before me this 9th day
of July, 1999.

NOTARY PUBLIC

"OFFICIAL SEAL"
JOSEPH R. MITCHELL
Notary Public, State of Illinois
My Commission Exp. 11/17/2002

PROFESSIONAL NATIONAL
TITLE NETWORK, INC.

Mail to:

JOSEPH R. MITCHELL-22726
3501 E. 106TH STREET,
SUITE 205
CHICAGO, ILLINOIS 60617
(312) 734-5062

99671025

* 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.

Local No. 545

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

July 13, 1998 (Date Issued) — Hammond Health Commissio

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Beatrice C. Hallahan
2. SEX: Female
3a. TIME OF DEATH: 5:20 Pm
3b. DATE OF DEATH (Month, Day, Yr.): July 8, 1998
4. SOCIAL SECURITY NUMBER: 337-03-8049
5a. AGE—Last Birthday (Years): 84
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo., Day, Yr.): July 5, 1914
7. BIRTHPLACE (City and State or Foreign Country): Chicago, IL
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: ---
9. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9a. FACILITY NAME (If not institution, give street and number): St. Margaret Mercy North Campus
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Cornelius Hallahan
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Illinois
13b. COUNTY: Cook
13c. CITY, TOWN, OR LOCATION: Chicago
13d. STREET AND NUMBER: 10950 Avenue M
13e. ZIP CODE: 60617
13f. INSIDE CITY LIMITS? ☐ No ☒ 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): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Walter Johnson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl Flanders

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Cornelius Hallahan
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10950 Avenue M Chicago, IL 60617
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 13, 1998 Oakland Memory Lanes Crematory
21c. LOCATION—City or Town, State: Dolton, IL
22a. EMBALMER'S NAME: James Betkowski
22b. EMBALMER'S LICENSE NO.: FD0920007?
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James Betkowski
24b. LICENSE NUMBER (of Licensee): FD0920007?
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son FHD#83007267 1235-119th St. Whiting, IN for Elmwood Chapel Chicago, IL 606

CAUSE OF DEATH

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): a. Congestive Heart Failure — Approximate Interval Between Onset and Death: 3 Weeks
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF):

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

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

CERTIFIER

28c. 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: [signature]
29c. MEDICAL LICENSE NO.: 46357
29d. DATE SIGNED (Month, Day, Year): July 9, 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): N. Al-Sharif, M. D. 800 MacArthur Blvd-Ste12 Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Granbur D. Granada M.D.
32. DATE FILED (Month, Day, Year): July 13, 1998

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)
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

* ATTENTION ESTATE: This 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.

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 105

S Date Issued JAN 26,1999 Franklin D. Grenado M.D. Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Cornelius E. Hallahan
2. SEX: Male
3a. TIME OF DEATH: 6:53P M
3b. DATE OF DEATH (Month, Day, Yr.): January 24, 1999
4. *SOCIAL SECURITY NUMBER: 323-14-4856
5a. AGE—Last Birthday (Years): 85
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): July 17, 1913
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL XXX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Mercy Hospital North Campus
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
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): Captain
12b. KIND OF BUSINESS/INDUSTRY: Great Lakes Towing
13a. RESIDENCE—STATE: Illinois
13b. COUNTY: Cook
13c. CITY, TOWN OR LOCATION: Chicago
13d. STREET AND NUMBER: 10950 Ave. M
13e. ZIP CODE: 60617
13f. INSIDE CITY LIMITS? ☐ No ☒ 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): 11; College (1 or more):

PARENTS

18. FATHER'S NAME (First, Middle, Last): James Hallahan
19. MOTHER'S NAME (First, Middle, Maiden Surname): Frances O'Mara

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Particia Notzen
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2602 Architect Chesterton, Ind.
20c. Relationship: Daughter

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): Regional Cremation Jan. 28, 1999
21c. LOCATION—City or Town, State: Munster, Ind.
22a. EMBALMER'S NAME: James F. Betkowski
22b. EMBALMER'S LICENSE NO.: FD09200077
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F. Betkowski
24b. LICENSE NUMBER (If Licensed): FD09200077
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Daran & Son FHD#8.007267 1235 - 119th St. Whiting, Ind. for Elmwood Chapel Chicago, Illinois

CAUSE OF DEATH

26. 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. CARCINOMA OF BLADDER — FEW Years
DUE TO (OR AS A CONSEQUENCE OF):
b. ABDOMINAL MASS — FEW Months
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: POSSIBLE RUPTURE OF ARTERIAL VEISEL

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

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:
29c. MEDICAL LICENSE NO: 36-49259
29d. DATE SIGNED (Month, Day, Year): 1/25/99

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29 (Type/Print): Manzoor Hussain MD 2315 E 93rd. St. Chicago, Illinois 60617

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Grenado M.D.
32. DATE FILED (Month, Day, Year): January 26, 1999

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