1 PLACE OF DEATH

County Anoka

Township or Village or City Columbia Hieghts

STATE OF MINNESOTA

Division of Vital Statistics

CERTIFICATE OF DEATH

293

Reg. District No. 2 — 7 No. in Registration Book 28

(Above numbers to be filled in only by local registrar or his deputy.)

No. 652 40th Ave N.E. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Mary G. Dunn

Residence. No. 652 40th Ave N.E. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (WRITE the word)
Female	White	Widowed

Married, widowed, or divorced (HUSBAND of or WIFE of) William A. Dunn

DATE OF BIRTH (month, day, and year) Nov 15, 1845

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	0	18	

OCCUPATION OF DECEASED

(a) Trade, Profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Unio

NAME OF FATHER John Hatcher

BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

Informant Frank Dunn

(Address) 620 40th Ave N.E.

Filed Dec 3, 1926 H. Thorkelsen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 1926

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1926, to Dec 2, 1926,

that I last saw h[illegible] alive on Dec 2 10 p.m., 1926,

and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

x Chronic gastric catarrh, duration 8 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Acute Gastro-enterostomy with acute dilatation of the heart, catarrh (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H. Thorkelsen M. D.

12/3, 1926 (Address) 657 40th ave N E

NOT FOR OFFICIAL USE

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Minneapolis	Dec 6, 26 19
20 UNDERTAKER	ADDRESS
R.F. Burr	Mpls.

Sub-Registrar

Received 19

MINNESOTA DEPARTMENT OF HEALTH
Division of Vital Statistics

CERTIFICATE OF DEATH 10315

REGISTERED NO. 021450 2463

1. PLACE OF DEATH: STATE OF MINNESOTA
a. COUNTY: Hennepin
b. TOWNSHIP OR
c. CITY OR VILLAGE: Minneapolis
e. LENGTH OF STAY in (b) or (c): 45 Yrs.
d. NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Minnesota
b. COUNTY: Hennepin
c. TOWNSHIP OR
d. CITY OR VILLAGE: Minneapolis
Is residence within its corporate limits? YES ☒ NO ☐
e. P. O. ADDRESS: 2500 - Emerson Ave. So. Apt. #2 ST.

3. NAME OF DECEASED (Type or Print): Kathryn M. Mulvihill
4. DATE OF DEATH (Month) (Day) (Year): May 26, 1955
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 18, 1889
9. AGE (In years last birthday): 66
If Under 1 Year: Months / Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Bear Creek, Wisc.
12. CITIZEN OF WHAT COUNTRY?: U. S. A
13. FATHER'S NAME: William Dunn
13b. MOTHER'S MAIDEN NAME: Mary Hackett
14. SPOUSE'S NAME: Frank R. 4201
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: -
17. INFORMANT'S OWN SIGNATURE: Frank R Mulvihill ADDRESS

MEDICAL CERTIFICATION

18. Enter only one cause on lines (a), (b) and (c).

*(Give disease, injury or complication which was the IMMEDIATE CAUSE of death, not mode of dying, as heart failure, asphyxia, etc.

I. DISEASE OR CONDITION LEADING DIRECTLY TO DEATH* (a) Lung Coronary Thrombus.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis & Hypertension
DUE TO (c) Always a disease of old age

TIME BETWEEN ONSET & DEATH: Less than 12 hrs

2. OTHER SIGNIFICANT CONDITIONS Contributing to death but not related to disease or condition causing death: Lymphosarcoma - Early involvement Rt Kidney.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, VILLAGE OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED While at Work ☐ Not While At Work ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/3, 1955, *to* 5/26, 1955, *that I last saw the deceased alive on* 5/26, 1955, *and that death occurred at* 6:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): F. Thompson MD
23b. ADDRESS: 333 E. Hennepin
23c. DATE SIGNED: 5/26/55

24a. BURIAL CREMATION REMOVAL (Specify): Burial
24b. DATE: 5/28/55
24c. NAME OF CEMETERY OR CREMATORY: St. Anthony Cemetery
24d. LOCATION (City, village or county) (State): Minneapolis, Minnesota

DATE FILED BY LOCAL REG.: MAY 31 1955
REGISTRAR'S SIGNATURE:
25. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER: Billman - Hunt Chapel Mpls.
ADDRESS: Mpls.

Signature of Sub-Registrar
Burial or removal permit issued 5-27-55 #5295

MINNESOTA STATE DEPARTMENT OF HEALTH
Division of Birth and Death Records and Vital Statistics

25580

Dist. No. ..... To be inserted by registrar

CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: STATE OF MINNESOTA
County Ramsey
Township .....
Village .....
City St. Paul
No. 1879 University St.
(If hospital or institution give its NAME instead of St. and No.)
Length of stay:
In hospital or institution ..... yrs. ..... mos. ..... days
In this community 25 yrs. ..... mos. ..... days

2 USUAL RESIDENCE OF DECEASED: (If an institution, give place of residence prior to admission)
State Minnesota
County Ramsey
Township .....
Village 1488
City St. Paul
No. 1879 University St.
Is residence within limits of city or incorporated village? Yes

3 FULL NAME Henry Dunn 134 163A

4 (a) SOCIAL SECURITY NO. —
4 (b) IF VETERAN, Name WAR no
5 SEX Male
6 COLOR OR RACE White
7 Single, Married, Widowed or Divorced (Write the word) Widowed
8 (a) If Married, Widowed or Divorced, NAME OF HUSBAND OR WIFE Helen Dunn
8 (b) AGE if alive — Years
9 DATE OF BIRTH (Month, day, year) March 4 1886
10 AGE Years 60 Months 3 Days ~~22~~ 0 IF LESS than 1 day, ...hrs. or ....min.
11 USUAL OCCUPATION Self employed
12 INDUSTRY OR BUSINESS cigar maker
13 BIRTHPLACE (City or Town) (State or Country) Beer Creek, Wisc.
Father
14 NAME Wm. A. Dunn
15 BIRTHPLACE (City or Town) (State or Country) Ireland
Mother
16 MAIDEN NAME Mary Jane Hacher
17 BIRTHPLACE (City or Town) (State or Country) Illinois
18 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Informant's own Signature x Mrs. R. A. Rhodes
Address 669 Thurnman, City
19 Buried at or Removed to Sunset Date 6-7- 1946 (Cremation—No—Yes)
20 Signature of Embalmer or Funeral Director: Earl Holcomb Emb. Lic. No. 2550 F. D. Lic. No. 234
Address St. Paul, Minnesota
Firm Name Fred W. Johnston Funeral Home
21 Date Received ....., 19.... Helen Dewall Signature of Local Registrar

MEDICAL CERTIFICATION

22 DATE OF DEATH Found June 4th. 1946

23 I HEREBY CERTIFY: That I attended deceased from ....., 19.... to ....., 19....
I last saw h..... alive on ....., 19....
To the best of my knowledge, death occurred on the date stated above, at ..... m.

	Duration
Immediate cause of death: Rat poisoning	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: None	

NOT FOR OFFICIAL USE

Physician Underline the cause to which death should be charged statistically.

24 If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence Found June 4th. 1946
(c) Where did injury occur? St. Paul Minn. (City or Town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury By taking rat poisoning

25 Signature C. A. Peterson Coroner M.D.
Address City Court House Date 6-6-46

Amended pursuant to authority received and filed in the Minnesota State Department of Health on .....

6005-3-6-42-5M blks. (2) 11874

Signature of Sub-Registrar ..... 19....
Burial or removal permit issued

1-19-37 5M Blks. (52) ① Social Security No. of Deceased ...? Age of Husband or Wife if Alive ... Years

STATE OF MINNESOTA

10810

1921

Division of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Olmsted

Township or

Village or

Reg. District No. ... No. in Registration Book 691
(Above numbers to be filled in only by local registrar or his deputy)

City Rochester, Minnesota No. Rochester State Hospital St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME FRANK DUNN
(Please PRINT names in capitals)

(2a) Residence, No. 2615 McKinley St. N. E. St., Minneapolis, Minnesota Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? ... ds.

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced
BUSBAND of
(or) WIFE of Mrs. Katie Thom Dunn

6. DATE OF BIRTH (month, day, and year) August 3, 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	1	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as engineer (type of), miner, sawyer, bookkeeper, etc. (Retired) R.R. switchman

9. Industry or business in which work was done, as railway, mine (kind of) saw mill, bank, etc. Railroad

10. Date deceased last worked at this occupation (month and year) November, 1937

11. Total time (years) spent in this occupation ?

12. BIRTHPLACE (city or town) (State or country) Lebnon, Wisconsin

FATHER

13. NAME (Print) William Dunn

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME (Print) Mary Hatcher

16. BIRTHPLACE (city or town) (State or country) Ohio

17. INFORMANT (Address) State Hospital records

18. BURIED AT OR REMOVED TO Minneapolis Date 9/7 1940 (Cremation—No. Yes)

19. UNDERTAKER (Address) J. H. Boyle Rochester Minn.

20. Filed 9-5-40 [illegible] Registrar

21. DATE OF DEATH (month, day, and year) September 4 1940

22. I HEREBY CERTIFY, That I attended deceased from August 15, 1940, to September 4, 1940

I last saw him alive on September 4, 1940; death is said to have occurred on the date stated above, at 2:35 P. M.

The PRIMARY UNDERLYING CAUSE of death was

	Duration
General arteriosclerosis	years

Contributory causes of importance in order of onset:

	Duration
(1) Uremia	3 days
(2) Bronchopneumonia	1 day
(3)	

Did an operation precede death? No

If so, state conditions for which it was undertaken

Date of operation ... Was there an autopsy? No

NOT FOR OFFICIAL USE

22. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? No Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) C. Stavickson M. D.

Sept 4, 1940 (Address) Asst Physician State Hospital Rochester Minn

Received SEP 7 1940

Sub-Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be properly given, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATE OF MINNESOTA

Division of Vital Statistics

CERTIFICATE OF DEATH

4771

1 PLACE OF DEATH

County Hennepin

Township Minnetonka or Village Hopkins, or City —

Reg. District No. — No. in Registration Book 86
(Above numbers to be filled in only by local registrar or his deputy.)

No. Glen Lake Sanatorium St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna Hall

(a) Residence. No. 2714 Benjamin St. N. E. St., Ward Minneapolis, Minn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (WRITE the word)
female	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur G. Hall

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~39~~ 38		9	16	

8 OCCUPATION OF DECEASED

(a) Trade, Profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

NOT FOR OFFICIAL USE

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER Wm. Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hackett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Glen Lake Sanatorium (Address) Hopkins, Minn.

15 Filed 7-8 1921 W. S. Frear REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30th 1921, to July 3rd 1921

that I last saw her alive on July 3rd 1921

and that death occurred on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary chronic

, duration at least 9 mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive sputum

(Signed) E. Marquette, M. D.

7, 2 1921 (Address) Glen Lake Sanatorium Hopkins Minn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL July 5 19

20 UNDERTAKER

ADDRESS

Sub-Registrar

Received

Any alteration, Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MINNESOTA

Division of Vital Statistics

19103

CERTIFICATE OF DEATH

2372

Reg. District No. ..... No. in Registration Book .....
(Above numbers to be filled in only by local registrar or his deputy.)

1 PLACE OF DEATH

County Hennepin

Township or Village or City Minneapolis No. ....., University Hospital St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME James J Dunn

(X) Residence. No. 801 11th ave S.E St., ... Ward .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (WRITE the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs James Dunn (Kitty Dunn)

7 DATE OF BIRTH (month, day, and year) 2-4-1873

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	49	5	4	

9 OCCUPATION OF DECEASED

(a) Trade, Profession, or particular kind of work: Switchman

(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

(c) Name of employer: Soo

10 BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10 NAME OF FATHER: Wm Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary H Hatches

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wisconsin

14 Informant: Mrs Kitty Dunn (Address) 801 - 11th Ave S.E.

15 Filed ..... 19..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15th 1922, to July 8th 1922, that I last saw him alive on July 8th 1922, and that death occurred on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Ruptured aneurism of arch of Aorta

..... duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Influenza Pneumonia

Not Flu

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted?

If not at place of death, Did accident contribute to death? ..... Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. S. Bradeen, M. D.

7/9, 19 (Address) Univ. Hosp. Mpls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: St Mary's

DATE OF BURIAL: July 11 1922

20 UNDERTAKER: Burn

ADDRESS: Maple

Sub-Registrar

Received

MINNESOTA DEPARTMENT OF HEALTH
Section of Vital Statistics

CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

1. DECEASED – NAME (FIRST, MIDDLE, LAST)			2. SEX	3. DATE OF DEATH (MONTH, DAY, YEAR)
Rhoda	Ellen	Dunn	Female	July 28, 1976

4a. AGE (IN YEARS LAST BIRTHDAY)	4b. UNDER ONE YEAR (MONTHS, DAYS)	4c. UNDER ONE DAY (HOURS, MINUTES)	5. DATE OF BIRTH (MONTH, DAY, YEAR)	6. RACE (SPECIFY)	7a. COUNTY OF DEATH
91			June 29, 1885	White	Hennepin

7b. LOCATION OF DEATH (CITY, VILLAGE OR TOWNSHIP)	7c. INSIDE CORPORATE LIMITS (SPECIFY YES OR NO)	7d. HOSPITAL OR OTHER INSTITUTION – NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER)	
St. Anthony	Yes	3132 Silver Lake Road	

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY)	11. SPOUSE – NAME	
Michigan	U. S. A.	Widowed	Stephen J. Dunn	

12. WAS DECEASED EVER IN U.S. ARMED FORCES (SPECIFY YES OR NO)	13. SOCIAL SECURITY NUMBER	14a. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF WORKING LIFE, EVEN IF RETIRED)	14b. KIND OF BUSINESS OR INDUSTRY
No	468-54-1195	Housewife	Home

15a. RESIDENCE – STATE	15b. COUNTY	15c. CITY, VILLAGE OR TOWNSHIP	15d. INSIDE CORPORATE LIMITS (SPECIFY YES OR NO)
Minnesota	Hennepin	St. Anthony	Yes

16a. FATHER – NAME	16b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	17. ADDRESS OF DECEDENT (STREET AND NUMBER, POST OFFICE)	
Frank Malone 144	Wisconsin	3132 Silver Lake Rd.	
18a. MOTHER – MAIDEN NAME	18b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	19. INFORMANT – NAME, ADDRESS	
Ella Sweet 145	Michigan	Mrs. Irving Johnson-3132 Silver Lake St. Anthony, Minn	

MEDICAL CERTIFICATION

20. PART I – DEATH WAS CAUSED BY (ENTER ONLY ONE CAUSE PER LINE (A), (B) AND (C)) — IF DIAGNOSIS DEFERRED CHECK BOX ☐ — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

A. IMMEDIATE CAUSE: Natural causes

B. DUE TO, OR AS A CONSEQUENCE OF:

C. DUE TO, OR AS A CONSEQUENCE OF:

PART II OTHER SIGNIFICANT CONDITIONS

21a. AUTOPSY (SPECIFY YES OR NO): No

21b. IF SO, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH

22a. ACCIDENT, SUICIDE, HOMICIDE OR UNDETERMINED (SPECIFY) — IF DEFERRED CHECK BOX ☐

22b. DATE OF INJURY (MONTH, DAY, YEAR, HOUR)

22c. INJURY AT WORK (SPECIFY YES OR NO)

22d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)

22e. LOCATION (STREET OR RFD NUMBER, CITY, VILLAGE OR TOWNSHIP, COUNTY, STATE)

22f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 20)

23a. CERTIFICATION – PHYSICIAN

I attended the deceased from _____ to _____ and last saw him/her alive on _____. I did, did not view the body after death.

Death occurred at _____ M. of the place and time and on the date stated above and to the best of my knowledge due to the causes stated.

23b. CERTIFICATION – MEDICAL EXAMINER OR CORONER

On the basis of the examination of the body and/or the investigation, in my opinion death occurred at 3:00P M. on the date and due to the causes stated above. The decedent was pronounced dead on _____ at _____ M.

23c. PHYSICIAN – SIGNATURE

23d. MEDICAL EXAMINER OR CORONER – SIGNATURE: John I. Coe M.D.

23e. PHYSICIAN – NAME (TYPE OR PRINT)

23f. MEDICAL EXAMINER OR CORONER – NAME (TYPE OR PRINT): JOHN I. COE, M.D., MEDICAL EXAMINER

23g. MAILING ADDRESS (PHYSICIAN, MEDICAL EXAMINER OR CORONER): 730 South 7th Street, Minneapolis, Minnesota 55415

23h. DATE SIGNED (MONTH, DAY, YEAR): 07 30 76

24a. BURIAL, CREMATION, REMOVAL (SPECIFY)	24b. CEMETERY OR CREMATORY – NAME	24c. LOCATION (CITY, VILLAGE OR COUNTY) (STATE)	
Burial	St. Mary's Cemetery	Minneapolis	Minnesota
24d. DATE OF BURIAL, CREMATION OR REMOVAL (MONTH, DAY, YEAR)	25a. FUNERAL HOME – NAME	25b. FUNERAL HOME – ADDRESS	
July 31, 1976	Billman-Hunt Chapel	2701 Central Ave. N. E. Mpls, Minn	
26a. DATE FILED BY LOCAL REGISTRAR (MONTH, DAY, YEAR)	26b. LOCAL REGISTRAR – SIGNATURE	27. MORTICIAN OR FUNERAL DIRECTOR – SIGNATURE	
8 2 76	M. McLaughlin, Deputy	Roger D. Sheets 2068	

SIGNATURE OF SUB REGISTRAR: Roger D. Sheets

BURIAL OR REMOVAL PERMIT ISSUED: July 31, 1976

DEPARTMENT OF HEALTH
(DADE COUNTY HEALTH UNIT)
MIAMI 32, FLORIDA
Telephone 9-1821

T. E. CATO, M. D., M. P. H.

STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH
FLORIDA

STATE FILE NO.
REGISTRAR'S NO. 5061
BIRTH NO

1. PLACE OF DEATH
a. COUNTY: DADE
CITY LIMITS: 23-10
b. CITY OR TOWN: MIAMI
LENGTH OF STAY: 1 YEAR
d. FULL NAME OF HOSPITAL OR INSTITUTION: 501 N.W. 33rd AVE

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: FLORIDA
b. COUNTY: DADE
c. CITY OR TOWN: MIAMI
d. STREET ADDRESS: 501 N.W. 33rd AVE.

3. NAME OF DECEASED (Type or Print): a. (First) MICHAEL b. (Middle) EDWARD c. (Last) DUNN
4. DATE OF DEATH: (Month) (Day) (Year) Nov. 15, 1954
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED: MARRIED
8. DATE OF BIRTH: JULY 1, 1875
9. AGE (In years last birthday): 79 (If under 1 year: Months, Days, Hours, Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BRAKEMAN
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (State or foreign country): LEBANON, WISCONSIN
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM DUNN
14. MOTHER'S MAIDEN NAME: AMY THATCHER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE: A W Dunn
ADDRESS: 3370 S.W. 19 ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture right hip. — 3 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 412 X-33
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Probable) (Specify)
21b. PLACE OF INJURY (e.g. In or about home, farm, factory, street, office, etc.)
21c. (CITY OR TOWN) (If rural, state RURAL) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from never, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 11 07 A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Melissa D. Browning M.D.
23b. ADDRESS: 158 Almeria Av. Coral Gables.
23c. DATE SIGNED: 11/15/54

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: Nov. 18, 1954
24c. NAME OF CEMETERY OR CREMATORY: FLAGLER CEMETERY
24d. LOCATION (City, town, or county) (State): MIAMI, FLA.

DATE REC'D BY LOCAL REGISTRAR: 11-15-54 REG.
REGISTRAR'S SIGNATURE: T E Cato M D
25. FUNERAL DIRECTOR'S SIGNATURE: L. Lustman
ADDRESS: FLAGLER FUNERAL SERVICE INC.

THIS IS A TRUE PHOTOSTATIC COPY OF THE LOCAL REGISTRARS RECORD OF DEATH:

SEAL

Ethel Henehan

This record VOID unless the Seal of the Deputy-Registrar appears thereon.

DEPUTY-REGISTRAR DIST. # 23 and DIRECTOR
BUREAU OF VITAL STATISTICS
MIAMI, FLORIDA

DADE COUNTY

DEPARTMENT OF PUBLIC HEALTH

1350 N. W. FOURTEENTH STREET

MIAMI, FLORIDA 33125

9-27-77

CERTIFICATE OF DEATH

STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

FLORIDA

STATE FILE NO.
REGISTRAR'S NO. 5061

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: DADE — CODE NO. 23-10
b. CITY OR TOWN: MIAMI — c. LENGTH OF STAY (in this place): 9 YEARS
d. FULL NAME OF HOSPITAL OR INSTITUTION: 501 N.W. 33rd AVE

2. USUAL RESIDENCE a. STATE: FLORIDA — b. COUNTY: DADE
c. CITY OR TOWN: MIAMI
d. STREET ADDRESS: 501 N.W. 33rd AVE

3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) EDWARD c. (Last) DUNN

4. DATE OF DEATH (Month) (Day) (Year): NOV. 15, 1954

5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED — 8. DATE OF BIRTH: JULY 1, 1875 — 9. AGE: 79

10a. USUAL OCCUPATION: BRAKEMAN — 10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD — 11. BIRTHPLACE: LEBANON, WISCONSIN — 12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: WILLIAM DUNN — 14. MOTHER'S MAIDEN NAME: AMY THATCHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?: NO — 16. SOCIAL SECURITY NO.: — 17. INFORMANT'S SIGNATURE: H.W. Hughes
ADDRESS: 1370 N.W. 19 ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES — DUE TO (b): Fracture right hip — 3 years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death:

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION: U 1 E X-23 — 20. AUTOPSY? YES ☐ NO X

21a. ACCIDENT, SUICIDE, HOMICIDE — 21b. PLACE OF INJURY — 21c. (CITY OR TOWN) (COUNTY) (STATE)

21d. TIME OF INJURY — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I ^never attended the deceased from ____, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__ and that death occurred at 11 07 A m, from the causes and on the date stated above.

23a. SIGNATURE: Malissa D Browning M.D. (Degree or title) — 23b. ADDRESS: 158 Minorca Ave, Coral Gables — 23c. DATE SIGNED: 11/15/54

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 24b. DATE: NOV. 18, 1954 — 24c. NAME OF CEMETERY OR CREMATORY: FLAGLER CEMETERY — 24d. LOCATION (City, town, or county) (State): MIAMI, FLA.

DATE REC'D BY LOCAL REGISTRAR: 11-15-54 — REGISTRAR'S SIGNATURE: L B Ostrom — 25. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: FLAGLER FUNERAL SERVICE, INC.

I HEREBY CERTIFY THE ABOVE TO BE A TRUE COPY OF THE LOCAL REGISTRAR'S RECORD OF DEATH.

WARNING: ... unless the raised ... Vital Records Unit ... affixed.)

Patricia Marchetti
DEPUTY REGISTRAR
VITAL RECORDS UNIT
MIAMI, FLORIDA

DADE COUNTY

DEPARTMENT OF PUBLIC HEALTH

1350 N. W. FOURTEENTH STREET

MIAMI, FLORIDA 33125

STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

FLORIDA

STATE FILE NO. 596

BIRTH NO. REGISTRAR'S NO.

1 PLACE OF DEATH a. COUNTY: Dade	CODE NO. 23-162	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Florida	b. COUNTY: Dade
c. CITY, TOWN OR LOCATION: Miami	c. IS PLACE OF DEATH INSIDE CITY LIMITS? YES [X] NO [ ]	c. CITY, TOWN, OR LOCATION: Miami	f. IS RESIDENCE INSIDE CITY LIMITS? YES [X] NO [ ]
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4241 SW 7th Street		d. STREET ADDRESS: 4241 SW 7th Street	

3 NAME OF DECEASED (Type or print)	First: MATILDA	Middle: MARY	Last: DUNN	4 DATE OF DEATH Month, Day, Year: January 14, 1970	
5 SEX: Female	6 COLOR OR RACE: White	7 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8 DATE OF BIRTH: June 6, 1890	9 AGE (In years last birthday): 79	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a KIND OF WORK (Give kind even if retired): Housewife	10b KIND OF BUSINESS OR INDUSTRY: Own Home	11 BIRTHPLACE (State or foreign country): Wisconsin		12 CITIZEN OF WHAT COUNTRY: USA	
13 FATHER'S NAME: Joseph P. La Londe		14 MOTHER'S MAIDEN NAME: Matilda Morrow			
15 SOCIAL SECURITY NO.: Unobtainable	17 INFORMANT'S SIGNATURE: Mrs. Eunice Lyons	Address: 4241 SW 7th Street	Miami, Florida		

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b): with arteriosclerosis Coronary artery disease — 4 years

DUE TO (c): chronic congestive failure

DUE TO (d): Final Complication

INTERVAL BETWEEN ONSET AND DEATH: Minutes / Hours / Days / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]	20c DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		
20b TIME OF INJURY: Hour, a.m. p.m. / Month, Day, Year			
20d INJURY OCCURRED: WHILE AT W. PR. [ ] NOT WHILE AT WORK [ ]	20e PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f CITY, TOWN OR LOCATION	COUNTY / STATE

21 I attended the deceased from 1959 to 1/14/70 and last saw her alive on 6/15/67

Death occurred at ABT 4:00 A.m. on the date stated above; and to the best of my knowledge, from the causes stated

22a SIGNATURE: [illegible] M.D.	(Degree or title)	22b ADDRESS: 1554 Alhambra Circle Coral Gables	22c DATE SIGNED: 1-14-70

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE: 1/17/70	24 NAME OF CEMETERY OR CREMATORY: Flagler Memorial Park	24d LOCATION (City, town, or county) (State): Miami, Florida	
24a SIGNATURE OF EMBALMER: [illegible]	ADDRESS: Lanier-Josberger Funeral Home, Miami	25 DATE RECD BY LOCAL REG: Jan 15 1970	26 REGISTRAR'S SIGNATURE: Beatrice Marchetti	

I HEREBY CERTIFY THE ABOVE TO BE A TRUE COPY OF THE LOCAL REGISTRAR'S RECORD OF DEATH.

WARNING:
(Not valid unless the raised seal of the Vital Records Unit is affixed.)

Beatrice Marchetti
DEPUTY REGISTRAR
VITAL RECORDS UNIT
MIAMI, FLORIDA