PLAINTIFF'S EXHIBIT WRG-424

MINNESOTA DEPARTMENT OF HEALTH
Section of Vital Statistics

CERTIFICATE OF DEATH

1a. COUNTY OF DEATH	Hennepin	1b. STATE	Minnesota
1c. COUNTY	Hennepin		
2a. CITY, VILLAGE OR TOWNSHIP	Minneapolis	2b. LENGTH OF STAY AT THIS PLACE	21 Years
2c. CITY, VILLAGE OR TOWNSHIP	Minneapolis		
3a. NAME OF HOSPITAL OR INSTITUTION	Saint Marys Hospital	3b. STREET ADDRESS OR LOCATION	2819 Humboldt North
3c. POST OFFICE	Minneapolis		
4a. IS PLACE OF DEATH INSIDE CORPORATE LIMITS?	YES X NO	4b. IS RESIDENCE INSIDE CORPORATE LIMITS?	X YES NO
4c. IS RESIDENCE ON A FARM?	YES NO X		
5. NAME OF DECEASED (Type or Print)	DENNIS H. CLEARY	6. DATE OF DEATH (Month, Day, Year)	March 6, 1964
7. SEX	Male	8. COLOR OR RACE	White
9. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	X	10. DATE OF BIRTH	April 26, 1906
11. AGE (If under 1 year, UNDER 1 DAY / DAYS / MONTHS)	57		
12. BIRTHPLACE (State or Foreign Country)	Wisconsin	13. CITIZEN OF WHAT COUNTRY?	U.S.A.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Sacker Retired	15. KIND OF BUSINESS OR INDUSTRY	B.F.Nelson Co.
16. FATHER'S NAME	William Cleary	17. MOTHER'S MAIDEN NAME	Angeline, Strang
18. SPOUSE'S NAME	Lavina		
19. RESIDENCE — STREET AND NUMBER OR RURAL ROUTE NUMBER	2819 Humboldt North	20. CITY, VILLAGE OR TOWN	Minneapolis
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) If yes, give war or dates of service	Yes W.W.II	22. SOCIAL SECURITY NO.	393-10-5596
23. INFORMANT (Name, Relationship or Title, Mailing Address)	Mrs. Lavina Cleary 2819 Humboldt No. Minneapolis		

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Fibrosis 2 Yrs

DUE TO (b) Pulmonary Carcinoma 2 Months

DUE TO (c) Silicosis 12 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION GIVEN IN PART I.

25. WAS OPERATION PERFORMED FOR ANY CONDITION IN PART I OR II DURING PAST 4 WEEKS? (Yes or No) If yes, give date

26. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? (Yes or No)

27. ACCIDENT, SUICIDE OR HOMICIDE (Specify)

28. DESCRIBE HOW INJURY OCCURRED

29. TIME OF INJURY (Hour, Month, Day, Year)

30. INJURY AT WORK? (Yes or No)

31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)

32. CITY, VILLAGE OR TOWNSHIP

33. I certify that I attended the deceased from 1957 to 1964 and that I last saw the deceased on March 3, 1964 and that death occurred at 2 P.M. on the date stated above and to the best of my knowledge, from the cause stated.

34. SIGNATURE AND DEGREE OR TITLE — Leo J. Kelly MD

35. ADDRESS — 1129 - 2 St NE

36. DATE SIGNED — 3/9/64

37. AUTHORIZATION TO REMOVE BODY FOR BURIAL, CREMATION OR REMOVAL FROM STATE

38. DATE OF BURIAL, CREMATION OR REMOVAL — Burial March 10, 1964

39. NAME OF CEMETERY OR CREMATORY — Fort Snelling Nat Cem.

40. LOCATION (City or Town, State) — Fort Snelling, Minnesota

41. SIGNATURE OF MORTICIAN OR FUNERAL DIRECTOR — Marie A. Mahoney

42. NAME AND ADDRESS OF FUNERAL ESTABLISHMENT — Kapala Funeral Service 230 13th Avenue N.E.

Will be handled with UNLOADING BRACE INK

MARGIN RESERVED FOR BINDING

Burial or removal permit issued

Signature of Sub Registrar

5939

115

191

910

1347