MINNESOTA DEPARTMENT OF HEALTH
Section of Vital Statistics

CERTIFICATE OF DEATH

017583

LOCAL FILE NUMBER 702 — STATE FILE NUMBER

1. DECEASED – NAME (FIRST / MIDDLE / LAST)	2. SEX	3. DATE OF DEATH (MONTH DAY YEAR)
JAMES CHARLES GRANT	MALE	JULY 8, 1970

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
51			October 6, 1918	Cauc.	Olmsted

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)
Rochester	Yes	St. Mary's Hospital

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

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
Yes	396-01-7690	Retired masonry foreman	Cement contracting

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

16a. FATHER – NAME	16b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	17. ADDRESS OF DECEDENT (STREET AND NUMBER / POST OFFICE)
Ralph Grant	Wisconsin	2057 Wustum Ave., Racine, Wisconsin
18a. MOTHER – MAIDEN NAME	**18b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)**	**19. INFORMANT – NAME (ADDRESS)**
Lillian Peterson	Wisconsin	Mayo Clinic Records, Rochester, Minnesota

MEDICAL CERTIFICATION

AUG 1 1970 RECD

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	Cardiac failure	minutes
B. DUE TO, OR AS A CONSEQUENCE OF	Dehiscence aortic valve prosthesis	4 months
C. DUE TO, OR AS A CONSEQUENCE OF	Bacterial infection	5 months

PART II OTHER SIGNIFICANT CONDITIONS

21a. AUTOPSY (SPECIFY YES OR NO)	21b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH
Yes	Yes

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	23b. CERTIFICATION – MEDICAL EXAMINER OR CORONER
I attended the deceased from 6-27-70 (MONTH DAY YEAR) to 7-8-70 and last saw him/her alive on 7-8-70. I did, did not view the body after death. Death occurred at 610P CDT. To the best of my knowledge death occurred at the place and time and on the date stated above and to the cause stated.	On the basis of the examination of the body and/or the investigation, in my opinion death occurred at _____ M., on the date and due to the cause stated above. The decedent was pronounced dead on _____ at _____ M.
23c. PHYSICIAN – SIGNATURE: A. H. Baggenstoss	23d. MEDICAL EXAMINER OR CORONER – SIGNATURE
23e. PHYSICIAN – NAME (TYPE OR PRINT): A. H. Baggenstoss, M. D.	23f. MEDICAL EXAMINER OR CORONER – NAME (TYPE OR PRINT)
23g. MAILING ADDRESS (PHYSICIAN, MEDICAL EXAMINER OR CORONER): In/For the Mayo Clinic, Rochester, Minnesota	23h. DATE SIGNED (MONTH DAY YEAR): July 9, 1970

24a. BURIAL, CREMATION, REMOVAL (SPECIFY)	24b. CEMETERY OR CREMATORY – NAME	24c. LOCATION (CITY, VILLAGE OR COUNTY) (STATE)
Removal	***** ****	Racine Wisconsin

24d. DATE OF BURIAL, CREMATION OR REMOVAL (MONTH DAY YEAR)	25a. FUNERAL HOME – NAME	25b. FUNERAL HOME – ADDRESS
7 9 70	Riley Funeral Home	Rochester, Minnesota

26a. DATE FILED BY LOCAL REGISTRAR (MONTH DAY YEAR)	26b. LOCAL REGISTRAR – SIGNATURE	27. MORTICIAN OR FUNERAL DIRECTOR – SIGNATURE
7-23-70	Marjorie Jones - Deputy	James L. Arndt