

06-17-1999

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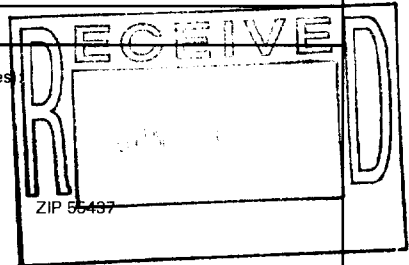
FORM PTO-1594
1-31-92

U.S. DEPARTMENT OF COMMERCE
Patent and Trademark Office



101068077

To the Honorable Commissioner of Patents and Trademarks. Please record the attached original documents or copy thereof.



1. Name of conveying party(ies):
Margot Vivian DeLaittre a/k/a Margot H. DeLaittre
 3420 Heritage Drive, Apartment 1
 Edina, MN 55435

Individual(s) Association
 General Partnership Limited Partnership
 Corporation-State of _____
 Other _____

Additional name(s) of conveying party(ies) attached? Yes No

2. Name and address of receiving party(ies):
 Name: **E. William DeLaittre**
 Street Address: **5027 Overlook Circle**
 City **Bloomington** State **MN** ZIP **55437**

Individual(s) citizenship **U.S.A.**
 Association _____
 General Partnership _____
 Limited Partnership _____
 Corporation-State _____
 Other _____

If assignee is not domiciled in the United States, a domestic representative designation is attached:
 Yes No
 (Designation must be a separate document from Assignment)

Additional name(s) & address(es) attached? Yes No

3. Nature of conveyance:

Assignment Merger
 Security Agreement Change of Name
 Other Death Certificate

Execution Date: January 2, 1998

4. Application number(s) or registration number(s):

A. Trademark Application No.(s) 75/211,573 B. Trademark registration No.(s) _____

Additional numbers attached? Yes No

5. Name and address of party to whom correspondence concerning document should be mailed:

Name: Conrad A. Hansen
 Internal Address: MOORE & HANSEN
2900 Norwest Center
 Street Address: 90 South Seventh Street,

 City: Minneapolis State: MN ZIP 55402

6. Total number of applications and registrations involved: 1

7. Total fee (37 CFR 3.41):.....\$ 40.00
 Enclosed
 Authorized to be charged to deposit account

8. Deposit account number:
13-4300
 (Attach duplicate copy of this page if paying by deposit account)

DO NOT USE THIS SPACE

9. Statement and signature.

To the best of my knowledge and belief, the foregoing information is true and correct and any attached copy is a true copy of the original document.

CONRAD A. HANSEN Conrad A Hansen 6-14-99
 Name of Person Signing Signature Date

Total number of pages comprising cover sheet: 1

OMB No. 0651-0011 (exp. 4/94)

Do not detach this portion

Mail documents to be recorded with required cover sheet information to:

Commissioner of Patents and Trademarks
Box Assignments
Washington, D.C. 20231

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TRADEMARK
REEL: 001913 FRAME: 0736

MINNESOTA DEPARTMENT OF HEALTH
Section of Vital Statistics
CERTIFICATE OF DEATH

Local File Number

State File Number

1a Name of Deceased - First MARGOT		Middle VIVIAN		Last DeLaitre		Suffix	
1b Alias		2 Social Security No. 471-07-1146		3 Sex Female		4 Date of Death December 28, 1997	
5 Date of Birth August 7, 1913		6a Age (in years) 84		Under 1 Yr. 6b months 6c days		Under 1 Day 6d hours 6e minutes	
7 Place of Birth (city and state/foreign country) Morris, Minnesota		8a Father's Name (first, middle) Alfred		8b Father's Last Name Humphries		9 Mother's Name (first, middle, maiden surname) Edith Richards	
10 Race White		11a Hispanic Origin <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes →		11b If Yes, Specify Cuban, Mexican, etc.		12 Decedent's Education 12a Primary/Secondary (0-12) 11 12b College (1-4, 5+)	
13a Marital Status Mar. Div. <input checked="" type="checkbox"/> Wid. Never Mar.		13b Name of Spouse (if wife, specify maiden name) Earle W. DeLaitre		14 Decedent's Usual Occupation Homemaker			
15 Kind of Business or Industry Own Home		16 U.S. Veteran <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		17a State of Residence Minnesota		17b County of Residence Hennepin	
17c City or Township of Residence Edina		17d Address of Decedent (number, street, zip) 3420 Heritage Drive, #120 55435					
17e Residence in City or Township <input checked="" type="checkbox"/> City Limits <input type="checkbox"/> Township Limits		18a City or Township of Death Edina		18b County of Death Hennepin			
19a Place of Death (specify one) <input checked="" type="checkbox"/> Hosp. <input type="checkbox"/> N.H. <input type="checkbox"/> Res. <input type="checkbox"/> Other →		Specify		19b If Hospital (specify one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER <input type="checkbox"/> DOA <input type="checkbox"/> Other			
19c Name of Facility Where Death Occurred (if not institution, specify street address) Fairview Southdale Hospital							
20a Name of Informant Pam DeLaitre				20b Informant is _____ of the deceased (spouse, child, parent, sibling, etc.) Daughter-in-law			
21 Method of Disposition: (check all that apply) <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Other →						22 Date of Disposition December 30, 1997	
23 Name of Cemetery				City State			
24 If Cremation, Specify Name of Crematory Metropolitan Crematory				25 If Cremation, Specify Name of M.E. / Coroner Authorizing Cremation Garry F. Peterson, M.D.			
26a Name of Funeral Establishment Cremation Society of Minnesota		26b License No. 0717		27a Signature of Funeral Service Licensee <i>[Signature]</i>		27b License No. 2747	28 Date Signed 12/30/97
29a Name of Person Certifying Cause of Death (please type) <i>[Signature]</i>				29b Title (check one) <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> Coroner / M.E. <input type="checkbox"/> D.O.		29c License No. of Certifier # 24253	
29d Address of Certifier (street & number) 225 Southdale Road Bldg				29e City Ed		29f State MN	29g Zip Code 55435
30 Signature of M.E. / M.E. / Coroner / D.O. <i>[Signature]</i>		31 Date Signed 11/2/98		32 Signature of Registrar <i>[Signature]</i>		33 Date Filed JAN 09 1998	
34 PART I IMMEDIATE cause of death (final disease or condition resulting in death) Enter the diseases, injuries, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory shock or heart failure. List only one cause per line. a. Cancer of Colon b. Lymphigus c. COPD Interval between onset and death.							
35 I attended the deceased from _____ to _____ and last saw him/her on 12-29-97 . I viewed the body after death <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
36 PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
37 Was Female Pregnant: At Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown In Last 12 Months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
39 MANNER OF DEATH <input checked="" type="checkbox"/> Natural		40 M.E./Coroner Notified <input type="checkbox"/> Yes <input type="checkbox"/> No		41 Autopsy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		42 Were autopsy results available when filing in cause of death <input type="checkbox"/> Yes <input type="checkbox"/> No	
43 Diagnosis Deferral <input type="checkbox"/> Yes <input type="checkbox"/> No		44a Place of Injury (street & number, city / township, state)					
44b Describe How Injury Occurred							
44c Type of Place Where Injury Occurred				44d Date of Injury		44e Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature of Sub-Registrar / Date
[Signature] 12/30/97
APPROVED BY MED. EXAMINER

PLEASE TYPE

TRADEMARK

STATE OF MINNESOTA
COUNTY OF HENNEPIN
CERTIFIED TO BE A TRUE AND
CORRECT COPY OF THE ORIGINAL ON
FILE AND OF RECORD IN MY OFFICE

JAN 13 1998

Patrick H. O'Connor
PATRICK H. O'CONNOR
DIRECTOR OF LICENSING

TRADEMARK

RECORDED: 06/16/1999

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