

STATE OF WYOMING
DEPARTMENT OF PUBLIC HEALTH

152
LOCAL FILE NUMBER

223

CERTIFICATE OF DEATH

TYPE, OR PRINT IN
PERMANENT INK
SEE HANDBOOK FOR
INSTRUCTIONS

STATE FILE NUMBER

DECEASED — NAME CARL MERLIN WORL					SEX M.	DATE OF DEATH (MONTH, DAY, YEAR) 9-26-1969	
RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY) 4. WHITE		AGE — LAST BIRTHDAY (YEARS) 50	UNDER 1 YEAR MOS. 6 DAYS 5b	UNDER 1 DAY HOURS 5c MIN. 6	DATE OF BIRTH (MONTH, DAY, YEAR) 6-30-1905	COUNTY OF DEATH SWEETWATER	
CITY, TOWN, OR LOCATION OF DEATH ROCK SPRINGS, WYOMING		INSIDE CITY LIMITS (SPECIFY YES OR NO) 7. YES		HOSPITAL OR OTHER INSTITUTION — NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) 74 SWEETWATER MEMORIAL HOSPITAL			
STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY) 8. NEBRASKA		CITIZEN OF WHAT COUNTRY 9. USA		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) 10. MARRIED		SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME) 11. ETHELYNE YOUNG	
SOCIAL SECURITY NUMBER 12. UNKNOWN		USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) 13a. CAR DEALER		KIND OF BUSINESS OR INDUSTRY 13b. FORD AGENCY			
RESIDENCE — STATE 14. WYOMING	COUNTY 14b. SUBLETTE	CITY, TOWN, OR LOCATION 14c. PINEDALE		INSIDE CITY LIMITS (SPECIFY YES OR NO) 14d. NO	STREET AND NUMBER 14e.		
FATHER — NAME 15. GRANT	MIDDLE WORL	MOTHER — MAIDEN NAME 16. HETTIE		ALLAN			
INFORMANT — NAME 17a. ETHELYNE WORL	MAILING ADDRESS 17b. PINEDALE, WYOMING, P.O. BOX 28, 82941						
PART I. DEATH WAS CAUSED BY: 18. IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) Uremia DUE TO, OR AS A CONSEQUENCE OF: (c) Chronic Glomerulonephritis				[ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)]			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2hrs
							1 yr
							10 years
PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)				AUTOPSY (YES OR NO) 19a. NO	IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH 19b.		
ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY) 20a.	DATE OF INJURY (MONTH, DAY, YEAR) 20b.	HOUR 20c.	HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18)				
INJURY AT WORK (SPECIFY YES OR NO) 20e.	PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY) 20f.	LOCATION 20g.	(STREET OR R.F.D. NO., CITY OR TOWN, STATE)				
CERTIFICATION — PHYSICIAN: I ATTENDED THE DECEASED FROM 21a. 9-26-69	MONTH DAY YEAR TO 21b. 9-26-1969	MONTH DAY YEAR 21c. 9-26-1969	AND LAST SAW HIM/HER ALIVE ON MONTH DAY YEAR 21c. 9-26-1969	I DID/DID NOT VIEW THE BODY AFTER DEATH. 21d. DID	DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE (HOUR) 21e. 11:PM	DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE (HOUR) 21e. 11:PM	DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE (HOUR) 21e. 11:PM
CERTIFICATION — MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. 22a.				HOUR OF DEATH 11:PM	THE DECEDENT WAS PRONOUNCED DEAD MONTH DAY YEAR 21c. 9-26-1969	21e. 11:PM	AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE (HOUR) 21e. 11:PM
CERTIFIER — NAME (TYPE OR PRINT) 23a. DR. H.P. GREAVES, MD	SIGNATURE 23b. <i>Dr. H.P. Greaves, MD</i>	DEGREE OR TITLE 23c. MD	DATE SIGNED (MONTH, DAY, YEAR) 23c. 10-13-1969				
MAILING ADDRESS — CERTIFIER 23d.	511 BROADWAY AVENUE, ROCK SPRINGS, WYOMING 82901						
BURIAL, CREMATION, REMOVAL (SPECIFY) 24a. REMOVAL	CEMETERY OR CREMATORIUM — NAME 24b. PINEDALE CITY CEMETERY	LOCATION 24c. PINEDALE, SUBLETTE CO, WYOMING					
DATE 24d. 9-27-1969	FUNERAL HOME — NAME AND ADDRESS 24e. VASE FUNERAL HOME, 154 ELK STREET, ROCK SPRINGS, WYOMING 82901	(STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)					
FUNERAL DIRECTOR — SIGNATURE 25b. <i>Robert Greaves</i>	REGISTRAR — SIGNATURE 26a. <i>Robert Greaves</i>	DATE RECEIVED BY LOCAL REGISTRAR 26b. October 16, 1969					

THIS IS TO CERTIFY THAT THIS REPRODUCTION IS A TRUE COPY OF A RECORD ON FILE IN
VITAL RECORDS SERVICES, DIVISION OF HEALTH AND MEDICAL SERVICES, WYOMING DEPARTMENT
OF HEALTH AND SOCIAL SERVICES, CHEYENNE, WYOMING.

L. J. Cohen, M.D.
LAWRENCE J. COHEN, M. D.
STATE REGISTRAR

BY *L. J. Cohen, M.D.*
VITAL RECORDS SERVICES

DATE ISSUED October 22, 1969