STATE OF WYOMING
DEPARTMENT OF PUBLIC HEALTH

# CERTIFICATE OF DEATH

1. LOCAL FILE NUMBER: 184 — STATE FILE NUMBER:

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| 1. DECEASED—NAME (First, Middle, Last): LEWIS SCHEINOST | 2. SEX: MALE | 3. DATE OF DEATH (Month, Day, Year): 12-8-1969 | |
| 4. RACE (White, Negro, American Indian, etc.): WHITE | 5a. AGE—LAST BIRTHDAY (Years): 76 | 5b. UNDER 1 YEAR: MOS. DAYS | 5c. UNDER 1 DAY: HOURS MIN. |
| 6. DATE OF BIRTH (Month, Day, Year): 4-19-1893 | 7. COUNTY OF DEATH: SWEETWATER | | |
| 8. CITY, TOWN, OR LOCATION OF DEATH: ROCK SPRINGS, WYOMING | 8a. INSIDE CITY LIMITS (Specify Yes or No): YES | 9. HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number): D.O.A. SWEETWATER MEMORIAL HOSPITAL | |
| 9. STATE OF BIRTH (If not in U.S.A., name country): NEBRASKA | 9. CITIZEN OF WHAT COUNTRY: U.S.A. | 10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED | 11. SURVIVING SPOUSE (If wife, give maiden name): DECEASED |
| 12. SOCIAL SECURITY NUMBER: 520-07-8189 | 12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET RANCHER | 13b. KIND OF BUSINESS OR INDUSTRY: RANCHING | |
| 14. RESIDENCE—STATE: WYOMING | COUNTY: SUBLETTE | 14b. CITY, TOWN, OR LOCATION: BIG PINEY | 14d. INSIDE CITY LIMITS (Specify Yes or No): NO |
| 14e. STREET AND NUMBER: SCHEINOST RANCH | | | |
| 15. FATHER—NAME (First, Middle, Last): ALBERT A. SCHEINOST | 16. MOTHER—MAIDEN NAME (First, Middle, Last): FANNIE [redacted] | | |
| 17a. INFORMANT—NAME: CAL SCHEINOST | 17b. MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip): LaBARGE, WYOMING 83123 | | |

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)

| | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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| 18 | IMMEDIATE CAUSE (a) | Internal Injuries Multiple | Instantaneous |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | DUE TO, OR AS A CONSEQUENCE OF: (b) | Automobile Accident | |
| | DUE TO, OR AS A CONSEQUENCE OF: (c) | | |

PART II. OTHER SIGNIFICANT CONDITIONS. CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a).

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| | | | 19a. AUTOPSY (Yes or No): NO | IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH 19b. |
| 20. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (Specify): ACCIDENT | 20a. DATE OF INJURY (Month, Day, Year): 12-8-1969 | 20c. HOUR: abt 4:10PM | 20d. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18.): TRUCK HE WAS DRIVING COLLIDED WITH THE REAR OF HIS SON's CAR THAT WAS PARKED | |
| 20e. INJURY AT WORK (Specify Yes or No): NO | 20f. PLACE OF INJURY (At home, farm, street, factory, office bldg., etc. (Specify)): HIGHWAY #30 SERVICE RD. | 20g. LOCATION (Street or R.F.D. No., City or Town, State): 6 miles west of Rock Springs, Sweetwater Co. Wyo. | | |

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| 21. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM (Month, Day, Year) 21a. 12-8-1969 TO 21b. 12-8-1969 | 21c. AND LAST SAW HIM/HER ALIVE ON (Month, Day, Year): DEAD WHEN SEEN | 21d. I DID/DID NOT VIEW THE BODY AFTER DEATH: DID | 21e. DEATH OCCURRED (Hour): Abt 4:35P M. | AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED. |
| 22. 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. HOUR OF DEATH: ABT 4:35PM M. | | 22a. THE DECEDENT WAS PRONOUNCED DEAD (Month, Day, Year): 12-8-1969 | HOUR: abt 4:35PM M. | |
| 23. CERTIFIER—NAME (Type or Print): DR. H.P.GREAVES, MD | 23b. SIGNATURE: [signature] | DEGREE OR TITLE: MD | 23c. DATE SIGNED (Month, Day, Year): 12-9-1969 | |
| 23d. MAILING ADDRESS—CERTIFIER (Street or R.F.D. No.): 511 BROADWAY AVENUE~~N AVENUE~~ | CITY OR TOWN: ROCK SPRINGS, | STATE: WYOMING | ZIP: 82901 | |

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| 24. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL | 24a. CEMETERY OR CREMATORY—NAME: BIG PINEY CEMETERY | LOCATION—CITY OR TOWN: BIG PINEY, | STATE: SUBLETTE CO. ~~WYOMING~~ WYO. |
| 24b. DATE (Month, Day, Year): 12-14-1969 | 25a. FUNERAL HOME—NAME AND ADDRESS (Street or R.F.D. No., City or Town, State, Zip): VASE FUNERAL HOME, 154 ELK STREET, ROCK SPRINGS, WYOMING 82901 | | |
| 25b. FUNERAL DIRECTOR—SIGNATURE: [signature] | 26. REGISTRAR—SIGNATURE: [signature] | 26b. DATE RECEIVED BY LOCAL REGISTRAR: December 18, 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.

[signature], M.D.

LAWRENCE J. COHEN, M. D.
STATE REGISTRAR

DATE ISSUED January 19, 1970

BY [signature]
VITAL RECORDS SERVICES