STATE OF WYOMING
DIVISION OF HEALTH AND MEDICAL SERVICES

CERTIFICATE OF DEATH

LOCAL FILE NUMBER: 16 | STATE FILE NUMBER: 1972 1643

TYPE, OR PRINT IN PERMANENT INK. SEE HANDBOOK FOR INSTRUCTIONS

DECEASED

1. DECEASED—NAME (First, Middle, Last): LOIS CRANE WELLS
2. SEX: Female
3. DATE OF DEATH (Month, Day, Year): June 25, 1972
4. RACE (White, Negro, American Indian, etc.) (Specify): White
5a. AGE—Last Birthday (Years): 47
5b. If Under 1 Year—Months:
5c. If Under 1 Day—Hours / Min.:
6. DATE OF BIRTH (Month, Day, Year): Oct. 10, 1924
7. COUNTY OF DEATH: Teton
7a. CITY, TOWN, OR LOCATION OF DEATH: Jackson
7c. INSIDE CITY LIMITS (Specify Yes or No): Yes
7b. HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number): St. John's Hospital
8. STATE OF BIRTH (If not in U.S.A., name country): Massachusetts
9. CITIZEN OF WHAT COUNTRY: U. S. A.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): James M. Wells
12. SOCIAL SECURITY NUMBER: Unknown
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
13b. KIND OF BUSINESS OR INDUSTRY: - - - - -
14a. RESIDENCE—STATE: Wyoming
14b. COUNTY: Sublette
14c. CITY, TOWN, OR LOCATION: Pinedale
14d. INSIDE CITY LIMITS (Specify Yes or No): No
14e. STREET AND NUMBER: - - - - -

USUAL RESIDENCE (Where deceased lived. If death occurred in institution, give residence before admission.)

PARENTS

15. FATHER—NAME (First, Middle, Last): William C. Crane
16. MOTHER—MAIDEN NAME (First, Middle, Last): Lois Whitin

17a. INFORMANT—NAME: James M. Wells
17b. MAILING ADDRESS (Street or R.F.D. No., City or Town, State, ZIP): Box D Pinedale, Wyoming

CAUSE

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

18. IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertensive cardiovascular
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: 4300

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (c): None

19a. AUTOPSY (Yes or No): -
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINATION OF DEATH: -

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (Specify): -
20b. DATE OF INJURY (Month, Day, Year): -
20c. HOUR: - M.
20d. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item): -
20e. INJURY AT WORK (Specify Yes or No): -
20f. PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.) (Specify): -
20g. LOCATION (Street or R.F.D. No., City or Town, State): -

CERTIFICATION

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM: 6-25-72 TO 6-25-72
21c. AND LAST SAW HIM/HER ALIVE ON: 6-25-72
21d. I DID/DID NOT VIEW THE BODY AFTER DEATH: Yes
21e. DEATH OCCURRED AT THE PLACE, DATE, AND TO (HOUR): 2:00P M TO THE CAUSES OF MY KNOWL

22a. 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: 10:30 A.M.
THE DECEDENT WAS PRONOUNCED DEAD (Month, Day, Year, Hour): 6-25-72 10:30
22b. CERTIFIER—NAME (Type or Print): W. M. Elmore M. D.
23b. SIGNATURE: W. M. Elmore
DEGREE OR TITLE: M. D.
23c. DATE SIGNED (Month, Day): 6-27-
23d. MAILING ADDRESS—CERTIFIER (Street or R.F.D. No., City or Town, State, ZIP): P. O. Box 404 Jackson, Wyoming

BURIAL

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. CEMETERY OR CREMATORY—NAME: Pinedale Cemetery
24c. LOCATION—CITY OR TOWN, STATE: Pinedale, Wyoming
24d. DATE (Month, Day, Year): June 26, 1972
25a. FUNERAL HOME—NAME AND ADDRESS (Street or R.F.D. No., City or Town, State, ZIP): The Benson Mortuary - P. O. Box 130 - Jackson, Wyoming 83
25b. FUNERAL DIRECTOR—SIGNATURE: H. D. Benson
25c. REGISTRAR—SIGNATURE: L. E. Bennett Deputy
26b. DATE RECEIVED BY LOCAL REGISTRAR: 7-1-72

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.

DATE ISSUED JULY 26, 1972

LAWRENCE J. COHEN, M.D.
STATE REGISTRAR

BY [signature]
DEPUTY STATE REGISTRAR
VITAL RECORDS SERVICES

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