

CERTIFICATION OF VITAL RECORD

STATE OF WYOMING

DEPARTMENT OF HEALTH

STATE OF WYOMING  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

TYPE OR PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

404 LOCAL FILE NUMBER

STATE FILE NUMBER

1. DECEDENT - NAME FIRST MIDDLE LAST  
Alvin G. Hjelrnstad

2. SEX  
Male

3. DATE OF DEATH (Mo., Day, Yr.)  
August 11, 2001

4. SOCIAL SECURITY NUMBER  
520-28-9258

5a. AGE - Last Birthday (Years)  
79

5b. UNDER 1 YEAR  
Months Days Hours

5c. UNDER 1 DAY  
Minutes

6. DATE OF BIRTH (Mo., Day, Yr.)  
August 07, 1922

7a. PLACE OF DEATH (Check only one)  
HOSPITAL  Outpatient  ER/Outpatient  DOA  OTHER:  Nursing Home  Residence  Other (Specify)

7b. FACILITY NAME (If not institution, give street and number)  
Wyoming Medical Center

7c. CITY, TOWN, OR LOCATION OF DEATH  
Casper

7d. COUNTY OF DEATH  
Natrona

8. STATE OF BIRTH (If not in U.S.A., name country)  
North Dakota

9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)  
Married

10. SURVIVING SPOUSE (If wife, give maiden name)  
Agnes Walz

11. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify yes or no)  
Yes

12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Heavy Equipment Operator

12b. KIND OF BUSINESS OR INDUSTRY  
Oil Refinery

13a. RESIDENCE - STATE  
Wyoming

13b. COUNTY  
Natrona

13c. CITY, TOWN OR LOCATION  
Mills

13d. STREET AND NUMBER  
411 7th Street

13e. INSIDE CITY LIMITS? (Specify yes or no)  
Yes

14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify no or yes - If yes, specify Cuban, Mexican, Puerto Rican, Etc.)  
No

15. RACE - American Indian, Black, White, Etc. (Specify)  
White

16. DECEDENT'S EDUCATION (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+) 3

17. FATHER'S NAME First Middle Last  
Anton Hjelrnstad

18. MOTHER'S NAME First Middle Maiden Surname  
Anna Nelson

19a. INFORMANT - NAME (Type or Print)  
Agnes Hjelrnstad

19b. RELATIONSHIP TO DECEDENT  
Wife

19c. MAILING ADDRESS STREET OR R.F.D. NUMBER CITY OR TOWN STATE ZIP CODE  
411 7th Street Mills Wyoming 82644

20a. Burial, Cremation, Removal from State, Other (Specify)  
Cremation

20b. DATE (Mo., Day, Yr.)  
August 14, 2001

20c. CEMETERY OR CREMATORY - NAME  
Wyoming Cremation Services

20d. LOCATION CITY OR TOWN STATE  
Casper, Wyoming

21a. FUNERAL SERVICE LICENSEE OR Person Acting As Such (Signature)  
*[Signature]*

21b. NAME OF FACILITY  
Memorial Chapel

21c. ADDRESS OF FACILITY  
92 710 E. 2nd St., Casper, WY.

22a. To the best of my knowledge, illness occurred on the date and place and due to the cause(s) stated.  
(Signature and Title) *[Signature]*

22b. DATE SIGNED (Mo., Day, Yr.)  
8/14/01

22c. HOUR OF DEATH  
3:20 p M

22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)  
Dan S. Grinstead M.D.

23a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.  
(Signature and Title) *[Signature]*

23b. DATE SIGNED (Mo., Day, Yr.)

23c. HOUR OF DEATH  
M

23d. PRONOUNCED DEAD (Mo., Day, Yr.)

23e. PRONOUNCED DEAD (Hour)  
M

24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN) OR CORONER (Type or Print)  
Dan S. Grinstead M.D., 1020 S Conwell, Casper, WY 82601

25a. REGISTRAR (Signature) *[Signature]*

25b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)  
August 15, 2001

PART I. Enter the disease, injuries, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. *Cardiac arrest*  
DUE TO (OR AS A CONSEQUENCE OF):

b. *Ischemic cardiac myopathy*  
DUE TO (OR AS A CONSEQUENCE OF):

c.   
DUE TO (OR AS A CONSEQUENCE OF):

d.   
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I

27. AUTOPSY (Specify yes or no)  
No

28. WAS CASE REFERRED TO CORONER (Specify yes or no)  
No

29a. MANNER OF DEATH  
 Natural  Pending Investigation  Accident  Suicide  Homicide  Could not be Determined

29b. DATE OF INJURY (Month, Day, Year)

29c. TIME OF INJURY

29d. INJURY AT WORK? (Specify yes or no)

29e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)

29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

VR 2-89  
11/99 15M

132653

This is a true and exact reproduction of the document on file in the office of Vital Records Services, Cheyenne, Wyoming.

DATE ISSUED AUG 21 2001

*[Signature]*  
Lucinda McCaffrey  
Deputy State Registrar

This copy is not valid unless prepared on paper with an engraved border displaying the date, seal and signature of the Deputy State Registrar.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE