

CERTIFICATE OF DEATH

MUST
BE
TYPED

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last)				2. SEX		3. DATE OF DEATH (Month, Day, Year)	
4. SOCIAL SECURITY NO		5a. AGE Last Birthday (Years)	5b. UNDER 1 YEAR (Months) (Days)	5c. UNDER 1 DAY (Hours) (Minutes)		6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City/State or Foreign Country)
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		9a. PLACE OF DEATH (Check only one) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
9b. FACILITY NAME (If not institution, give street and number)			9c. CITY, TOWN, OR LOCATION OF DEATH			9d. COUNTY OF DEATH	
10. MARITAL STATUS Married, Never Married, Widowed, Divorced (Specify)		11. SURVIVING SPOUSE (if wife, give maiden name)		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do Not use retired)		12b. KIND OF BUSINESS/INDUSTRY	
13a. RESIDENCE - State		13b. COUNTY		13c. CITY, TOWN, OR LOCATION		13d. STREET AND NUMBER	
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes		15. RACE - American Indian, Black, White, etc. (Specify)		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elem/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	

PARENTS

17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
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INFORMANT

19a. INFORMANT'S NAME				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
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DISPOSITION

20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____			20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)		20c. LOCATION (City, Town or State)		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such)				22. NAME AND ADDRESS OF FACILITY			

CERTIFIER

23a. To the best of my knowledge, death occurred at the time, date, place and due to the causes stated Signature and Title _____ <i>(MUST USE BLACK INK)</i>						23b. DATE SIGNED (Month, Day, Year)	
24. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28)							

CAUSE OF DEATH

25. TIME OF DEATH			26. DATE PRONOUNCED DEAD (Month, Day, Year)			27. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28. PART I. Enter the diseases, 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) Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between onset and death.	
a. _____ DUE TO (OR AS A CONSEQUENCE OF):							
b. _____ DUE TO (OR AS A CONSEQUENCE OF):							
c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributed to death but not resulting in the underlying cause given in Part I.				28a. If female, was there a pregnancy in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	28b. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	28c. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Did the deceased have Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No				28e. Was Diabetes an immediate, underlying, or contributing cause of or condition leading to death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
29. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		30a. DATE OF INJURY (Month, Day, Year)	30b. TIME OF INJURY	30c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	30d. DESCRIBE HOW INJURY OCCURRED		
30e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			30f. LOCATION (Street and Number or Rural Route Number, City or Town)				

REGISTRAR

31. REGISTRAR'S SIGNATURE						32. DATE FILED (Month, Day, Year)	
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