DECEDENT WORKSHEET

FOR DECEDENT: ,

PERSONAL INFORMATION

SSN	DATE OF DEATH	TIME OF DEATH
CITY, TOWN, OR LOCATION OF DEATH	SEX	EDUCATION
HOSPITAL OR OTHER		
COUNTY OF DEATH	If Hosp. or Inst. indicate DOA,OP/Emer. Rm. Inpatient	
RACE	HISPANIC	
CITIZEN OF WHAT COUNTRY	STATE OF	
DATE OF	AGE	MARITAL / ARMED FORCES?
SURVIVING SPOUSE		
OCCUPATION	INDUSTRY	
RESIDENCE		
CITY/TOWN	STATE	
COUNTY	IN CITY LIMITS?	
FATHER/PARENT		
MOTHER/PARENT		
INFORMANT		
INFORMANT ADDRESS ,		

DISPOSITION INFORMATION

BURIAL, CREMATION, REMOVAL, OTHER	CEMETERY OR CREMATORY - NAME	LOCATION
FUNERAL DIRECTOR	DIRECTOR LICENSE	
FUNERAL NAME AND ADDRESS		
TRADE CALL - NAME AND ADDRESS		

DECEDENT WORKSHEET

FOR DECEDENT: ,

CERTIFIER INFORMATION

PHYSICIAN	DATE SIGNED	TIME OF DEATH
CORONER		
DATE SIGNED	DATE PRONOUNCED	TIME PRONOUNCED
NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER		
NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) ,		LICENSE NUMBER
REGISTRAR	DATE FILED	

CAUSE OF DEATH INFORMATION

IMMEDIATE CAUSE (a)	Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF: (b)	Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF: (c)	Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF: (d)	Interval between onset and death

OTHER SIGNIFICANT CONDITIONS

DEATH DUE TO COMMUNICABLE DISEASE? **No**	AUTOPSY DONE?	CASE REFERRED TO CORONER?
MANNER OF DEATH	TOBACCO USE?	INJURY AT WORK?

DESCRIBE HOW INJURY OCCURRED		
LOCATION OF INJURY , ,		
DATE OF INJURY	HOUR OF INJURY	PLACE OF INJURY
IF VETERAN, NAME WAR AND BRANCH OF SERVICE		*RANK AND SERVICE NUMBER*

I certify that the information listed is correct:

Signature ***Date***