

NAME \_\_\_\_\_ CASE No. \_\_\_\_\_

COUNSELOR \_\_\_\_\_ DATE \_\_\_\_\_ SERV. CODE \_\_\_\_\_

EMB. AUTH. YES  NO  **VITAL STATISTICS** BU CR TR

DECEDENT'S PERSONAL DATA	1. NAME OF DECEDENT— FIRST (Given)			2. MIDDLE			3. LAST (Family)										
	AKA. ALSO KNOWN AS— Include full AKA(FIRST, MIDDLE, LAST)						4. DATE OF BIRTH mm/dd/ccyy		5. AGE Yrs.		IF UNDER ONE YEAR Months Days		IF UNDER 24 HOURS Hours Minutes		6. SEX		
	9. BIRTH STATE/FOREIGN COUNTRY			10. SOCIAL SECURITY NUMBER			11. EVER IN U.S.ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK			12. MARITAL STATUS (at Time of Death)			7. DATE OF DEATH mm/dd/ccyy		8. HOUR (24Hours)		
13. EDUCATION -Highest Level/Degree (see worksheet on back)			14/15. WAS DECEDENT SPANISH/HISPANIC/LATINO? (If yes, see worksheet on back.) <input type="checkbox"/> YES <input type="checkbox"/> NO			16. DECEDENT'S RACE— Up to 3 races maybe listed (see worksheet on back)											
17. USUAL OCCUPATION — Type of work for most of life. DO NOT USE RETIRED						18. KIND OF BUSINESS OR INDUSTRY ( e.g. grocery store, road construction, employment agency, etc.)						19. YEARS IN OCCUPATION					
USUAL RESIDENCE	20. DECEDENT'S RESIDENCE (Street and number or location)																
	21. CITY					22. COUNTY/PROVINCE					23. ZIP CODE			24. YEARS IN COUNTY		25. STATE/FOREIGN COUNTRY	
	26. INFORMANT'S NAME, RELATIONSHIP							27. INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP)									
SPOUSE AND PARENT INFORMATION	28. NAME OF SURVIVING SPOUSE — FIRST					29. MIDDLE					30. LAST (Maiden Name)						
	31. NAME OF FATHER — FIRST					32. MIDDLE					33. LAST					34. BIRTH STATE	
	35. NAME OF MOTHER — FIRST					36. MIDDLE					37. LAST (Maiden)					38. BIRTH STATE	
FUNERAL DIRECTORY/ LOCAL REGISTRAR	39. DISPOSITION DATE mm/dd/ccyy			40. PLACE OF FINAL DISPOSITION													
	41. TYPE OF DISPOSITION(S)						42. SIGNATURE OF EMBALMER						43. LICENSE NUMBER				
	44. NAME OF FUNERAL ESTABLISHMENT						45. LICENSE NUMBER			46. SIGNATURE OF LOCAL REGISTRAR			47. DATE mm/dd/ccyy				
	PLACE OF DEATH																
101. PLACE OF DEATH																	
102. IF HOSPITAL, SPECIFY ONE <input type="checkbox"/> IP <input type="checkbox"/> ER/OP <input type="checkbox"/> DOA																	
103. IF OTHER THAN HOSPITAL, SPECIFY ONE <input type="checkbox"/> Hospice <input type="checkbox"/> Nursing Home/LTC <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other																	
104. COUNTY					105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location)						106. CITY						

VITALS VERIFIED BY X \_\_\_\_\_

Doctor's Name		Informant's Name	
Address		Date of Birth	Soc. Sec#
City	Phone#	Cert. Copy #	Phone #

CEMETERY		
Name		
Section	Lot #	Grave #
Property Owner		
Requirements		
Open & Close Amount \$		
Other Charges. \$		
Name of Cemetery Rep -		

CREMATORY	
Name	
Cremation Date	
Delivery Date	Time
Type of Container	
Type of Urn	
Pacemaker yes no	Donate H. to H.?W
Name of Crematory Rep.	