STATE OF ABC

CERTIFICATION OF VITAL RECORD
DEPARTMENT OF HEALTH SERVICES

CERTIFICATE OF DEATH

12345

PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN

c. NAME OF HOSPITAL OR INSTITUTION

d. IS PLACE OF DEATH INSIDE CITY LIMITS?

USUAL RESIDENCE
a. STATE | b. COUNTY

c. CITY OR TOWN

d. STREET ADDRESS

e. IS RESIDENCE INSIDE CITY LIMITS?

NAME OF DECEASED | FIRST | LAST

DATE OF DEATH

SEX | COLOR OR RACE | MARITAL STATUS | DATE OF BIRTH | AGE

USUAL OCCUPATION | KIND OF BUSINESS OR INDUSTRY | BIRTHPLACE

FATHER'S NAME | MOTHER'S MAIDEN NAME

SOCIAL SECURITY NUMBER

CAUSE OF DEATH
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE a.
DUE TO b.
DUE TO c.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE

ACCIDENT ☐ SUICIDE ☐ HOMOCIDE ☐ | DESCRIBE HOW INJURY OCCURRED

TIME OF INJURY | HOUR | MONTH | DAY | YEAR

PLACE OF INJURY | CITY, TOWN, OR LOCATION | COUNTY | STATE

I hereby cetify that I attended the deceased from until .

SIGNATURE | ADDRESS | DATE SIGNED

BURIAL, CREMATION, REMOVAL | DATE | NAME OF CEMETARY OR CREMATORY

LOCATION | CITY OR TOWN | STATE

FUNERAL DIRECTOR SIGNATURE

REGISTRAR FILE NO. | DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE

SAMPLE