

# VITAL STATISTICS

1. DECEDENT'S (First, Middle, Last)				2. SEX	
3. DATE OF BIRTH (Month, Day, Year)	4a. AGE - Last Birthday (Years)	4b. UNDER 1 YEAR		4c. UNDER 1 DAY	
		Months	Days	HMOs	Minutes
5. DATE OF DEATH (Month, Day, Year)					
6. SOCIAL SECURITY NUMBER	7. BIRTHPLACE (City and State or Foreign Country)		8. COUNTY OF DEATH		
9. PLACE OF DEATH					
HOSPITAL: _____ INPATIENT _____ EMERGENCY ROOM / OUTPATIENT _____ DEAD ON ARRIVAL					
(Check only one) NON-HOSPITAL: _____ HOSPICE FACILITY _____ NURSING HOME / LONG TERM CARE FACILITY _____ DECEDENT'S HOME _____ OTHER (Specify)					
10. FACILITY NAME (If not institution, give street address.)			11 a. CITY TOWN, OR LOCATION OF DEATH		11 b. INSIDE CITY LIMITS?
					____ YES ____ NO
12. MARITAL STATUS (specify)			13. SURVIVING SPOUSE'S NAME (If wife, give maiden name.)		
Married _____ Married, but Separated _____ Widowed _____ Divorced _____ Never Married _____					
14a. RESIDENCE - STATE		14b. COUNTY		14c. CITY, TOWN OR LOCATION	
14d. STREET ADDRESS			14e. APT. NO.	141. ZIP CODE	14g. INSIDE CITY LIMITS?
					____ YES ____ NO
15a. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) Do not use "Retired"			15b. KIND OF BUSINESS / INDUSTRY		
16. DECEDENT'S RACE (Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.)					
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Specify Tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Isl. (Specify) <input type="checkbox"/> Other (Specify)					
17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify if decedent was of Hispanic or Haitian Origin.)					
<input type="checkbox"/> YES (It Yes, specify) <input type="checkbox"/> NO    Mexican    Puerto Rican    Cuban    CentraVSouth American Other Hispanic (Specify)    Haitian					
18. DECEDENT'S EDUCATION (Specify the decedent's highest degree or level of school completed at time of death.)					19. WAS DECEDENT EVER IN U.S. ARMED FORCES?
8th or less    High School but no diploma    _____ High School diploma or GED College but no degree    College degree (Specify): _____ Associate <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's    _____ Doctorate					<input type="checkbox"/> Yes <input type="checkbox"/> No
20. FATHER'S NAME (First, Middle, Last, Suffix)			21. MOTHER'S NAME (First, Middle, Last, Surname)		
22a. INFORMANT'S NAME		22b. RELATIONSHIP TO DECEDENT		23a. INFORMANT'S MAILING - STAT	
23b. CITY OR TOWN		23c. STREET ADDRESS		23d. ZIP CODE	
24. PLACE OF DISPOSITION (Name of cemetery, crematory or other place.)		25a. LOCATION - STATE		25b. LOCATION - CITY OR TOWN	
26a. METHOD OF DISPOSITION					
Burial    Entombment    Cremation    Donation    Removal from state    Other (Specify)					

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Misc: \_\_\_\_\_

Physician: \_\_\_\_\_ (MD/ME) Address: \_\_\_\_\_  
(circle one)

Phone Number: \_\_\_\_\_ Time of Death: \_\_\_\_\_ (AM/PM)  
(circle one)

Autopsy Performed (YES / NO) (circle one) Was case reported to the Medical Examiner? (YES / NO) (circle one)

Permission to Cremate by \_\_\_\_\_