DEPARTMENT OF HEALTH

Minnesota Documentation of Death

SFN

Deceased Name (First, Middle, Last, Suffix) | **Last Name Before First Marriage** | **Also Known As**

Date of Death MM DD YYYY

Sex ○ Male ○ Female ○ Unknown

Social Security Number - - ○ None ○ Unknown ○ Not Obtainable

Date of Birth ○ Unknown MM DD YYYY

Age (in years) | Under 1 Year: months, days | Under 1 Day: hours, minutes

Birth Country ○ Born in the United States ○ Not U.S. Specify ○ Unknown | State/Province | City/Town

Deceased's **Residence** Address ○ U.S. Address ○ Foreign country ○ Unknown | State/Province | County | City/Town | Street & Number, Zip Code | Inside City Limits? ○ Yes ○ No

Education (highest completed)
○ Unknown
○ 8th grade or less
○ 9th – 12th grade; no diploma
○ High School graduate or GED completed
○ Some college credit but no degree
○ Associate degree (e.g. AA,AS)
○ Bachelor's degree (e.g., BA,AB, BS)
○ Master's degree (e.g., MA, MS, MEng, Med, MSW, MBA)
○ Doctorate (e.g., MD, DDS, DVM,

Ever In Armed Forces? ○ Yes ○ No ○ Unknown

Deceased's Usual Occupation

Kind of Business or Industry

Hispanic Origin
○ No, Not Spanish/Hispanic/Latino
○ Yes, Hispanic Origin Known
☐ Mexican, Mexican American, Chicano
☐ Puerto Rican
☐ Cuban
☐ Other, specify
○ Unknown if Spanish/Hispanic/Latino

Race ○ Unknown
☐ White
African African/American
☐ Black/African American
☐ Ethiopian
☐ Liberian
☐ Ghanaian
☐ Other African
Specify
☐ Kenyan
☐ Sudanese
☐ Nigerian
☐ Somali
☐ American Indian or Alaska Native
Name of the Enrolled or Principal Tribe
Asian
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Other Asian
Specify
☐ Korean
☐ Vietnamese
☐ Hmong
☐ Cambodian
☐ Laotian

Pacific Islander
☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander Specify
☐ Other Race Specify

Marital Status at time of Death ○ Married ○ Never Married ○ Married But Separated ○ Widowed ○ Divorced ○ Unknown ○ Not Obtainable

Spouse's Name (First, Middle, Last, Suffix) | Last name before first marriage

Father/ParentTwo Name (First, Middle, Last, Suffix)

Mother / Parent One Name (First, Middle, Suffix) | Last Name Before First Marriage

Informant's Name (First, Middle, Last or Institution) | Relationship to Deceased | Address(Street & Number, City, State, Zip)

Place of Death
Hospital
○ Inpatient
○ Emergency Room/Outpatient
○ Dead on Arrival

Other than a Hospital
○ Hospice
○ Nursing home/Long term care
○ Deceased's home
○ Other

County
Facility Name and Address (Street & Number, City, State, Zip)

Physician/ME Providing Cause of Death Information (First, Middle, Last) License # Title | Funeral Home/Other Institution, Estab. # | Funeral Director Name (First, Middle, Last)

Method of Disposition ○ Burial ○ Cremation ○ Donation ○ Entombment ○ Removal from State ○ Other (Specify)

Disposition Facility	State/Province	City/Town
Cemetery	State/Province	City/Town

The information on this form is correct to the best of my knowledge

Signature Date

Minnesota Department of Health
Office of Vital Records
PO Box 64499
St. Paul, MN 55164-0499
651-201-5970