

ARIZONA DEPARTMENT OF HEALTH  
SERVICES BUREAU OF VITAL RECORDS

# DEATH REGISTRATION WORKSHEET

This form is for the collection of the data needed to complete the Arizona Certificate of Death. ***This is not a death certificate.***

Arizona Revised Statute §36-342. Disclosure of information: prohibition

A. The state registrar may provide information contained in vital records to persons, including federal, state, local and other agencies, as required by law and for statistical or research purposes. B. Except as authorized by law, a local registrar, a deputy local registrar or the state registrar or their employees shall not:

1. Permit inspection of a vital record or evidentiary document supporting the vital record.
2. Disclose information contained in a vital record.
3. Transcribe or issue a copy of all or part of a vital record.

1A. DECEDENT'S LEGAL FIRST NAME				1B. DECEDENT'S LEGAL MIDDLE NAME			
1C. DECEDENT'S LEGAL LAST NAME				1D. SUFFIX (Jr, II, etc)		1E. AKA'S IF ANY	
2. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Not Yet Determined		3. U.S. SOCIAL SECURITY NUMBER <input type="checkbox"/> None <input type="checkbox"/> Unknown		4. DATE OF DEATH  (mm/dd/yyyy)		5A. DATE OF BIRTH  (mm/dd/yyyy)	
		5B. AGE IN ____ Years ____ Months ____ Days ____ Hours ____ Minutes					
6A. DECEDENT'S BIRTH CITY OR TOWN		6B. DECEDENT'S BIRTH COUNTY		6C. DECEDENT'S BIRTH STATE		6D. DECEDENT'S BIRTH COUNTRY	
7. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		8. DECEDENT'S NAME PRIOR TO FIRST MARRIAGE				9. HRRF (Human Remains Release Form) <input type="checkbox"/> Yes <input type="checkbox"/> No	
10A. DECEDENT'S RESIDENCE STREET ADDRESS			10B. ZIP CODE	10C. RESIDENCE CITY	10D. RESIDENCE COUNTY		10E. RESIDENCE STATE
10F. RESIDENCE COUNTRY		11. IN CITY LIMITS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		12. HOW LONG IN THE STATE OF ARIZONA? ____ <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Minutes <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Weeks <input type="checkbox"/> In Transit <input type="checkbox"/> Unknown		13. RESIDED IN AZ. TRIBAL COMMUNITY? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  If yes, list name of Arizona Tribal Community on the line above	
14. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Married but Separated <input type="checkbox"/> Not Obtainable <input type="checkbox"/> Unknown							
15A. FIRST NAME OF SURVIVING SPOUSE		15B. MIDDLE NAME OF SURVIVING SPOUSE		15C. LAST NAME OF SURVIVING SPOUSE PRIOR TO FIRST MARRIAGE		15D. SUFFIX	15E. LAST NAME OF SURVIVING SPOUSE
16A. FATHER'S FIRST NAME		16B. FATHER'S MIDDLE NAME		16C. FATHER'S LAST NAME			16D. SUFFIX (Jr, II, etc)
17A. MOTHER'S FIRST NAME		17B. MOTHER'S MIDDLE NAME		17C. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE			17D. SUFFIX (Jr, II, etc)
18A. INFORMANT'S FIRST NAME		18B. INFORMANT MIDDLE NAME		18C. INFORMANT LAST NAME			18D. SUFFIX (Jr, II, etc)

18E. RELATIONSHIP TO DECEDENT	18F. INFORMANT'S EMAIL ADDRESS	18G. INFORMANT'S PHONE NUMBER
18H. INFORMANT'S MAILING ADDRESS		18I. I ATTEST THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE, TRUE AND VALID TO THE BEST OF MY KNOWLEDGE.  <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%; border-top: 1px solid black; padding-top: 5px;">Informant's Signature</div> <div style="width: 35%; border-top: 1px solid black; padding-top: 5px;">Date Signed</div> </div>
19A. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Donation/Burial <input type="checkbox"/> Donation/Cremation <input type="checkbox"/> Donation/Entombment  Removal: <input type="checkbox"/> From State <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Donation/Burial <input type="checkbox"/> Donation/Cremation <input type="checkbox"/> Donation/Entombment  <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____		19B. DATE OF DISPOSITION
20A. PLACE OF DISPOSITION - NAME OF FIRST DISPOSITION FACILITY		20B. PLACE OF DISPOSITION - NAME OF SECOND DISPOSITION FACILITY
21A. NAME OF FUNERAL DIRECTOR (first, middle, last, suffix)	21B. LICENSE NUMBER	21C. NAME OF FUNERAL HOME
22. ADDRESS OF FUNERAL HOME OR OTHER RESPONSIBLE PARTY		23. OTHER RESPONSIBLE PARTY RELATIONSHIP
24A. DECEDENT'S OCCUPATION	25. EDUCATION (SELECT ONE) <input type="checkbox"/> 8th grade or less; none <input type="checkbox"/> 9th through 12th grade, no diploma <input type="checkbox"/> High School graduate or GED completed <input type="checkbox"/> Some college credit, but not a degree <input type="checkbox"/> Associate degree (e.g.: AA, AS) <input type="checkbox"/> Bachelor's degree (e.g.: BA, AB, BS) <input type="checkbox"/> Master's degree (e.g.: MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g.: PhD, EdD, or Professional Degree e.g.: MD, DDS, DVM, LLB, JB) <input type="checkbox"/> Unknown <input type="checkbox"/> Refused <input type="checkbox"/> Not Obtainable <input type="checkbox"/> Not Classifiable	
24B. DECEDENT'S INDUSTRY	26. DECEDENT'S HISPANIC ORIGIN (Check the boxes that best corresponds with the decedent's ethnic identity as given by the informant) <input type="checkbox"/> No, Not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify) _____  <input type="checkbox"/> Not Obtainable <input type="checkbox"/> Unknown <input type="checkbox"/> Refused    _____	
27. DECEDENT'S RACE (Select all that Apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> White  <input type="checkbox"/> Black, African American  <input type="checkbox"/> American Indian/              Alaska Native (Specify)              Enrolled Tribe _____              Secondary Tribe _____  <input type="checkbox"/> Asian Indian         </div> <div style="width: 33%;"> <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) _____         </div> <div style="width: 33%;"> <input type="checkbox"/> Native Hawaiian  <input type="checkbox"/> Guamanian or Chamorro  <input type="checkbox"/> Samoan  <input type="checkbox"/> Other Pacific Islander (Specify) _____         </div> <div style="width: 33%;"> <input type="checkbox"/> Other (Specify) _____   <input type="checkbox"/> Refused  <input type="checkbox"/> Not Obtainable  <input type="checkbox"/> Unknown         </div> </div>		
28A. TYPE OF PLACE OF DEATH <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Emergency <input type="checkbox"/> Inpatient <input type="checkbox"/> Decedent's Residence <input type="checkbox"/> Hospice <input type="checkbox"/> Nursing Home/Long Term Care <input type="checkbox"/> Other; Specify _____		28B. PLACE OF DEATH FACILITY NAME

28C. PLACE OF DEATH FACILITY ADDRESS		28D. SPECIFY OTHER INSTITUTION OR ADDRESS WHERE DEATH OCCURRED	
29A. CERTIFIER TYPE <input type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Tribal Authority <input type="checkbox"/> Unknown, Not Classified			
29B. CERTIFIER'S LICENSE NUMBER	29C. CERTIFIER'S NAME (first, middle, last, suffix)		
29D. CERTIFIER'S TITLE <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Doctor of Medicine  <input type="checkbox"/> Tribal Law Enforcement  <input type="checkbox"/> APRN         </div> <div> <input type="checkbox"/> Doctor of Osteopathy  <input type="checkbox"/> Naturopathic Physician  <input type="checkbox"/> Other (Specify) _____         </div> <div> <input type="checkbox"/> C.N.M./C.M  <input type="checkbox"/> Nurse Midwife         </div> <div> <input type="checkbox"/> Physician Assistant (PA)  <input type="checkbox"/> Medical Doctor Intern/Resident         </div> </div>			
29E. CERTIFIER'S ADDRESS			29F. CERTIFIER'S ZIP CODE
29G. CERTIFIER'S CITY, TOWN, OR LOCATION		29H. CERTIFIER'S STATE	29I. CERTIFIER'S COUNTRY
30A. NAME OF ALTERNATE CERTIFIER		30B. TELEPHONE NUMBER	30C. FAX NUMBER
30D. EMAIL ADDRESS		31. FUNERAL DIRECTOR'S SIGNATURE - I ATTEST THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE, TRUE AND VALID TO THE BEST OF MY KNOWLEDGE.	
		<div style="display: flex; justify-content: space-between;"> <span>Signature _____</span> <span>Date Signed _____</span> </div>	