

DIRECTOR: _____

CASE NUMBER: _____

INFORMANT NAME & RELATIONSHIP: _____

INFORMANT SSN: _____

ADDRESS: _____

PHONE (H): _____

E-MAIL ADDRESS _____

(C): _____

VITAL STATISTICS

DCs Ordered: _____

PENDING / AMENDED

1. DECEDENT'S NAME (First, Middle, Last)

4. S.S. NUMBER		5. AGE		5b. UNDER ONE YEAR		5c. UNDER ONE DAY		6. DATE OF BIRTH (Month, Day, Year)		2. SEX		3. DATE OF DEATH (Month, Day, Year)	
				Mos		Days		Hrs					
8. WAS DECEDENT EVER IN THE ARMED FORCES? ☐ Yes ☐ No		9a. PLACE OF DEATH (Check Only One)										7. BIRTHPLACE (City & State or Country)	
		HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA											
9b. FACILITY NAME (If not institution, give street & number)		9c. CITY, TOWN OR LOCATION OF DEATH										9d. COUNTY OF DEATH	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, do NOT use retired)		10b. KIND OF BUSINESS/INDUSTRY		11. MARITAL STATUS (Married, Never Married, Divorced, Widowed)		12. SPOUSE (If wife, give maiden name - Unless divorced)							
13a. RESIDENCE: STATE		13b. COUNTY		13c. CITY, TOWN OR LOCATION		13d. STREET & NUMBER							
13e. INSIDE CITY LIMITS ☐ Yes ☐ No		13f. ZIP CODE		14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No If YES, specify Cuban, Mexican, Puerto Rican, Spanish, etc.) ☐ No ☐ Yes (Specify)		15. RACE (American Indian, Black, White, etc. Specify)		16. EDUCATION / DEGREE RECEIVED					
17. FATHER'S NAME: (First, Middle, Last)		18. MOTHER'S NAME: (First, Middle, Maiden Name)		19. INFORMANT'S NAME & RELATIONSHIP									
20a. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Removal from State		20b. PLACE OF DISPOSITION (Name of Cemetery or Crematory or other place)		20c. LOCATION (City, County, State & Zip Code)									
PHYSICIAN'S NAME		PHONE NUMBER		ADDRESS									
TIME OF DEATH		DATE & TIME PRONOUNCED DEAD		CORONER NOTIFIED		CORONER CO-SIGN		AUTOPSY?					