

REQUIRED STATISTICAL INFORMATION FOR FILING DEATH CERTIFICATE

Name of the Deceased _____
First Name Middle Name Last name

Also Known As _____
First Name Middle Name Last name

Usual Residence _____
Street Address City State Zip

Phone # _____ County _____ Years in County _____

Birth date _____ Birthplace (*State or Foreign Country*) _____ Age _____

Sex (*Male/Female*) _____ Race(s) _____ Weight _____ Height _____

Marital status (*Specify*) _____ Name of Spouse (if any) _____
(Married, never married, divorced, widow) (If wife, provide Maiden Name)

Social Security Number _____ Highest degree of education _____

Primary Occupation _____ Number of Years _____
(Do not state 'retired')

Type of Industry _____
(i.e. education/sales/medical)

Father's Name _____ Birthplace _____
First Middle Last (State or Foreign Country)

Mother's Maiden Name _____ Birthplace _____
First Middle Last (State or Foreign Country)

Veteran: Branch of Service _____ Date of enlistment _____ Date of Discharge _____ Serial No: _____

Type of Disposition Requested _____
Burial, Cremation with ashes returned to family, Cremation with burial,

Place of Disposition _____
Name of cemetery where deceased is to be buried or place where ashes will be buried/scattered

Final Resting Place (*Ashes only*) _____
Name of cemetery or person's name & address where ashes will be returned

Physician's full name: _____ Tel: _____ FAX: _____

Physician's Address: _____
Street Address City State Zip

Hospice _____ Phone: _____ Contact: _____

Person providing information (*Informant*) _____
First Middle Last

Relationship to deceased _____ E-mail address: _____ Tel: _____

Address _____
Street City State Zip

Signature _____ Date _____