# 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 _______________________