**Documentation of Death**

**Deceased Name (First, Middle, Last, Suffix)**

**Prior to First Marriage**

**Also Known As**

<table>
<thead>
<tr>
<th>Date of Death</th>
<th>Sex</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Death</th>
<th>Age (in years)</th>
<th>Under 1 Year</th>
<th>Under 1 Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>months</td>
<td>days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hours</td>
<td>minutes</td>
</tr>
</tbody>
</table>

**Birth Country**

- Born in the United States
- Not U.S. Specify
- Unknown

**Birth Country**

- State/Province
- City/Town

**Deceased’s Residence Address**

- U.S. Address
- Foreign country
- Unknown

**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

**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

**Spouse’s Name**

(First, Middle)

**Last Name Prior to First Marriage**

**Father’s Name (First, Middle, Last, Suffix)**

**Mother’s Name (First, Middle, Suffix)**

**Last Name Prior to 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

**Method of Disposition**

- Burial
- Cremation
- Donation
- Entombment
- Removal from State
- Other (Specify)

**Physician/ME Providing Cause of Death Information (First, Middle, Last)**

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

**Funeral Home/Other Institution, Estab. #**

**Funeral Director Name (First, Middle, Last)**

**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**
<table>
<thead>
<tr>
<th>Deceased Name (First, Middle, Last, Suffix)</th>
<th>Also Known As</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Medical Examiner providing this information</td>
<td>Title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Date of Death</th>
<th>Time of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YYYY</td>
<td>MM DD YYYY</td>
<td>MM DD YYYY</td>
</tr>
</tbody>
</table>

Was the Medical Examiner Contacted?  
- Yes  
- No  
Date last saw deceased:  

Did INJURY or TRAUMA contribute to the cause of death?  
- Yes  
- No  
If Yes, please explain:  

Is there any reason to postpone final disposition?  
- Yes  
- No  
If Yes, please explain:  

### Cause of Death

**Part I** Enter the chain of events—diseases, injuries, or complications that directly caused death. Do not enter terminal events such as cardiac arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause per line. Add additional lines if necessary.

**IMMEDIATE CAUSE** (final disease or condition resulting in death)

a.  
Due to (or as a consequence of)

b.  
Due to (or as a consequence of)

c.  
Due to (or as a consequence of)

d.  
Due to (or as a consequence of)

**UNDERLYING CAUSE** (disease or injury that initiated events resulting in death)

**LAST**

**Part II** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Was an autopsy performed?  
- Yes  
- No  
Autopsy Results Available to complete the cause of death?  
- Yes  
- No  

Did Tobacco use contribute to death?  
- Yes  
- No  
- Probably  
- Unknown  
If Female

- Not pregnant within past year  
- Pregnant at time of death  
- Not pregnant, but pregnant within 42 days of death  
- Not pregnant, but pregnant 43 days to 1 year before death  
- Unknown if pregnant within the past year  
Manner of Death  
- Natural  
- Accident  
- Suicide  
- Homicide  
- Pending Investigation  
- Could not be determined  

**Complete injury information below if Manner of Death is not Natural**

Date of Injury  

<table>
<thead>
<tr>
<th>MM DD YYYY</th>
<th>Time of Injury</th>
<th>Injury at Work?</th>
<th>If Transportation Injury, specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>PM</td>
<td>Military</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Place of Injury (e.g., Deceased’s home, construction site, restaurant, wooded area)

Location of Injury (Street & Number, Apt. #, City or Town, State, Zip Code)

Describe How Injury Occurred

Completed by: ___________________________  
Signature: ___________________________  
Date: ___________________________  

Form # D102 Dec/2013