

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-017413

FILED VS APR 22 1960

2 4063

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS (if outside, give location)		
a. COUNTY b. CITY OR TOWN c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION			a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS (if outside, give location)		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last			<b>4. DATE OF DEATH</b> Month Day Year		
First Middle Last Type or print			Month Day Year		
<b>5. SEX</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		<b>6. COLOR OR RACE</b> Negro <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Negro <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/>		Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country)
Give kind of work done during most of working life, even if retired			Kind of business or industry		City and state or country
<b>13a. FATHER'S NAME</b>		<b>13b. MOTHER'S MAIDEN NAME</b>		<b>14. NAME OF HUSBAND OR WIFE</b>	
Name		Maiden name		Name	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address
Yes, no, or unknown (If yes, give war or dates of service)			Social Security No.		Informant Address
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)					Interval between onset and death
DUE TO (b)					Interval between onset and death
DUE TO (c)					Interval between onset and death
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other significant conditions contributing to death				Pregnancy in last 90 days	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
Was autopsy performed?	Accident Suicide Homicide		Describe how injury occurred		
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year			<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
Time of injury			Injury occurred while at work?		
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	
Place of injury		City, town, or location		County	
<b>21. I attended the deceased from _____ to _____ and last saw him alive on _____</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title)			<b>22b. ADDRESS</b>		<b>22c. DATE SIGNED</b>
Signature			Address		Date signed
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town, or county) (State)
Burial, cremation, removal		Date	Name of cemetery or crematory		Location
<b>24. FUNERAL DIRECTOR</b> ADDRESS			<b>25. DATE REG. BY LOCAL REG.</b>		<b>26. REGISTRAR'S SIGNATURE</b>
Funeral director address			Date reg. by local reg.		Registrar's signature

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.