BIOGRAPHICAL INFORMATION REQUIRED FOR COMPLETING A DEATH CERTIFICATE

FULL NAME (*First*) (*Middle*) (*Maiden*) (*Last*) (*Suffix*)

SEX Male ☐ Female ☐

DATE OF DEATH (*mo.*) (*day*) (*year*)
(or today's date if completing form prior to death)

AGE years

DATE OF BIRTH (*mo.*) (*day*) (*year*)

MILITARY SERVICE Yes ☐ No ☐

BRANCH: Navy ☐ Coast Guard ☐ Marine ☐ Air Force ☐ Army ☐

STATE (OR FOREIGN COUNTRY) OF RESIDENCE

COUNTY OF RESIDENCE (If Independent city, leave blank)

CITY OR TOWN OF RESIDENCE

Inside City or Town limits? Yes ☐ No ☐

STREET ADDRESS or RT. NO. OF RESIDENCE ZIP CODE

NAME OF FATHER (first) (middle) (last) (suffix)

NAME OF MOTHER (include MAIDEN NAME) (first) (middle) (maiden) (last)

RACE

OF HISPANIC ORIGIN? If yes, specify Cuban, Mexican, Puerto Rican, etc...
No ☐ Yes ☐ _____

EDUCATION (Specify only highest grade completed)
Grade(0-12)_____ Diploma ☐ GED ☐ College (1-4 or 5+)_____
Assoc..Degree ☐ Bach. Degree ☐ Master ☐ PhD ☐

CITIZEN OF WHAT COUNTRY

BIRTHPLACE (state or country only)

NEVER MARRIED ☐ DIVORCED ☐ MARRIED ☐ WIDOWED ☐

IF MARRIED OR WIDOWED, NAME OF SPOUSE (If divorced leave blank)

SOCIAL SECURITY NUMBER

USUAL OR LAST OCCUPATION

KIND OF BUSINESS OR INDUSTRY

NAME OF BUSINESS OR INDUSTRY

NAME OF CEMETERY (If applicable)

ADDRESS OF CEMETERY (If applicable)

NAME OF MINISTER (If applicable)

NAME OF RESPONSIBLE PERSON / INFORMANT

ADDRESS OF RESPONSIBLE PERSON / INFORMANT

HOME PHONE OF RESPONSIBLE PERSON / INFORMANT

CELL NUMBER

OTHER NUMBER

EMAIL OF RESPONSIBLE PERSON / INFORMANT

IF THE RESPONSIBLE PERSON KNOWS OF ANYONE WITH EQUAL OR GREATER RIGHTS AS NEXT OF KIN, YOU MUST LIST THEM BELOW WITH CONTACT INFO.

NAME:_____RELATIONSHIP:_____ PHONE OR EMAIL:_____

NAME:_____RELATIONSHIP:_____ PHONE OR EMAIL:_____

NAME:_____RELATIONSHIP:_____ PHONE OR EMAIL:_____

NAME:_____RELATIONSHIP:_____ PHONE OR EMAIL:_____

NAME:_____RELATIONSHIP:_____ PHONE OR EMAIL:_____

NAME:_____RELATIONSHIP:_____ PHONE OR EMAIL:_____

NAME:_____RELATIONSHIP:_____ PHONE OR EMAIL:_____

The following information is required if you are completing this information after a death has occurred, but not if doing Pre-Need.

NAME OF ATTENDING PHYSICIAN

ADDRESS OF ATTENDING PHYSICIAN

OFFICE PHONE NUMBER OF PHYSICIAN

OFFICE FAX NUMBER OF PHYSICIAN

CELL NUMBER OF PHYSICIAN

EMAIL OF PHYSICIAN

NAME OF HOSPITAL OR INSTITUTION of DEATH (If residence – describe: i.e. own home, son's home, etc.)

COUNTY (If Independent city, leave blank)

CITY OR TOWN

Inside City or Town limits? Yes ☐ No ☐

STREET ADDRESS OR RT. NO.