



INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No.

State No.

1. Decedent's Legal Name (First, Middle, Last)				1a. Maiden Last Name (If Female)		2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)	
5. Social Security Number	6a. Age - Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year)		8. Birthplace (City And State Or Foreign Country)	
	Months	Days	Hours	Minutes					
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival				10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (If Not Institution, Give Street And Number)									
12. City Or Town, State, And Zip Code					13. County Of Death			14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name			15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation			17. Kind Of Business/Industry	
18. Residence - State		18a. County			18b. City Or Town			18c. Street And Number	18d. Apt. No.
							18e. Zip Code	18f. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education			20. Decedent Of Hispanic Origin			21. Decedent's Race			
22. Father's Name (First, Middle, Last)				23. Mother's Name (First, Middle, Last)			23a. Mother's Maiden Last Name		
24. Informant's Name		24a. Relationship To Decedent		24b. Mailing Address (Street And Number, City, State, Zip Code)					
25. Place Of Disposition									
25a. Method Of Disposition: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)			25c. Location - City, Town, And State				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility					27a. Funeral Home License Number:		
27b. Signature Of Indiana Funeral Service Licensee:					27c. License Number (Of Licensee):				
Cause Of Death (See Instructions And Examples)									
28. Part I. Enter The <u>Chain Of Events</u> —Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.								Approximate Interval: Onset To Death	
Immediate Cause (Final Disease Or Condition Resulting In Death)								A. _____ Due To (Or As A Consequence Of):	
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last								B. _____ Due To (Or As A Consequence Of):	
								C. _____ Due To (Or As A Consequence Of):	
								D. _____ Due To (Or As A Consequence Of):	
Part II. Enter Other <u>Significant Conditions Contributing To Death</u> But Not Resulting In The Underlying Cause Given In Part I						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			38. Apt. No.	38a. Zip Code	
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number			38c. Apt. No.	38d. Zip Code	
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)			
41. Signature, Of Person Certifying Cause Of Death:					42. Certifier (Check Only One) <input type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death:						44. License Number		45. Date Certified	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature Of Local Health Officer:					49. For Registrar Only - Date Filed (Month/Day/Year):				