

STATE OF OKLAHOMA CERTIFICATE OF DEATH

STATE FILE NUMBER

1. DECEDENT'S LEGAL NAME (First, Middle, Last, Suffix)				1a. LAST NAME PRIOR TO FIRST MARRIAGE		2. SEX					
3. SOCIAL SECURITY NUMBER		4. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		5a. AGE- Last birthday (years)		5b. UNDER 1 YEAR		5c. UNDER 1 DAY		6. DATE OF BIRTH (Mo/Day/Yr)	
				Months		Days		Hours		Minutes	
7. BIRTHPLACE (City and State or Foreign Country)				8a. RESIDENCE-State				8b. RESIDENCE-County		8c. RESIDENCE-City or Town	
8d. RESIDENCE-Zip Code			8e. RESIDENCE-Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No			8f. RESIDENCE-Street and Number			8g. RESIDENCE-Apt. Number		
9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married, but separated <input type="checkbox"/> Unknown						10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)					
11. FATHER'S NAME (First, Middle, Last)						12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)					
13. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the 'No' box if the decedent is not Spanish/Hispanic/Latino) <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (specify) _____				14. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native _____ (Name of the enrolled or principal tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____				15. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death.) <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th - 12 th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's degree (e.g. MEd, MA, MS, MEng, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, JD)			
16. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED.)						17. KIND OF BUSINESS / INDUSTRY					
18a. INFORMANT'S NAME				18b. RELATIONSHIP TO DECEDENT				18c. MAILING ADDRESS (Street and Number, City, State, Zip Code)			
19. 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) _____				20. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)				21. LOCATION - City, Town and State			
22. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY						23. SIGNATURE OF FUNERAL HOME DIRECTOR OR FAMILY MEMBER ACTING AS SUCH					
						24. FH ESTABLISHMENT LICENSE #					

DATE OF DEATH: _____
To be completed by the Funeral Home

DECEDENT'S LEGAL NAME: _____

PHYSICIAN'S NAME: _____

Type or print with black, permanent ink. THIS IS A PERMANENT RECORD.

25. PLACE OF DEATH (Check only one: see instructions)													
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival						IF DEATH OCCURRED OTHER THAN IN A HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (specify): _____							
26. FACILITY NAME (If not institution, give street & number)						27. CITY OR TOWN, STATE AND ZIP CODE OF LOCATION OF DEATH				28. COUNTY OF DEATH			
29. DATE OF DEATH (Mo/Day/Yr)			30. TIME OF DEATH			31. WAS MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No			32. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No		33. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
34. 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. 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. b. _____ Due to (or as a consequence of): Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST . c. _____ Due to (or as a consequence of): d. _____										Approximate interval: Onset to death: _____		35. PART II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I.	
36. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				37. 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				38. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
39. DATE OF INJURY (Mo/Day/Yr)			40. TIME OF INJURY			41. PLACE OF INJURY (e.g., Decedent's home; construction site; wooded area)			42. DESCRIBE HOW INJURY OCCURRED:		43. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		
44. LOCATION OF INJURY: State: _____ City or Town: _____ Zip Code: _____ Street & Number: _____ Apartment Number: _____						45. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (specify) _____							
46. CERTIFIER (Check only one): ATTENDING PHYSICIAN: <input type="checkbox"/> Physician in charge of the patient's care <input type="checkbox"/> Physician in attendance at time of death only To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature of Certifier: _____						47. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 34)							
						48. LICENSE NUMBER		49. DATE CERTIFIED (Mo/Day/Yr)					
50. REGISTRAR'S SIGNATURE						52. DATE RECEIVED BY STATE REGISTRAR (Mo/Day/Yr)							

Note to the Attending Physician: Do not sign unless the death occurred due to a natural disease process. Unnatural deaths are the responsibility of the Medical Examiner. To be completed by the Attending Physician or Medical Examiner