

## DEATH CERTIFICATE INFORMATION

(This information must be correct, it can take 4 to 6 weeks to correct after certified copies are issued)

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

|   | DECEDENT'S NAME   |  |  |  | PERMIT NUMBER  | CASE NUMBER     |             |   |  |  |  |   |  |  |  |  |
|---|---|--|--|--|--|-----------------|-------------|---|--|--|--|---|--|--|--|--|
| DECEDENT  | FIRST   | MIDDLE                                   | LAST   |  |  |                 |             |   |  |  |  |   |  |  |  |  |
|   | SEX   |  | DATE OF DEATH (Month, Day, Year)   |  | SOCIAL SECURITY NUMBER   |                 |             |   |  |  |  |   |  |  |  |  |
|   | AGE-Last Birthday (years)                                       |  | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">UNDER 1 YEAR</th> <th colspan="2">UNDER 1 DAY</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Minutes</td> </tr> </table> |  | UNDER 1 YEAR   |                 | UNDER 1 DAY |   | Months                                 | Days                                     | Hours  | Minutes   | DATE OF BIRTH (Month, Day, Year)         |  |  |  |
| UNDER 1 YEAR  |   | UNDER 1 DAY                              |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| Months  | Days  | Hours                                    | Minutes  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| BIRTHPLACE (City and State or Foreign Country)  |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)   |   |  |  | Branch of Service  |  |                 |             |   |  |  |  |   |  |  |  |  |
| PLACE OF DEATH (Check only one)   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>HOSPITAL <input type="checkbox"/> Inpatient</td> <td><input type="checkbox"/> ER/Outpatient</td> <td><input type="checkbox"/> Dead On Arrival</td> </tr> <tr> <td>NON-HOSPITAL <input type="checkbox"/> Hospice Facility</td> <td><input type="checkbox"/> Nursing Home / Long Term Care Facility</td> <td><input type="checkbox"/> Decedent's Home</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other (specify) _____</td> </tr> </table>  |   |  |  |  |  |                 |             | HOSPITAL <input type="checkbox"/> Inpatient | <input type="checkbox"/> ER/Outpatient | <input type="checkbox"/> Dead On Arrival | NON-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) _____ |  |  |
| HOSPITAL <input type="checkbox"/> Inpatient   | <input type="checkbox"/> ER/Outpatient                          | <input type="checkbox"/> Dead On Arrival |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| NON-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) _____  |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| INSIDE CITY LIMITS? (Yes or No)   |   |  |  | FACILITY NAME (If not institution, give street and number)   |  |                 |             |   |  |  |  |   |  |  |  |  |
| CITY, TOWN OR LOCATION OF DEATH   |   |  |  | COUNTY OF DEATH  |  |                 |             |   |  |  |  |   |  |  |  |  |
| DECEDENT'S USUAL OCCUPATION   |   |  |  | KIND OF BUSINESS/INDUSTRY  |  |                 |             |   |  |  |  |   |  |  |  |  |
| MARITAL STATUS (Specify)  |   |  |  | RESIDENCE-STATE  |  |                 |             |   |  |  |  |   |  |  |  |  |
| <input type="checkbox"/> Married <input type="checkbox"/> Married, but Separated <input type="checkbox"/> Widowed<br><input type="checkbox"/> Divorced <input type="checkbox"/> Never Married   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| SURVIVING SPOUSE (if wife, give maiden name)  |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| COUNTY  |   | CITY, TOWN OR LOCATION                   |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| STREET AND NUMBER   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| INSIDE CITY LIMITS? (Yes or No)   |   | ZIP CODE                                 |  | WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes - If yes, specify Haitian, Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes |  |                 |             |   |  |  |  |   |  |  |  |  |
| DECEDENT'S RACE (Specify race(s) indicating what the decedent considered him/herself to be. More than (1) may be specified.)<br><input type="checkbox"/> White <input type="checkbox"/> Black/African Amer. <input type="checkbox"/> Asian/Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino<br><input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____<br><input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guam./Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Isl. (Specify) _____<br><input type="checkbox"/> Amer. Indian/Alaskan Native (specify tribe) _____ <input type="checkbox"/> Other (Specify) _____ |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| DECEDENT'S EDUCATION (Specify the highest degree/level of school completed at time of death.)<br><input type="checkbox"/> 8th or less <input type="checkbox"/> High School, but no diploma <input type="checkbox"/> High School Diploma/GED<br><input type="checkbox"/> College, but no degree <input type="checkbox"/> College Degree (Specify): _____<br><input type="checkbox"/> Associate's <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate  |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| FATHER'S NAME (First, Middle, Last)   |   |  |  | MOTHER'S NAME (First, Middle, Maiden Surname)  |  |                 |             |   |  |  |  |   |  |  |  |  |
| INFORMANT'S NAME (Type/Print)   |   |  |  | RELATIONSHIP TO DECEDENT   |  |                 |             |   |  |  |  |   |  |  |  |  |
| MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
|   |   |  |  |  | METHOD OF DISPOSITION  |                 |             | DISPOSITION                                 |  |  |  |   |  |  |  |  |
|   |   |  |  |  | <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal From State <input type="checkbox"/> Donation<br><input type="checkbox"/> Other (Specify) _____ |                 |             |   |  |  |  |   |  |  |  |  |
|   |   |  |  |  | PLACE OF DISPOSITION (Name of Cemetery, Crematory or Other Place)  |                 |             |   |  |  |  |   |  |  |  |  |
| LOCATION - City or Town, State  |   |  |  |  | HOUR OF DEATH  |                 |             |   |  |  |  |   |  |  |  |  |
|   |   |  |  |  | M  |                 |             |   |  |  |  |   |  |  |  |  |
| NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)   |   |  |  |  |  |                 |             | CERTIFIER                                   |  |  |  |   |  |  |  |  |
| Phone: _____  |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print)   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| Phone: _____  |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| WAS AN AUTOPSY PERFORMED? (Yes or No)   |   |  |  | CASE REPORTED TO MEDICAL EXAMINER (Yes or No)  |  |                 |             |   |  |  |  |   |  |  |  |  |
|   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| TOTAL # OF DEATH CERTIFICATES:  |   |  |  | WITH (Long)  |  | WITHOUT (Short) |             |   |  |  |  |   |  |  |  |  |
|   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| Spouse Information  |   |  |  |  |  |                 |             | SPOUSE INFORMATION                          |  |  |  |   |  |  |  |  |
| PHONE NUMBER  |   |  |  | CAN BE CONTACTED   |  |                 |             |   |  |  |  |   |  |  |  |  |
|   |   |  |  | YES NO   |  |                 |             |   |  |  |  |   |  |  |  |  |
| SOCIAL SECURITY NUMBER  |   |  |  | DATE OF BIRTH  |  |                 |             |   |  |  |  |   |  |  |  |  |
| OTHER INFORMATION TO BE VERIFIED (Enter Line Number)  |   |  |  |  |  |                 |             | OTHER INFORMATION                           |  |  |  |   |  |  |  |  |
|   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
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|   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| DATE APPROVED   |   |  |  |  | TIME APPROVED  |                 |             | APPROVED BY SIGNATURE                       |  |  |  |   |  |  |  |  |
|   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
| APPROVED BY SIGNATURE   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |
|   |   |  |  |  |  |                 |             |   |  |  |  |   |  |  |  |  |

PARENTS



# BREWER & SONS

Funeral Homes & Cremation Services

*A Family Owned Service Company*

## FOLLOW-UP PROGRAM QUICK REFERENCE GUIDE FOR CERTIFIED COPIES OF DEATH CERTIFICATE

TOTAL

\_\_\_\_\_  
NAME OF DECEASED

### Section One: Require Cause of Death

#### **SOCIAL SECURITY** 1-800-772-1213

\_\_\_\_\_ Death Certificate needed. (Funeral Home will Contact.)

#### **VETERANS ADMINISTRATION** 1-800-827-1000

\_\_\_\_\_ Number of Death Certificates needed.

#### **PENSIONS**

\_\_\_\_\_ Number of Death Certificates needed.

#### **LIFE INSURANCE POLICIES**

\_\_\_\_\_ Number of Death Certificates needed.

#### **LIFE INSURANCE ON MORTGAGES, LOANS & CREDIT CARDS**

\_\_\_\_\_ Number of Death Certificates needed.

#### **FUNERAL PREARRANGEMENTS, INSURANCE POLICY**

\_\_\_\_\_ Number of Death Certificates needed.

#### **FAMILY MEMBERS**

\_\_\_\_\_ Number of Death Certificates needed.

**TOTAL** \_\_\_\_\_ Long; With Cause of Death

### Section Two: Cannot Have Cause of Death (Right of Privacy Laws Prevent Certificates from Having a Cause of Death)

#### **BANK ACCOUNTS**

\_\_\_\_\_ Number of Death Certificates needed.

#### **REAL ESTATE**

\_\_\_\_\_ Number of Death Certificates needed.

#### **WIDOW OR WIDOWER'S EXEMPTION ON PROPERTY TAX**

\_\_\_\_\_ Death Certificate needed.

#### **MOBILE HOME**

\_\_\_\_\_ Number of Death Certificates needed.

#### **AUTOMOBILES**

\_\_\_\_\_ Number of Death Certificates needed.

#### **STOCKS, BONDS & MUTUAL FUNDS**

\_\_\_\_\_ Number of Death Certificates needed.

#### **PROBATE ATTORNEY OR TRUST FUND**

\_\_\_\_\_ Number of Death Certificates needed.

**TOTAL** \_\_\_\_\_ Short; Without Cause of Death

WITH "Long"

WITHOUT "Short"