Appendix D: Sample Forms

TYPE OR PRINT IN PERMANENT BLACK INK.

I.D. TAG NO.

Local File Number

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS

CERTIFICATE OF DEATH

136-

State File Number

SAMPLE

DECEDENT

1. DECEDENT'S NAME First | Middle | Last
2. SEX
3. DATE OF DEATH *(Month, Day, Year)*
4. SOCIAL SECURITY NUMBER
5a. AGE-Last Birthday *(Years)*
5b. Under 1 Year — Mos. | Days
5c. Under 1 Day — Hours | Mins.
6. BIRTHPLACE *(City and State or Foreign Country)*
7. DATE OF BIRTH *(Month, Day, Year)*
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No
9a. PLACE OF DEATH *(Check one only.)* HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other *(Specify)*
9b. FACILITY NAME *(If not an institution, give street and number.)*
9c. CITY, TOWN, OR LOCATION OF DEATH
9d. COUNTY OF DEATH
10a. DECEDENT'S USUAL OCCUPATION *(Give kind of work done during most of working life. Do not use retired.)*
10b. KIND OF BUSINESS/INDUSTRY
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced. *(Specify)*
12. SPOUSE *(If Married, Widowed)*
13a. RESIDENCE - STATE
13b. COUNTY
13c. CITY, TOWN OR LOCATION
13d. STREET AND NUMBER
13e. INSIDE CITY LIMITS? ☐ Yes ☐ No
13f. ZIP CODE
14. WAS DECEDENT OF HISPANIC ORIGIN? *(Specify No or Yes) If yes, specify Cuban, Mexican, Puerto Rican, etc.* ☐ No ☐ Yes
15. RACE American Indian, Black, White, etc. *(Specify)*
16. DECEDENT'S EDUCATION *(Specify only highest grade completed.)* Elementary/Secondary (0-12) | College (1-4 or 5+)

PARENTS

17. FATHER'S NAME First | Middle | Last
18. MOTHER'S NAME First | Middle | Maiden
19. INFORMANT'S NAME and relationship to deceased

DISPOSITION

20a. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Mausoleum ☐ Removal from State ☐ Donation ☐ Other *(Specify)*
20b. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place.)*
20c. LOCATION (City or Town, State)
21a. SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
21b. OREGON LICENSE NO. *(Of Licensee)*
22. NAME, ADDRESS AND ZIP CODE OF FACILITY

REGISTRAR

23. DATE FILED *(Month, Day, Year)*
24. REGISTRAR'S SIGNATURE

RESERVED FOR REGISTRAR'S USE

1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____ 9. ____

CERTIFIER

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH M
28. WAS MEDICAL EXAMINER NOTIFIED? (The Medical Examiner MUST be notified of all injury and poisoning deaths.) ☐ Yes ☐ No
29. To the best of my knowledge, death occurred at the time, date, place, and due to the cause(s) and manner stated. *(Signature)*
30. DATE SIGNED *(Month, Day, Year)*

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH M
31b. DATE PRONOUNCED DEAD *(Month, Day, Year, Hour)* M
32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place, and due to the cause(s) and manner stated. *(Signature)*
33. DATE SIGNED *(Month, Day, Year)* COUNTY

34. NAME, TITLE, ADDRESS AND ZIP CODE OF CERTIFIER/MEDICAL EXAMINER *(Type or Print)*
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER *(Type or Print)*

10. ____ 11. ____ 12. ____ 13. ____ 14. ____

CAUSE OF DEATH

DESIGNATE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE, STATING THE *UNDERLYING CAUSE LAST.*

36. IMMEDIATE CAUSE *(ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) Do not enter mode of dying (e.g., Cardiac or Respiratory Arrest).*

PART I
(a) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(b) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(c) — Interval between onset and death

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.

37. Did tobacco use contribute to the death? ☐ Yes ☐ Probably ☐ No ☐ Unknown
38. AUTOPSY ☐ Yes ☐ No
39. IF YES, were findings considered in determining cause of death? ☐ Yes ☐ No ☐ N/A
40. MANNER OF DEATH ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Undetermined Manner ☐ Suicide ☐ Homicide ☐ Legal Intervention
41a. DATE OF INJURY *(Month, Day, Year)*
41b. TIME OF INJURY M
41c. INJURY AT WORK? ☐ Yes ☐ No
41d. DESCRIBE HOW INJURY OCCURRED
41e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. *(Specify)*
41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

15. ____ 16. ____

CAUSE OF DEATH INSTRUCTIONS ARE ON REVERSE SIDE OF GREEN AND PINK COPY.

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ORIGINAL-VITAL STATISTICS COPY

45-2 (08/03)