TYPE OR PRINT IN PERMANENT BLACK INK.

I.D. TAG NO.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

1. Legal Name (Include AKAs, if any) First / Middle / Last / Suffix					**2.** Death Date (MON DD YYYY)
3. Sex (M/F)	**4a.** Age – Last Birthday	**4b.** Under 1 Year Months / Days	**4c.** Under 1 Day Hours / Minutes	**5.** Social Security Number	**6.** County of Death
7. Birthdate (MON DD YYYY)	**8a.** Birthplace (City/Town, or County)	**8b.** (State or Foreign Country)		**9.** Decedent's Education	
10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.)	**11.** Decedent's Race(s)			**12.** Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☐ No	
13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8)				**14.** City/Town	
15. Residence County	**16.** State or Foreign Country	**17.** Zip Code + 4		**18.** Inside City Limits? ☐ Yes ☐ No ☐ Unknown	
19. Marital Status at Time of Death	**20.** Spouse's Name (If married or widowed, give name prior to first marriage.)				
21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.")				**22.** Kind of Business/Industry (DO NOT USE COMPANY NAME.)	
23. Father's Name (First, Middle, Last, Suffix)				**24.** Mother's Name Prior to First Marriage (First, Middle, Last)	
25. Informant's Name	**26.** Telephone Number	**27.** Relation to Decedent	**28.** Mailing Address (Number & Street, City/Town, State, Zip + 4)		
29. Place of Death	**30.** Facility Name				
31. Location of Death (Give address.)	**32.** City/Town or Location of Death	**33.** State	**34.** Zip Code + 4		
35. Method of Disposition	**36.** Place of Disposition (Name of cemetery, crematory, or other place)	**37.** Location			
38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4)					
39. Date of Disposition (MON DD YYYY)	**40. Funeral Director's Signature** ▶	**41.** OR License Number			
42. Registrar's Signature ▶	**43. Date Received** (MON DD YYYY)	**44.** Local File Number			
45. Record Amendment					

TO BE COMPLETED BY MEDICAL CERTIFIER

46. Was case referred to Medical Examiner? ☐ Yes ☐ No	**47.** Autopsy? ☐ Yes ☐ No	**48.** Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No	**49.** Time of Death	
CAUSE OF DEATH (See instructions and examples.)				
50. Enter the chain of events - 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.				Approximate Interval: Onset to Death
Final disease or condition resulting in death→	**IMMEDIATE CAUSE** ↓ a.			
Sequentially list conditions, if any, leading to the cause listed on line a.	Due to (or as a consequence of) ↓ b.			
ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).	Due to (or as a consequence of) ↓ c.			
	Due to (or as a consequence of) ↓ d.			
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:				
52. Manner of Death ☐ Natural ☐ Homicide ☐ Accident ☐ Undetermined ☐ Suicide ☐ Pending	**53.** If Female ☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Unknown if pregnant within the past year ☐ Not pregnant, but pregnant within 42 days before death		**54.** Did tobacco use contribute to death? ☐ Yes ☐ Probably ☐ No ☐ Unknown	
55. Date of Injury (MON DD YYYY)	**56.** Time of Injury	**57.** Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)	**58.** Injury at Work? ☐ Yes ☐ No ☐ Unknown	
59. Location of Injury (Number & Street, City/Town, State, Zip + 4)				
60. Describe how injury occurred.			**61.** If transportation injury, specify. ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____	
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4)				
63. Name and Title of Attending Physician if Other than Certifier				
64. Title of Certifier	**65.** License Number	**66.** Date Signed (MON DD YYYY)		
67. Medical Certifier – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ▶	**68.** 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. ▶			
69. Record Amendment				

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