

COMMONWEALTH OF VIRGINIA - CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS - RICHMOND

COPY A

FOR DIVISION OF VITAL RECORDS

REGISTRATION AREA NUMBER	CERTIFICATE NUMBER	MEDICAL EXAMINER'S CERTIFICATE	STATE FILE NUMBER
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DECEDENT	1. FULL NAME OF DECEDENT (first) (middle) (last)			2 SEX male female	
	3. DATE OF DEATH (mo.) (day) (year)	4. AGE (years)	IF UNDER 1 YEAR (months) (days)	IF UNDER 1 DAY (hours) (minutes)	5. DATE OF BIRTH (mo.) (day) (year)

PLACE OF DEATH	7. NAME OF HOSPITAL OR INSTITUTION OF DEATH (if none, so state)			DOA <input type="checkbox"/>	Out Pat. Emer Rm <input type="checkbox"/>	Inpatient <input type="checkbox"/>	8. COUNTY OF DEATH (if independent city, leave blank)
	9. CITY OR TOWN OF DEATH			inside city or town limits? (yes) (no)	10. STREET ADDRESS OR RT. NO. OF PLACE OF DEATH		

USUAL RESIDENCE OF DECEDENT	11. STATE (OR FOREIGN COUNTRY) OF DECEDENT'S RESIDENCE			12. COUNTY OF DECEDENT'S RESIDENCE (if independent city, leave blank)		
	13. CITY OR TOWN OF RESIDENCE			inside city or town limits? (yes) (no)	14. STREET ADDRESS OR RT. NO. OF RESIDENCE	

PERSONAL DATA OF DECEDENT	15. NAME OF DECEDENT'S FATHER			16. MAIDEN NAME OF DECEDENT'S MOTHER			
	17. RACE OF DECEDENT	18. OF HISPANIC ORIGIN? If yes, specify Cuban, Mexican, Puerto Rican, etc. (no) (yes)		19. EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
	20. CITIZEN OF WHAT COUNTRY	21. BIRTHPLACE (state or country)	22. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	23. IF MARRIED OR WIDOWED, NAME OF SPOUSE (if divorced leave blank)			
	24. SOCIAL SECURITY NUMBER	25. USUAL OR LAST OCCUPATION	26. KIND OF BUSINESS OR INDUSTRY	27. INFORMANT - OR SOURCE OF INFORMATION - RELATIONSHIP			

CAUSE OF DEATH TO MEDICAL EXAMINER:	28. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						INTERVAL BETWEEN ONSET AND 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 immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST (B) DUE TO (OR AS A CONSEQUENCE OF):						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						28a. AUTOPSY? AUTHORIZED BY (yes) (no)	

MEDICAL CERTIFICATION	28b. IF FEMALE, WAS THERE A PREGNANCY IN PAST 3 MONTHS? (yes) (no) (unknown)		28c. IF EXTERNAL CAUSE, IT WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH		28d. DESCRIBE HOW INJURY RELATING TO DEATH OCCURRED	
	28e. TIME OF INJURY (mo.) (day) (year) A.M. P.M.		28f. INJURY OCCURRED while at work <input type="checkbox"/> not while at work <input type="checkbox"/>		28g. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	
	28h. (city or town) (county) (state)		28i. I CERTIFY that I took charge of the remains described above, viewed the body, made inquiry and in my opinion death resulted at or about		28j. (AM) (PM) from	
	NATURAL CAUSES <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> UNDETERMINED <input type="checkbox"/> PENDING <input type="checkbox"/>		ACTUAL SIGNATURE		DATE SIGNED:	
NAME OF MEDICAL EXAMINER (Type or Print)			ADDRESS OF MEDICAL EXAMINER			

FUNERAL DIRECTOR	29. BURIAL <input type="checkbox"/> REMOVAL <input type="checkbox"/> CREMATION <input type="checkbox"/>			30. PLACE OF BURIAL, REMOVAL, ETC. (name of cemetery or crematory) (city or county) (state)		
	31. (Signature of funeral director or person legally filing this certificate) Funeral Service Licensee / Next of Kin			NAME OF FUNERAL HOME AND ADDRESS:		

REGISTRAR	32. (signature of registrar)	DATE RECORD FILED:
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