

DECEDENT'S BIRTH NO.

REGISTRATION DISTRICT NO.
REGISTERED NUMBER

STATE OF ILLINOIS

STATE FILE NUMBER

MEDICAL CERTIFICATE OF DEATH

Type or Print in PERMANENT INK See Funeral Directors, Hospital, or Physicians Handbook for INSTRUCTIONS

DECEASED-NAME FIRST MIDDLE LAST SEX DATE OF DEATH (MONTH, DAY, YEAR)

COUNTY OF DEATH AGE-LAST BIRTHDAY (YRS) UNDER 1 YEAR UNDER 1 DAY DATE OF BIRTH (MONTH, DAY, YEAR)

CITY, TOWN, TWP, OR ROAD DISTRICT NUMBER HOSPITAL OR OTHER INSTITUTION-NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) IF HOSP. OR INST, INDICATE D.O.A. OP/EMER. RM, INPATIENT (SPECIFY)

A DECEASED B C D E

BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY) MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) NAME OF SURVIVING SPOUSE (MAIDEN NAME, IF WIFE) WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO)

SOCIAL SECURITY NUMBER USUAL OCCUPATION KIND OF BUSINESS OR INDUSTRY EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED)

RESIDENCE (STREET AND NUMBER) CITY, TOWN, TWP, OR ROAD DISTRICT NO. INSIDE CITY (YES/NO) COUNTY

STATE ZIP CODE RACE (WHITE, BLACK, AMERICAN INDIAN, etc.) (SPECIFY) OF HISPANIC ORIGIN? (SPECIFY NO OR YES-IF YES, SPECIFY CUBAN, MEXICAN, PUERTO RICAN, etc.)

PARENTS

FATHER-NAME FIRST MIDDLE LAST MOTHER-NAME FIRST MIDDLE (MAIDEN) LAST

INFORMANT'S NAME (TYPE OR PRINT) RELATIONSHIP MAILING ADDRESS (STREET AND NO. OR R.F.D., CITY OR TOWN, STATE, ZIP)

1 2 3

18. PART I. Enter the diseases, 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.

CAUSE

Immediate Cause (Final disease or condition resulting in death) CONDITIONS, IF ANY WHICH GIVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.

4 5 N P

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I. AUTOPSY (YES/NO) WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (YES/NO)

DATE OF OPERATION, IF ANY MAJOR FINDINGS OF OPERATION IF FEMALE, WAS THERE A PREGNANCY IN PAST THREE MONTHS?

CERTIFIER

I (DID) (DID NOT) ATTEND THE DECEASED (MONTH, DAY, YEAR) AND LAST SAW HIM/HER ALIVE ON WAS CORONER OR MEDICAL EXAMINER NOTIFIED? (YES/NO) HOUR OF DEATH

TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED. DATE SIGNED (MONTH, DAY, YEAR)

22a. SIGNATURE NAME AND ADDRESS OF CERTIFIER (TYPE OR PRINT) ILLINOIS LICENSE NUMBER

22c. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (TYPE OR PRINT) NOTE: IF AN INJURY WAS INVOLVED IN THIS DEATH THE CORONER OR MEDICAL EXAMINER MUST BE NOTIFIED.

DISPOSITION

BURIAL, CREMATION, REMOVAL (SPECIFY) CEMETERY OR CREMATORY-NAME LOCATION CITY OR TOWN STATE DATE (MONTH, DAY, YEAR)

FUNERAL HOME NAME STREET AND NUMBER OR R.F.D. CITY OR TOWN STATE ZIP

25a. FUNERAL DIRECTOR'S SIGNATURE FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER

25b. LOCAL REGISTRAR'S SIGNATURE DATE FILED BY LOCAL REGISTRAR (MONTH, DAY, YEAR)

26a. FUNERAL DIRECTOR'S SIGNATURE DATE FILED BY LOCAL REGISTRAR (MONTH, DAY, YEAR)