**COMMONWEALTH OF VIRGINIA – CERTIFICATE OF DEATH**

DEPARTMENT OF HEALTH – DIVISION OF VITAL RECORDS - RICHMOND

REGISTRATION AREA NUMBER CERTIFICATE NUMBER STATE FILE NUMBER

1. FULL NAME OF DECEDENT (first) (middle) (last) (suffix)
2. SEX 3. DATE OF DEATH 4. DATE OF BIRTH 5. AGE IF UNDER 1 YEAR IF UNDER 1 DAY

**DECEDENT**

MALE FEMALE NOT DETERMINED ACTUAL PRESUMED APPROXIMATE FOUND ON

Years Months Days Hours Minutes

1. WAS DECEDENT EVER IN U.S. ARMED FORCES?

YES NO UNKNOWN

1. BIRTHPLACE (U.S STATE OR FOREIGN COUNTRY) 8. SOCIAL SECURITY NUMBER IF NO SSN, CHECK APPROPRIATE BOX

NONE NOT OBTAINABLE UNKNOWN

**USUAL RESIDENCE OF DECEDENT**

9. STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.) 10. CITY OR TOWN OF RESIDENCE INSIDE CITY OR TOWN LIMITS?

YES NO

11. COUNTY OF DECEDENT’S RESIDENCE (if independent city, leave blank) 12. U.S. STATE (OR FOREIGN COUNTRY) OF DECEDENT’S RESIDENCE 12a. ZIP CODE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 13. RACE OF DECEDENT **(**CHECK ONE OR MORE) |  |  | AMERICAN INDIAN OR ALASKAN NATIVE | (SPECIFY |
| WHITE BLACK OR AFRICAN AMERICAN | FILIPINO | KOREAN | OTHER PACIFIC ISLANDER (SPECIFY) |  |
| ASIAN INDIAN CHINESE | SAMOAN | VIETNAMESE | OTHER ASIAN (SPECIFY) |  |
| NATIVE HAWAIIAN GUAMANIAN OR CHAMORRO | JAPANESE | UNKNOWN | OTHER (SPECIFY) |  |

**PERSONAL DATA OF**

1. DECEDENT OF HISPANIC ORIGIN?

NON-HISPANIC CENTRAL OR SOUTH AMERICAN CUBAN MEXICAN PUERTO RICAN OTHER (SPECIFY)

UNKNOWN

**DECEDENT**

1. EDUCATION (HIGHEST GRADE COMPLETED) ELEMENTARY/SECONDARY (0-12)

HIGH SCHOOL DIPLOMA GED YEARS OF COLLEGE

ASSOCIATE DEGREE BACHELOR’S DEGREE MASTER’S DEGREE DOCTORATE/PROFESSIONAL DEGREE UNKNOWN

1. CITIZEN OF WHAT COUNTRY 17. USUAL OR LAST OCCUPATION 18. KIND OF BUSINESS OR INDUSTRY
2. MARITAL STATUS

NEVER MARRIED MARRIED WIDOWED DIVORCED SEPARATED UNKNOWN

1. IF MARRIED, SEPARATED OR WIDOWED, NAME OF SPOUSE (if divorced leave blank)
2. NAME OF DECEDENT’S FATHER (FIRST, MIDDLE, LAST, SUFFIX**)** 22. MOTHER’S FULL MAIDEN NAME (FIRST, MIDDLE, LAST)

**INFORMANT’S**

**DETAILS**

23. INFORMANT’S RELATIONSHIP OR SOURCE OF INFORMATION 24. FULL NAME OF INFORMANT OR NAME OF SOURCE

1. NAME OF HOSPITAL OR INSTITUTION OF DEATH (if none, so state) 25a. SELECT ONE IF DEATH OCCURRED IN HOSPITAL DOA OUT PAT. EMER RM INPATIENT

**PLACE OF DEATH**

1. SPECIFY IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL

HOSPICE FACILITY NURSING HOME LONG TERM CARE FACILITY DECEDENT’S HOME CORRECTIONAL FACILITY OTHER (SPECIFY)

1. CITY OR TOWN OF DEATH 28. STREET ADDRESS OR RT. NO OF PLACE OF DEATH 28a. ZIP CODE 28b. COUNTY OF DEATH (if independent city, leave blank)

**ONLY THE FOLLOWING MAY LEGALLY FILE A DEATH CERTIFICATE**

**LICENSED FUNERAL DIRECTOR/ LICENSEE**

**VIRGINIA STATE ANATOMICAL PROGRAM**

**NEXT OF KIN**

1. METHOD OF DISPOSITION

BURIAL ENTOMBMENT / MAUSOLEUM CREMATION / INCINERATION BURIAL AT SEA DONATION OTHER (SPECIFY) REMOVAL FROM STATE **(IF KNOWN, PLEASE ALSO CHECK FINAL METHOD OF DISPOSITION WHEN REMOVING FROM STATE, FROM OPTIONS SHOWN)**

1. PLACE OF DISPOSITION - NAME OF CEMETERY OR CREMATORY
2. PLACE OF DISPOSITION – STREET ADDRESS OF CEMETERY OR CREMATORY 31a. CITY / COUNTY 31b. STATE 31c. ZIP CODE 31d. COUNTRY
3. SIGNATURE OF FUNERAL DIRECTOR/LICENSEE , VSAP OR NEXT OF KIN (ACTUAL SIGNATURE) 32a. DIRECTOR/LICENSEE’S NO. 32b. NAME OF FUNERAL HOME OR FACILITY
4. NAME OF FUNERAL DIRECTOR / LICENSEE, VSAP OR NEXT OF KIN (TYPE OR PRINT) 33a.. STREET ADDRESS OF FUNERAL HOME / FACILITY, VSAP OR NEXT OF KIN (Include street address, city, state

and zip code)

**CAUSE OF DEATH** TO

PHYSICIAN:

Complete and sign medical certification (item **35-40a**) and return both copies to funeral director as soon as possible after determination of cause.

1. TIME OF DEATH: To the best of my knowledge, death occurred at –
2. PART I. Enter the diseases, injuri

|  |  |  |
| --- | --- | --- |
| es, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.  (A) | | INTERVAL BETWEEN ONSET AND DEATH |
| (B) | DUE TO (OR AS A CONSEQUENCE OF ): |  |
| (C) | DUE TO (OR AS A CONSEQUENCE OF ): |  |
| (D) | DUE TO (OR AS A CONSEQUENCE OF ): |  |

# IMMEDIATE CAUSE

(Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease

or injury that initiated events resulting in death) **LAST**

A.M. P.M. ACTUAL APPROXIMATE PRESUMED FOUND ON

NOTE: If

“Pending” must be indicated, so state in **PART**

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**I** and notify

1. WAS THE MEDICAL EXAMINER CONTACTED?

36a. AUTOPSY? 36b. WERE FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? 37. DID TOBACCO USE CONTRIBUTE TO DEATH?

registrar of final decision as soon as

YES NO

1. IF FEMALE:

YES NO YES NO

YES NO POSSIBLY UNKNOWN

possible

PREGNANT AT TIME OF DEATH UNKNOWN IF PREGNANT WITHIN THE PAST YEAR NOT PREGNANT, BUT PREGNANT WITHIN 42 DAYS OF DEATH

NOT PREGNANT WITHIN PAST YEAR NOT PREGNANT, BUT PREGNANT WITHIN 43 DAYS TO 1 YEAR BEFORE DEATH NOT APPLICABLE ( if decedent’s age is 0-5 or 75+ years)

1. IF EXTERNAL, TO WHAT EXTENT IT CONTRIBUTED TO CAUSE OF DEATH?
2. WAS THIS A MILITARY DEATH? 40a. IF MILITARY DEATH, SELECT MANNER OF DEATH

NATURAL ACCIDENT SUICIDE HOMICIDE UNDETERMINED PENDING

PRIMARY CONTRIBUTING YES NO

# ITEMS 41 TO 47 IN THIS SECTION SHOULD ONLY BE COMPLETED FOR MILITARY DEATHS

**INJURY INFORMATION**

To be filled

1. DATE OF INJURY 42. TIME OF INJURY

A.M. P.M

1. INJURY AT WORK?

YES NO UNKNOWN

1. PLACE OF INJURY (home, farm, factory, street, office, bldg, etc.)

out only for **MILITARY DEATHS**

1. LOCATION OF INJURY – STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.) 45a. CITY / COUNTY 45b. STATE 45c. ZIP CODE 45d. COUNTRY
2. IF TRANSPORTATION INJURY, SPECIFY DRIVER/OPERATOR PASSENGER PEDESTRIAN OTHER (SPECIFY)
3. DESCRIBE HOW INJURY RELATING TO DEATH OCCURRED
4. SIGNATURE OF PERSON COMPLETING THE CAUSE OF DEATH 48a. TITLE MEDICAL DOCTOR PHYSICIAN ASSISTANT DOCTOR OF OSTEOPATHY (D.O.).

NURSE PRACTITIONER OTHER

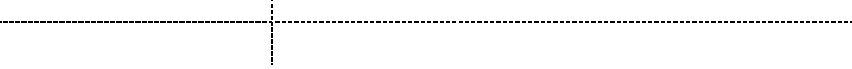
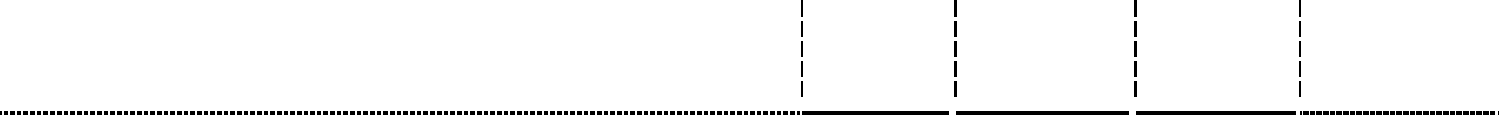
48b. DATE SIGNED:

**MEDICAL CERTIFICATION**

1. NAME OF PERSON PROVIDING THE MEDICAL CERTIFICATION OF DEATH **(Type or Print)** 49a. ADDRESS OF PERSON PROVIDING THE MEDICAL CERTIFICATION OF DEATH **(Type or Print)** 49b. MEDICAL LICENSE NO.
2. **ARE YOU A DESIGNEE?**

YES NO

1. IF YES, PLEASE PROVIDE THE NAME OF AUTHORIZING OR ABSENT PHYSICIAN 51a. ADDRESS OF AUTHORIZING PHYSICIAN
2. SIGNATURE OF REGISTRAR 52a. PRINTED NAME OF REGISTRAR 52b. DATE RECORD FILED:



**REGISTRAR**

1. RESERVED FOR REGISTRAR’S USE