CREMATION CARE OF ILLINOIS
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Release and Removal Authorization

Date_____

The undersigned, being of an authorized relation of the deceased, and having legal right, do hereby authorize_____ to release the remains of _____to
Cremation Care of Illinois.

Signature_____Relation_____
Address _____Phone #_____

Signature_____Relation_____

Address _____Phone#_____

The above person hereby represents that they are the same and nearest relation to the above- named deceased person and/or legally authorized representative to grant this permission.

Verbal Authorization was granted by_____
Funeral Director as Witness _____
_____

1404 N. Indigo Drive
Mt. Prospect, Illinois 60056

(847)401-0265