

Washington State Death Worksheet

Local File Number

State File Number

1. Legal Name (Include AKA's if any) First Middle LAST Suffix				2. Death Date(MM/DD/YYYY)	
				6. County of Death	
3. Sex (M/F)	4a. Age-Last Birthday (Years)	4b. Under 1 Year Months Days	4c. Under 1 Day Hours Minutes	5. Social Security Number	
12. Was Decedent ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		7. Birthdate (MM/DD/YYYY)		8a. Birthplace (City, Town, or County)	8b. (State or Foreign Country)
9. Decedent's Education-(Check the box that best describes the highest degree or level of school completed at the time of death.) <input type="checkbox"/> 8 th grade or less (Specify): _____ <input type="checkbox"/> 9 th - 12 th grade; no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree(e.g., AA, AS) <input type="checkbox"/> Bachelor's degree(e.g., BA, AB, BS) <input type="checkbox"/> Master's degree(e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate(e.g., PhD EdD) or Professional degree(e.g., MD, DDS, DVM, LLB, JD)		10. Was Decedent of Hispanic Origin? (Check the box that best describes whether the decedent was Spanish/Hispanic/Latino or check the "No" box if decedent was not Spanish/Hispanic/Latino.) <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify): _____		11. Decedent's Race (Check one or more races to indicate what the decedent considered himself or herself to be.) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe): _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian(Specify): _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify): _____ <input type="checkbox"/> Other (Specify): _____	
13a. Residence: Number and Street (e.g., 624 SE 5 th St.) (Include Apt. No.)				13b. City or Town	
13c. Residence: County		13d. Tribal Reservation Name (if applicable)	13e. State or Foreign Country		13f. Zip Code + 4
13g. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		14. Estimated length of time at residence. (Specify units (e.g., 6 years, 6 month, etc.))	15. Marital Status at Time of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
16. Surviving Spouse's Name (Give name prior to first marriage)					
17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED))			18. Kind of Business/Industry (Do not use Company Name)		
Parents' & Informant's Information					
19. Father's Name (First, Middle, Last, Suffix)			20. Mother's Name Before First Marriage (First, Middle, Last)		
21. Informant's Name			22. Relationship to Decedent		
23. Mailing Address: Number&Street or RFD No. City or Town State Zip					
Place of Death					
24. If Death Occurred in a Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival			If Death Occurred Somewhere Other than a Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify): _____		
25. Facility Name (If not a facility, give number & street)			26. City, Town, or Location of Death	26b. State	27. Zip Code
Disposition					
28. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Body not Recovered <input type="checkbox"/> Other(Specify): _____		29. Place of Disposition (Name of cemetery, crematory, other place)		30. Location-City/Town, and State	
31. Time of Death (24 Hours)	32. NJA/ME #	33. Doctor's Name		34. Doctor's Phone Number	
35. I understand that the information shown above will appear on the death certificate. By signing, I understand that the death certificate will be filed as it appears and that I am financially responsible for any changes I choose to make and any additional copies I may need ordered.					
X Signed _____		Relationship to Deceased _____		Date _____	

Part 1 completed by Funeral Director