STATE OF ILLINOIS REGISTRATION DISTRICT NO. **CERTIFICATE OF DEATH** OCAL FILE STATE FILE NUMBER NUMBER 1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) 2. SEX 3. DATE OF DEATH (Month/Day/Year) (Spell Month) 4. COUNTY OF DEATH 5a. AGE AT LAST BIRTHDAY (Years) 6. DATE OF BIRTH (Month/Day/Year) 5b. UNDER 1 YEAR 5c. UNDER 1 DAY 7a. CITY OR TOWN 7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) Standard Certificate 7c. PLACE OF DEATH (Check only one; see instructions) IF DEATH OCCURRED IN A HOSPITAL IF DEATH OCCURRED SOMEWHERE OTHER THAN HOSPITAL Hospice Facility Nursing Home/Long-Term care facility Inpatient Emergency Room/Outpatient Dead on Arrival Other (Specify): 8. BIRTHPLACE 11. SURVIVING SPOUSES NAME (If wife, give full name prior to first 12. EVER IN THE US ARMED FORCES? 9. SOCIAL SECURITY NUMBER 10. MARITAL STATUS AT TIME OF DEATH (City and State or Foreign Country) Married but separated Widow 2003 U.S. Never Married YES NO Divorced Unknown 13a. RESIDENCE (Street and Number) 13c. CITY OR TOWN 13b. APT. NO. 13d. INSIDE CITY LIMITS? Yes No the 13e, COUNTY 13f. STATE 13a, ZIP CODE 14. FATHER'S NAME (First, Middle, Last) 15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) 16a. INFORMANT'S NAME 16b. RELATIONSHIP 16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 17. METHOD OF DISPOSITION: Burial Entom 18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) 19. LOCATION - CITY, TOWN AND STATE 20. DATE OF DISPOSITION (Month/Dav/Year) Cremation Donation Other (Specify): 21a. FUNERAL HOME NAME STREET NUMBER CITY OR TOWN STATE ZIP 21b. FUNERAL DIRECTOR'S SIGNATURE 21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER Division of Vital 23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) 22. LOCAL REGISTRAR'S SIGNATURE CAUSE OF DEATH (See instructions and examples) APPROXMATE INTERVAL BETWEEN ONSET AND DEATH 24. PART I. Enter the *chain of events* - diseases, injuries or complications - that directly cause the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE**. Enter only one cause on a line. Add additional lines if necessary. Department of Public Health IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): equentially list conditions, if any, leading to the cause listed on lina a. Enter the UNDERLYING CAUSE Due to (or as a consequence of): (disease or injury initiated the events resulting in death) LAST Due to (or as a consequence of): PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I. Yes No 25. WAS AN AUTOPSY PERFORMED? 26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? Yes No 28. IF FEMALE: 27. DID TOBACCO USE 29. MANNER OF DEATH CONTRIBUTE TO DEATH? Yes Probably No Unknown Not pregnant within the past 12 months Not pregnant within 42 days of death Not pregnant, but pregnant 43 days to 1 year before death Pregnant at time of death Pregnant within one year of death but time unknown Unknown if pregnant within the past 12 months Suicide Homicide Natural Accident Pending Investigation 1/08) 31. TIME OF INJURY 32. PLACE OF INJURY (e.g. Decedent's home; construction site, restaurant, wooded area) 33. INJURY AT WORK? Yes No ☐ A.M. ☐ P.M. 34. LOCATION OF INJURY Street and Number Apartment Number City or Town State ZIP Code 35. DESCRIBE HOW INJURY OCCURRED: 36. IF TRANSPORTATION INJURY, SPECIFY Passenger Other (Specify) 37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE 38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? 39. DATE PRONOUNCED (Month/Day/Year) 40. TIME OF DEATH Yes No ☐ A.M. ☐ P.M. 41. CERTIFIER (Check only one) Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 42. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) 43. PHYSICIAN'S LICENSE NUMBER 44. TITLE OF CERTIFIER 45. DATE CERTIFIED (Month/Day/Year) 46. SIGNATURE OF CERTIFIER 47. DECEDENT'S EDUCATION - Check the box that best describes the highest degree or level of school completed at the time of death. 48. DECEDENT OF HISPANIC ORIGIN? - Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino. 49. DECEDENT'S RACE - Check one or more races to indicate what the decedent considered himself or herself to be. ☐ Black or African American White 8th grade or less No, Not Spanish/Hispanic/Latino American Indian or Alaskan Native 9th - 12th grade; no diploma Yes, Mexican American, Chicano (Name of the enrolled or principle tribe) High school graduate or GED complete Yes, Puerto Rican Some college credit, but no degree Asian Indian Chinese Filipino Japanese Korean Yes, Cuban Asssociate degree (e.g. AA, AS) Yes, other Spanish/Hispanic/Latino ☐ Vietnamese ☐ Other Asian (Specify) ___ Bachelor's degree (e.g. BA, AB, AS) Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)

 □ Native Hawaiin
 □ Guamanian or Chamorro
 □ Samoan

51. BUISNESS/INDUSTRY (Enter type of buisness or industry, NOT COMPANY NAME)

Other Pacific Islander (Specify)

Other (Specify)

Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

50. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life, DO NOT USE RETIRED).

Unknown