

**Ohio Department of Health
VITAL STATISTICS
CERTIFICATE OF DEATH**
TYPE OR PRINT IN PERMANENT BLACK INK

Reg. Dist. No. _____

Primary Reg. Dist. No. _____

Registrar's No. _____

State File No. _____

DO NOT WRITE IN MARGIN RESERVED FOR OOH DATA CODING

a. _____
b. _____
c. _____
d. _____
e. _____

DECEDENT

IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION →

1. Decedent's Name (First, Middle, LAST)				2. Sex		3. Date of Death (Month, Day, Year)	
4. Social Security Number		5a. Age-Last Birthday (Years)	5b. Under One Year Months Days	5c. Under 1 Day Hours Minutes		6. Date of Birth (Month, Day, Year)	7. Birthplace (City, County and State or Foreign Country)
8. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No		9a. Place of Death (Check Only One) Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
9b. Facility Name (If Not Institution, Give Street and Number)				9c. City, Village, Twp., or Location of Death			9d. County of Death
10. Marital Status-Married, Never Married, Widowed, Divorced (Specify)		11. Surviving Spouse (If Wife, Give Maiden Name)		12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use Retired)		12b. Kind of Business/Industry	
13a. Residence-State		13b. County	13c. City, Town, Twp., or Location			13d. Street and Number	
13e. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		13f. ZIP Code	14. Was Decedent of Hispanic Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)		15. Race-American Indian, Black, White, etc. (Specify)	16. Decedent's Education (Specify Only Highest Grade Completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
19a. Informant's Name (Type/Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ZIP Code)			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of Cemetery, Crematory, or Other Place)			20c. Location City or Town, State		
20d. Date of Disposition		21a. Name of Embalmer (First, Middle, Last)			21b. License Number		
22a. Signature of Funeral Director or Other Person		22b. License Number (of Licensee)		23. Name and Address of Facility (Include City, State and ZIP code)			

PARENTS

INFORMANT

DISPOSITION

Location of Body _____ Dr. _____

Doctors Tele# _____ Time of Death _____

Nerxt of Kin _____ Tele# _____

Adress _____

Who's Signing Release _____

If Shipper Name and Address of Funeral Home

Decedants Social Security