ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES - BUREAU OF VITAL STATISTICS
P.O. Box 110675, Juneau, AK 99811-0675

# CERTIFICATE OF DEATH

DATE FILED

STATE FILE NO.

To be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle,Last)

2. SEX

3. SOCIAL SECURITY NUMBER

4a. AGE-Last Birthday (Years)

4b. UNDER 1 YEAR Months Days

4c. UNDER 1 DAY Hours Minutes

5 DATE OF BIRTH (MM/DD/YY)

6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE-STATE

7b. COUNTY

7c. CITY OR TOWN

7d. STREET AND NUMBER

7e. APT No.

7f. ZIP CODE

7g. INSIDE CITY LIMITS? ☐ Yes ☐ No

8. EVER IN US ARMED FORCES? ☐ Yes ☐ No ☐ Unknown

9. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown

10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)

11. FATHER'S NAME (First, Middle, Last)

12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle Last)

13a. INFORMANT'S NAME

13b. RELATIONSHIP TO DECEDENT

13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

14. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.
- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

15. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino(a). Check the 'No' box if the decedent is not Spanish/Hispanic/Latino(a).
- ☐ No, not Spanish/Hispanic/Latino(a)
- ☐ Yes, Mexican, Mexican American, Chicano(a)
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino

Specify _____

16. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaskan Native (Name of the enrolled or principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro(a)
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) _____
- ☐ Other (Specify) _____

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

18. KIND OF BUSINESS OR INDUSTRY

19. PLACE OF DEATH

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL ☐ Hospice Facility ☐ Nursing home/long term care facility ☐ Decedent's home ☐ Other (Specify):

20. FACILITY NAME (If not institution, give street & number)

21. CITY OR TOWN, STATE AND ZIP CODE

22. COUNTY OF DEATH

23. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)_____

24. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)

25. LOCATION - CITY,TOWN AND STATE

26. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

27. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT

28. LICENSE NUMBER (Of Licensee)

To Be Completed By: MEDICAL CERTIFIER

ITEMS 29-33 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

29.DATE PRONOUNCED DEAD (MM/DD/YY)

30. TIME PRONOUNCED DEAD

31. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)

32. LICENSE NUMBER

33.DATE SIGNED (MM/DD/YY)

34.ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YY)

35. ACTUAL OR PRESUMED TIME OF DEATH

36. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH

37. PART I. Enter the chain of events - diseases, injuries, or complications-that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate Interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition ⟶ resulting in death) Sequentially list conditions, if any, leading to the cause listed on line a Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

a. _____ Due to (or as a consequence of):

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

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

38. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

39. WERE AUTOPSY FINDINGS AVAILABLE TO THE CAUSE OF DEATH? ☐ Yes ☐ No

40. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

41. IF FEMALE ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within past year

42. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

43.DATE OF INJURY (MM/DD/YY)

44. TIME OF INJURY

45. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)

46. INJURY AT WORK? ☐ Yes ☐ No

47 LOCATION OF INJURY: (Street & Number, Apt. No., City or Town, State, Zip Code)

48. DESCRIBE HOW INJURY OCCURRED:

49.IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Unknown ☐ Other (Specify) _____

50. CERTIFIER (Check only one):
- ☐ Certifying physician - to the best of my knowledge, death occurred due to the cause(s) and manner stated.
- ☐ Pronouncing & Certifying physician - 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. Signature of certifier:

51.NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 37)

52. TITLE OF CERTIFIER

53. LICENSE NUMBER

54.DATE CERTIFIED (MM/DD/YY)



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