

# STATE OF ILLINOIS CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO.		LOCAL FILE NUMBER		STATE FILE 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)	5b. UNDER 1 YEAR Months      Days	5c. UNDER 1 DAY Hours      Minutes		6. DATE OF BIRTH (Month/Day/Year)	
7a. CITY OR TOWN			7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)				
7c. PLACE OF DEATH (Check only one: see instructions)							
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):			
8. BIRTHPLACE (City and State or Foreign Country)		9. SOCIAL SECURITY NUMBER		10. 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		11. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage)	12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No
13a. RESIDENCE (Street and Number)			13b. APT. NO.	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13e. COUNTY	13f. STATE	13g. 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: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment Other (Specify):		18. PLACE OF DISPOSITION (Name of cemetery, crematory, other)		19. LOCATION - CITY, TOWN AND STATE		20. DATE OF DISPOSITION (Month/Day/Year)	
21a. FUNERAL HOME	NAME	STREET AND NUMBER		CITY OR TOWN		STATE	ZIP
21b. FUNERAL DIRECTOR'S SIGNATURE					21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER		
22. LOCAL REGISTRAR'S SIGNATURE					23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)		
<b>CAUSE OF DEATH (See instructions and examples)</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24. 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 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.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____ Due to (or as a consequence of):							
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 b. _____ Due to (or as a consequence of):							
c. _____ 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.						25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
						26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		28. IF FEMALE: <input type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Pregnant within one year of death but time unkn <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past 12 months			29. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determine <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation		
30. DATE OF INJURY (Month/Day/Year)		31. TIME OF INJURY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)			33. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify):		
37. I (DID) (DID NOT) ATTEND THE DECEASED AND LAST SAW HIM/HER ALIVE ON (Month/Day/Year)		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year)		40. TIME OF DEATH <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
41. CERTIFIER (Check only one): <input type="checkbox"/> Physician in charge of patient's care: To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Physician in attendance at the 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. <input type="checkbox"/> 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. <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12 grade; no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associated 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, <input type="checkbox"/> Doctorate(e.g. PhD, EdD) or Professional de <input type="checkbox"/> Unknown		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. <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:		49. 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 Alaskan Native (Name of the enrolled or principle 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)			
50. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED).					51. BUSINESS/INDUSTRY (Enter type of business or industry, NOT COMPANY NAME)		

 Illinois Department of Public Health - Division of Vital Records  
VR200 (Rev. 1/08)