TYPE / PRINT IN PERMANENT BLACK INK. SEE INSTRUCTIONS

ARKANSAS DEPARTMENT OF HEALTH
Vital Records
CERTIFICATE OF DEATH

NAME OF DECEDENT _____
For use by Initiator of Death Certificate

To Be Completed / Verified by FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix)	2. SEX	3a. DATE OF DEATH (Mo/Day/Yr)	3b. TIME OF DEATH ☐ AM ☐ PM

4. SOCIAL SECURITY NO.	5a. AGE – Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo/Day/Yr)	7. BIRTHPLACE (City and State or Foreign Country)

8a. RESIDENCE STATE or FOREIGN COUNTRY	8b. COUNTY	8c. CITY OR TOWN

8d. NUMBER AND STREET	8e. APT. NO.	8f. ZIP CODE	8g. INSIDE CITY LIMITS? ☐ Yes ☐ No

9. EVER IN US ARMED FORCES? ☐ Yes ☐ No	10. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Widowed ☐ Never Married ☐ Married, but Separated ☐ Divorced ☐ Unknown	11. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage.)

12a. IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room / Outpatient ☐ Dead on Arrival	12b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Decedent's Home ☐ Hospice Facility ☐ Nursing Home / Long Term Care Facility ☐ Other (Specify)_____	12c. COUNTY OF DEATH

12d. FACILITY NAME (If not institution, give number & street)	12e. CITY OR TOWN	12f. ZIP CODE

13. FATHER'S NAME (First, Middle, Last)	14. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

15a. INFORMANT'S NAME	15b. RELATIONSHIP TO DECEDENT	15c. MAILING ADDRESS (Number and Street or PO Box, City, State, Zip Code)

16a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)_____

16b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)	16c. LOCATION – CITY, TOWN, AND STATE

17a. EMBALMER'S NAME ☐ Not Embalmed	17b. EMBALMER'S LICENSE #	17c. SIGNATURE (FUNERAL SERVICE LICENSEE OR OTHER AGENT)

17d. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY	17e. LICENSE #

To Be Completed / Verified by MEDICAL CERTIFIER

18a. DATE PRONOUNCED DEAD (Mo/Day/Yr)	18b. TIME PRONOUNCED DEAD ☐ AM ☐ PM	18c. NAME AND TITLE OF PERSON PRONOUNCING DEATH (PRINT / TYPE)	19. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH

20. 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.

APPROXIMATE INTERVAL: Onset to Death

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)

d. _____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.	21a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No
	21b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

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

23. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown	24. IF FEMALE: ☐ Not pregnant within past year ☐ Not pregnant, but pregnant within 42 days of death ☐ Unknown if pregnant within last year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant 43 days to 1 year before death

25a. DATE OF INJURY (Mo/Day/Yr)	25b. TIME OF INJURY ☐ AM ☐ PM	25c. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)	25d. INJURY AT WORK? ☐ Yes ☐ No

25e. LOCATION OF INJURY: (Number, Street, Apartment No., City, State, Zip Code)

25f. DESCRIBE HOW INJURY OCCURRED:	25g. IF TRANSPORTATION INJURY, SPECIFY. ☐ Driver / Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)_____

26a. 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 – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the causes(s) and manner stated.
- ☐ Coroner – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the causes(s) and manner stated.
- ☐ Hospice Registered Nurse - To the best of my knowledge, death occurred due to the cause(s) and manner stated.

SIGNATURE: _____ TITLE_____ DATE: _____(Mo/Day/Yr)

26b. NAME AND COMPLETE MAILING ADDRESS OF PERSON SIGNING ITEM 26a. (Type / Print)	26c. LICENSE #

27a. SIGNATURE OF REGISTRAR	27b. FOR REGISTRAR ONLY - DATE FILED (Mo/Day/Yr)

For Statistical Use Only

To Be Completed / Verified by FUNERAL DIRECTOR

28. 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 completed
- ☐ 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)

29. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if the decedent is not Spanish/Hispanic/Latino.

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino

(Specify)_____

30. 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
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) _____
- ☐ Other (Specify) _____

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

32. KIND OF BUSINESS / INDUSTRY