

KENTUCKY CERTIFICATE OF DEATH

116 _____

To Be Completed By: Funeral Director (Must Be Typed)	1a. DECEDENT'S LEGAL NAME (First, Middle, Last) (Include AKA's if any)						1b. IF FEMALE, DECEDENT'S LAST NAME PRIOR TO FIRST MARRIAGE		2. SEX				
	3. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month)		4. SOCIAL SECURITY NUMBER		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. COUNTY OF DEATH			
	8. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Dead on Arrival OTHER: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____												
	9. FACILITY NAME (If not institution, give street and number)						10. CITY OR TOWN, STATE AND ZIP CODE						
	11. BIRTHPLACE (City and State or Foreign Country)				12. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married but Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown			13. SURVIVING SPOUSE (If wife, give name prior to first marriage)					
	14. DECEDENT'S USUAL OCCUPATION (Kind of work done during most of working life.) (Do not use retired)				15. KIND OF BUSINESS/INDUSTRY			16. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	17a. RESIDENCE- State		17b. COUNTY		17c. CITY OR TOWN		17d. STREET AND NUMBER		17e. ZIP CODE	17f. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	18. 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"/> 8 th Grade or Less <input type="checkbox"/> 9 th -12 th Grade; No Diploma <input type="checkbox"/> High School Graduate or GED Completed <input type="checkbox"/> Some College Credit but No Degree <input type="checkbox"/> Associates 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, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)				19. 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.) <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) _____				20. 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"/> Native Hawaiian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Other (Specify) _____				
	21. FATHER'S NAME (First, Middle, Last)					22. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)							
	23a. INFORMANT'S NAME			23b. RELATIONSHIP TO DECEDENT		23c. MAILING ADDRESS (Street and Number, City, State, Zip Code)							
24. METHOD OF DISPOSITION (Check only one): <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) _____				25. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)			26. LOCATION – City, Town and State						
27. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such) _____ <small>(Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.118</small>				DATE SIGNED (Mo/Day/Yr)	28. KY LICENSE NUMBER (of licensee)		29. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY						
30. DATE PRONOUNCED DEAD (Mo/Day/Yr)			31. ACTUAL OR PRESUMED TIME OF DEATH			32. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No							
CAUSE OF DEATH													
33. PART I. Enter the <u>chain of events</u> – 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 each line. IMMEDIATE CAUSE (Final disease or condition) _____ Sequelae _____ Enter (disease resulting) _____ PART _____ PHONE _____ FAX _____ # CERTIFIEDS REQUESTED (\$6 EA): _____ (VET GETS 2 FREE) PLEASE INCLUDE A COPY OF KY PROVISIONAL THAT ACCOMPANIED BODY								Approximate Interval Between Onset and Death					
44. DESCRIBE HOW INJURY OCCURRED: _____						45. LOCATION OF INJURY (Street and Number, City or Town, State, Zip Code) _____ <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify) _____							
46. TO BE COMPLETED BY CERTIFIER: To the best of my knowledge, death occurred at the time and place stated above.						47. DATE CERTIFIED (Mo/Day/Yr)				48. LICENSE NUMBER		49. TITLE OF CERTIFIER	
SIGNATURE _____ <small>(Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.118</small>						50. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (ITEM 33)							
51. REGISTRAR'S SIGNATURE						52. DATE FILED (Mo/Day/Yr)							

DEATH CERTIFICATE FILING REQUEST
 TO: DC FILING SERVICE
 FAX TO: 866-290-1259 or 877-906-3079
 EMAIL TO: info@dcfiling.com