INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No……

TRANSIT PERMIT #

State No……..

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)

5. Social Security Number	6a. Age – Yrs	6b. Under 1 Year (Months)	6c. Under 1 Month (Days)	6d. Under 1 Day (Hours)	6e. Under 1 Hour (Minutes)	7. Date Of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)

9. Ever In U.S. Armed Forces?	10. If Death Occurred In A Hospital:	10a. If Death Occurred Somewhere Other Than A Hospital:
☐ Yes ☐ No Unknown ☐	☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival	☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number)

12. City Or Town, State, And Zip Code	13. County Of **Death**	14. Marital Status At Time Of Death
		☐ Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife)Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry

18. Residence – State	18a. County	18b. City Or Town

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
			☐ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
UNKNOWN	NO	UNKNOWN

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):		

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☐ No		

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):

28. Part … proximate
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31. Did To…
☐ Yes ☐ …

34. Date O… …k? …No

38. Locatio…

FUNERAL HOME _____

ADDRESS _____

CONTACT _____ EMAIL _____

PHONE _____ FAX _____

CERTIFIEDS REQUESTED: _____

PLEASE INCLUDE A COPY OF INDIANA PROVISIONAL THAT ACCOMPANIED BODY

39 Describe How Injury Occurred	40. If Transporation Injury, Specify:
	☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death:	42. Certifier (Check Only One)
	☐ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified

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