COMMONWEALTH OF VIRGINIA – CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH – DIVISION OF VITAL RECORDS - RICHMOND

REGISTRATION AREA NUMBER | CERTIFICATE NUMBER | STATE FILE NUMBER

DECEDENT

1. FULL NAME OF DECEDENT (first) (middle) (last) (suffix)

2. SEX — MALE ☐ FEMALE ☐ NOT DETERMINED ☐
3. DATE OF DEATH — ☐ ACTUAL ☐ PRESUMED ☐ APPROXIMATE ☐ FOUND ON
4. DATE OF BIRTH
5. AGE Years | IF UNDER 1 YEAR Months Days | IF UNDER 1 DAY Hours Minutes

6. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES ☐ NO ☐ UNKNOWN ☐
7. BIRTHPLACE (U.S STATE OR FOREIGN COUNTRY)
8. SOCIAL SECURITY NUMBER
IF NO SSN, CHECK APPROPRIATE BOX — NONE ☐ NOT OBTAINABLE ☐ UNKNOWN ☐

USUAL RESIDENCE OF DECEDENT

9. STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.)
10. CITY OR TOWN OF RESIDENCE — INSIDE CITY OR TOWN LIMITS? ☐ YES ☐ NO
11. COUNTY OF DECEDENT'S RESIDENCE (if independent city, leave blank)
12. U.S. STATE (OR FOREIGN COUNTRY) OF DECEDENT'S RESIDENCE
12a. ZIP CODE

PERSONAL DATA OF DECEDENT

13. RACE OF DECEDENT (CHECK ONE OR MORE)
☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ FILIPINO ☐ KOREAN
☐ ASIAN INDIAN ☐ CHINESE ☐ SAMOAN ☐ VIETNAMESE
☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ JAPANESE ☐ UNKNOWN
☐ AMERICAN INDIAN OR ALASKAN NATIVE (SPECIFY________________________ ________________________
☐ OTHER PACIFIC ISLANDER (SPECIFY) ________________________ ________________________
☐ OTHER ASIAN (SPECIFY) ________________________ ________________________
☐ OTHER (SPECIFY) ________________________ ________________________

14. DECEDENT OF HISPANIC ORIGIN?
☐ NON-HISPANIC ☐ CENTRAL OR SOUTH AMERICAN ☐ CUBAN ☐ MEXICAN ☐ PUERTO RICAN ☐ OTHER (SPECIFY)________________________ ☐ UNKNOWN

15. EDUCATION (HIGHEST GRADE COMPLETED)
☐ ELEMENTARY/SECONDARY (0-12) __________ ☐ HIGH SCHOOL DIPLOMA ☐ GED ☐ YEARS OF COLLEGE ______
☐ ASSOCIATE DEGREE ☐ BACHELOR'S DEGREE ☐ MASTER'S DEGREE ☐ DOCTORATE/PROFESSIONAL DEGREE ☐ UNKNOWN

16. CITIZEN OF WHAT COUNTRY
17. USUAL OR LAST OCCUPATION
18. KIND OF BUSINESS OR INDUSTRY

19. MARITAL STATUS
☐ NEVER MARRIED ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ UNKNOWN
20. IF MARRIED, SEPARATED OR WIDOWED, NAME OF SPOUSE (if divorced leave blank)

21. NAME OF DECEDENT'S FATHER (FIRST, MIDDLE, LAST, SUFFIX)
22. MOTHER'S FULL MAIDEN NAME (FIRST, MIDDLE, LAST)

INFORMANT'S DETAILS

23. INFORMANT'S RELATIONSHIP OR SOURCE OF INFORMATION
24. FULL NAME OF INFORMANT OR NAME OF SOURCE

PLACE OF DEATH

25. NAME OF HOSPITAL OR INSTITUTION OF DEATH (if none, so state)
25a. SELECT ONE IF DEATH OCCURRED IN HOSPITAL — DOA ☐ OUT PAT. EMER RM ☐ INPATIENT ☐

26. SPECIFY IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL
☐ HOSPICE FACILITY ☐ NURSING HOME ☐ LONG TERM CARE FACILITY ☐ DECEDENT'S HOME ☐ CORRECTIONAL FACILITY ☐ OTHER (SPECIFY)________________________

27. CITY OR TOWN OF DEATH
28. STREET ADDRESS OR RT. NO OF PLACE OF DEATH
28a. ZIP CODE
28b. COUNTY OF DEATH (if independent city, leave blank)

ONLY THE FOLLOWING MAY LEGALLY FILE A DEATH CERTIFICATE

LICENSED FUNERAL DIRECTOR/ LICENSEE

VIRGINIA STATE ANATOMICAL PROGRAM

NEXT OF KIN

29. METHOD OF DISPOSITION
☐ BURIAL ☐ ENTOMBMENT / MAUSOLEUM ☐ CREMATION / INCINERATION ☐ BURIAL AT SEA ☐ DONATION ☐ OTHER (SPECIFY)________________________
☐ REMOVAL FROM STATE **(IF KNOWN, PLEASE ALSO CHECK FINAL METHOD OF DISPOSITION WHEN REMOVING FROM STATE, FROM OPTIONS SHOWN)**

30. PLACE OF DISPOSITION - NAME OF CEMETERY OR CREMATORY

31. PLACE OF DISPOSITION – STREET ADDRESS OF CEMETERY OR CREMATORY
31a. CITY / COUNTY
31b. STATE
31c. ZIP CODE
31d. COUNTRY

32. SIGNATURE OF FUNERAL DIRECTOR/LICENSEE , VSAP OR NEXT OF KIN (ACTUAL SIGNATURE)
32a. DIRECTOR/LICENSEE'S NO.
32b. NAME OF FUNERAL HOME OR FACILITY

33. NAME OF FUNERAL DIRECTOR / LICENSEE, VSAP OR NEXT OF KIN (TYPE OR PRINT)
33a.. STREET ADDRESS OF FUNERAL HOME / FACILITY, VSAP OR NEXT OF KIN (Include street address, city, state and zip code)

CAUSE OF DEATH TO PHYSICIAN:

Complete and sign medical certification (item **35-40a**) and return both copies to funeral director as soon as possible after determination of cause.

NOTE: If "Pending" must be indicated, so state in **PART I** and notify registrar of final decision as soon as possible

34. TIME OF DEATH: To the best of my knowledge, death occurred at – ________ ☐ A.M. ☐ P.M. ☐ ACTUAL ☐ APPROXIMATE ☐ PRESUMED ☐ FOUND ON

35. PART I. Enter the diseases, injuries, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE → (A)
(Final disease or condition resulting in death)
DUE TO (OR AS A CONSEQUENCE OF):
(B)
Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**
DUE TO (OR AS A CONSEQUENCE OF):
(C)
DUE TO (OR AS A CONSEQUENCE OF):
(D)

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

36. WAS THE MEDICAL EXAMINER CONTACTED? ☐ YES ☐ NO
36a. AUTOPSY? YES ☐ NO ☐
36b. WERE FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? YES ☐ NO ☐
37. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ YES ☐ NO ☐ POSSIBLY ☐ UNKNOWN

38. IF FEMALE:
☐ PREGNANT AT TIME OF DEATH ☐ UNKNOWN IF PREGNANT WITHIN THE PAST YEAR ☐ NOT PREGNANT, BUT PREGNANT WITHIN 42 DAYS OF DEATH
☐ NOT PREGNANT WITHIN PAST YEAR ☐ NOT PREGNANT, BUT PREGNANT WITHIN 43 DAYS TO 1 YEAR BEFORE DEATH ☐ NOT APPLICABLE (if decedent's age is 0-5 or 75+ years)

39. IF EXTERNAL, TO WHAT EXTENT IT CONTRIBUTED TO CAUSE OF DEATH? PRIMARY ☐ CONTRIBUTING ☐
40. WAS THIS A MILITARY DEATH? ☐ YES ☐ NO
40a. IF MILITARY DEATH, SELECT MANNER OF DEATH — NATURAL ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED ☐ PENDING ☐

INJURY INFORMATION To be filled out only for **MILITARY DEATHS**

ITEMS 41 TO 47 IN THIS SECTION SHOULD ONLY BE COMPLETED FOR MILITARY DEATHS

41. DATE OF INJURY
42. TIME OF INJURY ________ ☐ A.M. ☐ P.M
43. INJURY AT WORK? ☐ YES ☐ NO ☐ UNKNOWN
44. PLACE OF INJURY (home, farm, factory, street, office, bldg, etc.)

45. LOCATION OF INJURY – STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.)
45a. CITY / COUNTY
45b. STATE
45c. ZIP CODE
45d. COUNTRY

46. IF TRANSPORTATION INJURY, SPECIFY ☐ DRIVER/OPERATOR ☐ PASSENGER ☐ PEDESTRIAN ☐ OTHER (SPECIFY)________________________

47. DESCRIBE HOW INJURY RELATING TO DEATH OCCURRED

MEDICAL CERTIFICATION

48. SIGNATURE OF PERSON COMPLETING THE CAUSE OF DEATH
48a. TITLE ☐ MEDICAL DOCTOR ☐ PHYSICIAN ASSISTANT ☐ DOCTOR OF OSTEOPATHY (D.O.). ☐ NURSE PRACTITIONER ☐ OTHER________________________
48b. DATE SIGNED:

49. NAME OF PERSON PROVIDING THE MEDICAL CERTIFICATION OF DEATH (Type or Print)
49a. ADDRESS OF PERSON PROVIDING THE MEDICAL CERTIFICATION OF DEATH (Type or Print)
49b. MEDICAL LICENSE NO.

50. ARE YOU A DESIGNEE? ☐ YES ☐ NO
51. IF YES, PLEASE PROVIDE THE NAME OF AUTHORIZING OR ABSENT PHYSICIAN
51a. ADDRESS OF AUTHORIZING PHYSICIAN

REGISTRAR

52. SIGNATURE OF REGISTRAR
52a. PRINTED NAME OF REGISTRAR
52b. DATE RECORD FILED:

53. RESERVED FOR REGISTRAR'S USE

NOT FOR REPORTING PURPOSES