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| **REGISTRATION DISTRICT NO.** | | | | **STATE OF ILLINOIS**  **CERTIFICATE OF DEATH**  **STATE FILE NUMBER** | | | | | | | | | | | | | | | | | | | | | | | |
| **LOCAL 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** | | | | **5c. UNDER 1 DAY** | | | | **6. DATE OF BIRTH (Month/Day/Year)** | | | | | | | | |
| **Months** | | **Days** | | **Hours** | | **Minutes** | |
| **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**  Inpatient Emergency Room/Outpatient Dead on Arrival | | | | | | | | | | **IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL**  Hospice facility Nursing Home/Long-term care facility Decedent's home **Other (Specify):** | | | | | | | | | | | | | | | | | |
| **8. BIRTHPLACE**  **(City and State or Foreign Country)** | | | **9. SOCIAL SECURITY NUMBER** | | | | | | | **10. MARITAL STATUS AT TIME OF DEATH**  Married Married but separated Widowed Divorced Never Married Unknown | | | | | | | | **11. SURVIVING SPOUSE'S NAME**  **(If wife, give full name prior to first marriage)** | | | | | | | | **12. EVER IN U.S. ARMED FORCES?**  Yes No | |
| **13a. RESIDENCE (Street and Number)** | | | | | | | | | **13b. APT. NO. 13c. CITY OR TOWN** | | | | | | | | | | | **13d. INSIDE CITY LIMITS?**  Yes 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:** Burial Cremation Donation 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)** | | | | | | | | | | |
| **CAUSE OF DEATH (See instructions and examples)**  **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 dea a.** | | | | | | | | | | | | | | | | | | | | | | | **APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH** | | | | |
|  | | | | |
| **Sequentially list conditions, if**  **any, leading to the cause listed b. on line a. Enter the**  **UNDERLYING CAUSE (disease**  **or injury that initiated the events c. resulting in death) LAST** | | | | **Due to (or as a consequence of):** | | | | | | | | | | | | | | | | | | |  | | | |  |
| **Due to (or as a consequence of):** | | | | | | | | | | | | | | | | | | |  | | | |
| **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.** | | | | | | | | | | | | | | | | | | | 1. **WAS AN AUTOPSY PERFORMED?** Yes No 2. **WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH?** Yes No | | | | | | | | |
| **27. DID TOBACCO USE CONTRIBUTE TO DEATH?**  Yes Probably  No Unknown | | **28. IF FEMALE:**  Not pregnant within past 12 months Pregnant at time of death  Not pregnant, but pregnant within 42 days of death Pregnant within one year of death but time unkno Not pregnant, but pregnant 43 days to 1 year before death Unknown if pregnant within the past 12 months | | | | | | | | | | | | | | | | | **29. MANNER OF DEATH**  Natural Suicide Could not be determine Accident Homicide Pending Investigation | | | | | | | | |
| **30. DATE OF INJURY (Month/Day/Year)** | | | | | | | **31. TIME OF INJURY**  A.M. P.M. | | | | | **32. PLACE OF INJURY (e.g. Decedent's home; construction site;restaurant;wooded area)** | | | | | | | | | | | | | **33. INJURY AT WORK?**  Yes 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:**  Driver/Operator Pedestrian Passenger **Other (Specify):** | | | | | | | | | |
| **37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON** | | | | | | | | | **38. WAS MEDICAL EXAMINER OR**  **CORONER CONTACTED?** Yes No | | | | | | | **39. DATE PRONOUNCED (Month/Day/Year)** | | | | | | | | **40. TIME OF DEATH**  A.M. P.M. | | | |
| **41. CERTIFIER (Check only one):**  Physician in charge of patient's care: To the best of my knowledge, death occurred due to the cause(s) and manner stated.  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.  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** | | | | | |

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| **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.**  8th grade or less  9th - 12 grade; no diploma  High school graduate or GED completed Some college credit, but no degree Associated degree(e.g. AA, AS) Bachelor's degree(e.g. BA, AB, BS) Master's degree(e.g. MA, MS, MEng, MEd,  Doctorate(e.g. PhD, EdD) or Professional d 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.**  No, not Spanish/Hispanic/Latino  Yes, Mexican, Mexican American, Chicano Yes, Puerto Rican  Yes, Cuban  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.**  White Black or African American American Indian or Alaskan Native  **(Name of the enrolled or principle tribe)**  Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian(Specify)  Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander(Specify)  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)** |

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