Jansen Family Funeral Home 4705 Pine Street / PO Box 77 Columbiaville, MI 48421

Daniel L. Jansen, Manager / Owner [www.jansenprofessionalservices.com](http://www.jansenprofessionalservices.com/)

Phone 810-793-6234

Michigan Death Certificate

Please Use the attached PDF of a Michigan Death Certificate to obtain the needed vitals to complete a death certificate. Please return this with DC Information. Fax 810-793-4752

Expedited - An individual is placed on your DC till it is completed.

1 Week Max ( $40 Extra ) This Service is included in all Direct Cremations already. Dc’s mailed to your funeral home.

- DC is completed 1-3 weeks. This service is provided in our standard cost already. Dc’s mailed to your funeral home.

Standard

Expedited Service

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Standard Service

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**Select One**

No

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Yes

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Cremation

How Many Death Certificates are Needed ?

\*\* Don’t assume a FREE veterans copy will be provided by all clerks offices.

Important Notes:

Item 8C - Please check on this item in order to insure accuracy.

This is not always the city listed in the mailing address.

Our funeral home will obtain the place of death, date of death, and time of death. Items - 4, 7A, 7B, 7C, 28A, 28B, 28C, 29, 30, 31, 39, 40A

Any item left blank will be listed on the certificate as “UNKNOWN” A Proof will be faxed before Dc is filed at clerks office.

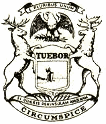
If you want Dc’s mailed to another location - Please advise us of the change

TYPE/PRINT

IN

CITY

UNINCORPORATED



**STATE OF MICHIGAN**

LF

CF

DEPARTMENT OF COMMUNITY HEALTH

**CERTIFICATE OF DEATH**

STATE FILE NUMBE

1. DECEDENT'S NAME *(First Middle Last)*

4. DATE OF DEATH *(Month Day Year)*

5. NAME AT BIRTH OR OTHER NAME USED FOR PERSONAL BUSINESS *(include AKA's if any)*

6a. AGE - Last Birthday

*(Years)*

6c. UNDER 1 DAY

7a. LOCATION OF DEATH *(Enter place officially pronounced dead in 7a 7b 7c)*

HOSPITAL OR OTHER INSTITUTION *-* Name *(if not in either give street and number and zip code)*

7c. COUNTY OF DEATH

8a. CURRENT RESIDENCE - STATE

8d. STREET AND NUMBER *(Include Apt. No. if applicable)*

8w. ZIP CODE

11. DECEDENT'S EDUCATION - What is the highest degree or level of school completed at the time of death?

12. RACE - American Indian, White, Black, etc. *if Asian give nationality ie. Chinese Filipino Asian Indian etc.) (Enter all that apply)*

14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES?

*(yes or no)*

15. USUAL OCCUPATION *Give kind of work done during most of working life. Do not use retired.*

18. NAME OF SURVIVING SPOUSE *(if wife give name before first married)*

19. FATHER'S NAME *(First Middle Last)*

20. MOTHER'S NAME BEFORE FIRST MARRIED *(First Middle Last)*

21a. INFORMANT'S NAME *(Type/Print)*

21c. MAILING ADDRESS *(Street and Number or Rural Route Number City or Village State Zip Code)*

22. METHOD OF DISPOSITION *Burial Cremation Entombment Donation Removal Storage (Specify)*

23b. LOCATION - City or Village, State

INFORMANT

PARENTS

DECEDENT

17. MARITAL STATUS - Married, Never Married, Widowed, Divorced *(Specify)*

16. KIND OF BUSINESS OR INDUSTRY

13b. HISPANIC ORIGIN

*(Yes or No)*

13a. ANCESTRY - Mexican, Cuban, Arab, African, English, French, Dutch, etc.

*(Enter all that apply)* If American Indian race, enter principal tribe

10. SOCIAL SECURITY NUMBER

9. BIRTHPLACE *(City and State or Country)*

PLACE

TOWNSHIP

OR VILLAGE

*(inside limits of)*

8c. LOCALITY - *(check the box that describes the location)*

8b. COUNTY

7b. CITY, VILLAGE, OR TOWNSHIP OF DEATH

6b. UNDER 1 YEAR

3. SEX

2. DATE OF BIRTH *(Month Day Year)*



CERTIFIER *(Type or Print)*

34. NAME AND ADDRESS OF CERTIFYING PHYSICIAN *(Type or Print)*

35a. REGISTRAR'S SIGNATURE

35b. DATE FILED *(Month Day Year)*

36. 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. Enter only one cause on a line.

Approximate

Interval Between

CERTIFICATION

32. MEDICAL EXAMINER'S CASE NUMBER *(if applicable)*

30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) *(Specify)*

29. MEDICAL EXAMINER CONTACTED? *(Yes or No)*

28b. PRONOUNCED DEAD ON

*(Mo. Day Yr.)*

M

28a. ACTUAL OR PRESUMED TIME OF DEATH

25. LICENSE NUMBER

*(of Licensee)*

23a. PLACE OF DISPOSITION *(Name of Cemetery Crematory or other location)*

21b. RELATIONSHIP TO DECEDENT



MEDICAL EXAMINER

CAUSE OF DEATH

NAME OF DECEDENT

For use by physician or institution

PERMANENT BLACK INK



24. SIGNATURE OF MORTUARY SCIENCE LICENSEE

26. NAME AND ADDRESS OF FUNERAL FACILITY

27a. CERTIFIER *(Check only one)*

Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated.

28c. TIME PRONOUNCED DEAD

M

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 cause(s) and manner stated.

Signature and Title

31. IF HOSPITAL, Inpatient, Outpatient, Emergency Room, DOA *(Specify)*

27b. DATE SIGNED *(Mo. Day Yr.)*

27c. LICENSE NUMBER

33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN

DISPOSITION

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If **diabetes** was an immediate,  underlying or contributing a. | | | | | | | | | Onset and Death |
| cause of death be sure to  record diabetes in either Part I or Part II of the cause of  death section, as appropriate. b.  IMMEDIATE CAUSE (Final  disease or condition resulting in death)  Sequentially list conditions, c. | |  | | | | | | |  |
|  | | | | | | |  |
| **IF ANY** leading to the cause listed on line a. Enter the  **UNDERLYING CAUSE** d. | |  | | | | | | |  |
| (disease or injury that  initiated the events resulting in death) **LAST**  PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 37. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes Probably  No Unknown | 38. IF FEMALE  Not pregnant within past year Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to 1 year before death  Unknown if pregnant within the past year | |
| 39. MANNER OF DEATH - Accident, Suicide, Homicide, Natural, Indeterminate or Pending *(Specify)* | | | | 40a. WAS AN AUTOPSY PERFORMED?  *(Yes or No)* | 40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF  DEATH? *(Yes or No)* | | |
| 41a. DATE OF INJURY  *(Mo. Day Yr.)* | | | 41b. TIME OF INJURY  M | 41c. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 41d. INJURY AT WORK  *(Yes or No)* | 41e. PLACE OF INJURY - At home,  farm, street, construction site, wooded area, etc. *(Specify)* | | | 41f. IF TRANSPORTATION  INJURY - Driver/Operator, Passenger, Pedestrian, etc. *(Specify)* | | 41g. LOCATION - Street or RFD No. City, Village or Twp. State | | | |