TYPE IN PERMANENT DARK INK.

ALABAMA

CERTIFICATE OF DEATH

STATE FILE NO.101

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| 1. DECEASED LEGAL NAME (First, Middle, Last) (Type last name all capitals) | 2. LAST NAME PRIOR TO FIRST MARRIAGE | 3. COUNTY OF DEATH |
| 4. CITY, TOWN, OR LOCATION OF DEATH AND ZIP CODE | 5. INSIDE CITY LIMITS?□ Yes □ No | 6. PLACE OF DEATH (Facility Name) – Hospital or Other Institution – (if not in either, give street and number) |
| 7. IF HOSPITAL (Specify Inpatient, ER, Outpatient, or DOA) | 8. SEX □ Unknown□ Female □ Male | 9. SOCIAL SECURITY NUMBER | 10. BIRTHPLACE (State or Foreign Country) |
| 11. AGE – Last Birthday (Years) | UNDER 1 YEAR | UNDER 1 DAY | 12. DATE OF BIRTH (Month, Day, Year) | 13. MARITAL STATUS (Specify Married, Never Married, Widowed, Divorced) |
| Months | Days | Hours | Minutes |
| 14. EVER IN US ARMED FORCES?□ Yes □ No | 15. SURVIVING SPOUSE (NAME PRIOR TO FIRST MARRIAGE) | 16. DECEASED RESIDENCE-STATE | 17. COUNTY |
| 18. CITY, TOWN, OR LOCATION AND ZIP CODE | 19. STREET ADDRESS (Apt, Lot, Unit - if applicable) | 20. INSIDE CITY LIMITS?□ Yes □ No |
| 21. FATHER/PARENT NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) | 22. MOTHER/PARENT NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) |
| 23. INFORMANT NAME AND RELATIONSHIP TO DECEASED | 24. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, County, Zip Code, Apt, Lot) |
| 25. DATE OF DISPOSITION (Month, Day, Year) | 26. METHOD OF DISPOSITION: □ Burial □ Cremation □ Entombment □ Hospital Disposal□ Medical Donation □ Other (Specify):  |
| 27. CEMETERY OR CREMATORY (Name) | 28. LOCATION (City or Town, State) |
| 29. FUNERAL HOME (Name and Address) | 30. FUNERAL HOME (License Number) |
| 31. FUNERAL DIRECTOR – SIGNATURE | 32. DATE SIGNED BY FUNERAL DIRECTOR (Month, Day, Year) | 33. FUNERAL DIRECTOR (License Number) |
| 34. **Certifying Physician** (Physician certifying cause of death) “To the best of my knowledge death occurred at the time and date, 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, place and due to the cause(s) and manner stated.”**Signature:**  | 35. DATE SIGNED (Month, Day, Year) |
| 36. DATE OF DEATH (Month, Day, Year) | 37. TIME OF DEATH | 38. DATE PRONOUNCED DEAD (Month, Day, Year) | 39. TIME PRONOUNCED DEAD |
| 40. NAME, ADDRESS, CITY, STATE, AND ZIP CODE OF PERSON CERTIFYING CAUSE OF DEATH (Item 44) | 41. LICENSE NUMBER |
| 42. **REGISTRAR – Signature FOR STATE OR COUNTY USE ONLY** | 43. **FOR REGISTRAR ONLY**- DATE FILED (Month, Day, Year) |

# MEDICAL CERTIFICATION

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| 44. **PART I. CAUSE OF DEATH** 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.IMMEDIATE CAUSE (Finaldisease or condition ---------> a. resulting in death) Due to (or as a consequence of):Sequentially list conditions, b. if any, leading to the cause Due to (or as a consequence of):listed on line a. Enter the**UNDERLYING CAUSE** c. (disease or injury that Due to (or as a consequence of):initiated the events resultingin death) **LAST** d.  | Approximate interval: Onset to death |
| 45. **PART II.** Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I. | 1. MANNER OF DEATH
	* Natural □ Homicide □ Accident
	* Pending Investigation □ Suicide □ Undetermined
 |
| 47. DID TOBACCO USE CONTRIBUTE TO DEATH?□ Yes □ Probably □ No □ Unknown | 48. 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 |
| 49. DATE OF INJURY (Month, Day, Year) | 50. TIME OF INJURY | 51. PLACE OF INJURY (e.g., Decedent’s home; construction site; restaurant; wooded area) | 52. INJURY AT WORK?□ Yes □ No |
| 53. LOCATION OF INJURY: (Street or R.F.D. No., City or Town, County, State) | 1. IF TRANSPORTATION INJURY, SPECIFY:
	* Driver/Operator □ Passenger □ Pedestrian
	* Other (Specify)
 |
| 55. DESCRIBE HOW INJURY OCCURRED: | 56. AUTOPSY/TOXICOLOGY PERFORMED? Autopsy □ Yes □ No □ Unknown Toxicology □ Yes □ No □ Unknown | 57. WERE FINDINGS CONSIDERED? Autopsy □ Yes □ No Toxicology □ Yes □ No |

THIS IS A LEGAL RECORD AND MUST BE FILED WITHIN FIVE (5) DAYS AFTER DEATH ADPH-HS-2 Rev. SAMPLE 12/01/15

**NAME OF DECEASED**

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| **FUNERAL HOME USE ONLY – DO NOT DETACH** |
| 58. HOSPICE CARE?□ Yes □ No □ Unknown | 1. DECEASED 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 Alaska Native

(Name of the enrolled or principal tribe) * + Asian Indian
	+ Chinese
	+ Filipino
	+ Japanese
	+ Korean
	+ Vietnamese
	+ Other Asian (Specify)
	+ Native Hawaiian
	+ Guamanian or Chamorro
	+ Samoan
	+ Other Pacific Islander (Specify)
	+ Other (Specify)
	+ Unknown
 | 1. DECEASED 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 - 12th grade; no diploma
	* High school graduate or GED completed
	* Some college credit, but no degree
	* Trade school
	* Associate degree (e.g., AA, AS)
	* Bachelor’s degree (e.g., BA, AB, BS)
	* Master’s degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
	* Doctorate (e.g., PhD, EdD) or Professional degree

(e.g., MD, DDS, DVM, LLB, JD)* + Unknown
 |
| 1. DECEASED OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the “No” box if decedent was 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) * + Unknown
 |
| 62. DECEASED USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED). | 63. KIND OF BUSINESS/INDUSTRY |

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