TYPE OR PRINT IN PERMANENT BLACK INK.

I.D. TAG NO.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS

CERTIFICATE OF DEATH

136- STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

1. Legal Name (Include AKAs, if any) First Middle Last Suffix | **2.** Death Date (MON DD YYYY)

3. Sex (M/F) | **4a.** Age – Last Birthday | **4b.** Under 1 Year Months Days | **4c.** Under 1 Day Hours Minutes | **5.** Social Security Number | **6.** County of Death

7. Birthdate (MON DD YYYY) | **8a.** Birthplace (City/Town, or County) | **8b.** (State or Foreign Country) | **9.** Decedent's Education

10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.) | **11.** Decedent's Race(s) | **12.** Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☐ No

13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8) | **14.** City/Town

15. Residence County | **16.** State or Foreign Country | **17.** Zip Code + 4 | **18.** Inside City Limits? ☐ Yes ☐ No ☐ Unknown

19. Marital Status at Time of Death | **20.** Spouse's Name (If married or widowed, give name prior to first marriage.)

21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.") | **22.** Kind of Business/Industry (DO NOT USE COMPANY NAME.)

23. Father's Name (First, Middle, Last, Suffix) | **24.** Mother's Name Prior to First Marriage (First, Middle, Last)

25. Informant's Name | **26.** Telephone Number | **27.** Relation to Decedent | **28.** Mailing Address (Number & Street, City/Town, State, Zip + 4)

29. Place of Death | **30.** Facility Name

31. Location of Death (Give address.) | **32.** City/Town or Location of Death | **33.** State | **34.** Zip Code + 4

35. Method of Disposition | **36.** Place of Disposition (Name of cemetery, crematory, or other place) | **37.** Location

38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4)

39. Date of Disposition (MON DD YYYY) | **40. Funeral Director's Signature** ▶ | **41.** OR License Number

42. Registrar's Signature ▶ | **43. Date Received** (MON DD YYYY) | **44.** Local File Number

45. Record Amendment

TO BE COMPLETED BY MEDICAL CERTIFIER

46. Was case referred to Medical Examiner? ☐ Yes ☐ No | **47.** Autopsy? ☐ Yes ☐ No | **48.** Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No | **49.** Time of Death

CAUSE OF DEATH (See instructions and examples.)

50. 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. DO NOT ABBREVIATE.

		Approximate Interval: Onset to Death
Final disease or condition resulting in death→ Sequentially list conditions, if any, leading to the cause listed on line a. ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).	**IMMEDIATE CAUSE** ↓ a.	
	Due to (or as a consequence of) ↓ b.	
	Due to (or as a consequence of) ↓ c.	
	Due to (or as a consequence of) ↓ d.	

51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:

52. Manner of Death ☐ Natural ☐ Homicide ☐ Accident ☐ Undetermined ☐ Suicide ☐ Pending | **53.** If Female ☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Unknown if pregnant within the past year ☐ Not pregnant, but pregnant within 42 days before death | **54.** Did tobacco use contribute to death? ☐ Yes ☐ Probably ☐ No ☐ Unknown

55. Date of Injury (MON DD YYYY) | **56.** Time of Injury | **57.** Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area) | **58.** Injury at Work? ☐ Yes ☐ No ☐ Unknown

59. Location of Injury (Number & Street, City/Town, State, Zip + 4)

60. Describe how injury occurred. | **61.** If transportation injury, specify. ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4)

63. Name and Title of Attending Physician if Other than Certifier

64. Title of Certifier | **65.** License Number | **66.** Date Signed (MON DD YYYY)

67. Medical Certifier – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ▶

68. 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. ▶

69. Record Amendment

ORIGINAL - VITAL RECORDS COPY

45-2 (06/06)