

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
N.C. VITAL RECORDS

CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. _____ LOCAL NO. _____ COUNTY OF DEATH _____ STATE FILE NO. _____

DECEDENT
TYPE/PRINT IN PERMANENT BLACK, BLUE-BLACK OR BLUE INK

DECEDENT'S LEGAL NAME
1a. FIRST _____ 1b. MIDDLE _____ 1c. LAST _____ 1d. SUFFIX _____ 1e. LAST NAME PRIOR TO FIRST MARRIAGE _____
aka _____ aka _____ aka _____

2. SEX _____ 3a. AGE-LAST BIRTHDAY (Yrs) _____ 3b. UNDER 1 YEAR _____ 3c. UNDER 1 DAY _____ 4. DATE OF BIRTH (Month/Day/Year) _____ 5. BIRTHPLACE (County/State or Foreign Country) _____ 6. DATE OF DEATH (Month/Day/Year) _____
Months _____ Days _____ Hours _____ Minutes _____

PLACE OF DEATH (Check only one)
7a. IF DEATH OCCURRED IN A HOSPITAL Inpatient ER/Outpatient DOA Hospice facility Nursing home/Long term care facility Decedent's home Other (Specify) _____
7b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL _____

7c. FACILITY NAME (If not institution, give street and number) _____ 7d. CITY OR TOWN _____ 7e. COUNTY OF DEATH _____

8. MARITAL STATUS Married Married, but separated Widowed Divorced Never married Unknown 9. SURVIVING SPOUSE (Give name prior to first marriage) _____ 10a. DECEDENT'S USUAL OCCUPATION (Do not use retired) _____ 10b. KIND OF BUSINESS/INDUSTRY _____

11. SOCIAL SECURITY NUMBER _____ 12a. RESIDENCE--STATE OR FOREIGN COUNTRY _____ 12b. COUNTY _____ 12c. CITY OR TOWN _____

12d. STREET AND NUMBER _____ 12e. INSIDE CITY LIMITS Yes No 12f. ZIP CODE _____ 13. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes No

14. 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-12th grade; no diploma
 High school graduate or GED completed
 Some college credit, but no degree
 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)

15. 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) _____

16. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
 White Other Asian (Specify) _____
 Black or African American
 American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
 Native Hawaiian or Guamanian or Chamorro
 Samoan
 Other Pacific Islander (Specify) _____
 Asian Indian Japanese
 Chinese Korean Other (Specify) _____
 Filipino Vietnamese

PARENTS

17. FATHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage) _____ 18. MOTHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage) _____

19a. INFORMANT'S NAME _____ 19b. RELATIONSHIP TO DECEDENT _____ 19c. MAILING ADDRESS (Street and Number, City, State, Zip Code) _____

DISPOSITION

20a. METHOD OF DISPOSITION Burial Cremation Donation Entombment Removal from State Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) _____ 20c. LOCATION (City or Town and State) _____

21a. SIGNATURE OF FUNERAL DIRECTOR _____ 21b. LICENSE NUMBER _____ 21c. NAME OF EMBALMER _____ 21d. LICENSE NUMBER _____

22. NAME AND ADDRESS OF FUNERAL HOME _____

MEDICAL CERTIFICATION

23. 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 on lines b, c and/or d. Enter only one cause on a line. DO NOT ABBREVIATE. Approximate interval: Onset to death

IMMEDIATE CAUSE
(Final disease or condition resulting in death) → a. _____ Due to (or as a consequence of) _____
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) LAST } b. _____ 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. 24a. WAS AN AUTOPSY PERFORMED? Yes No 24b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? Yes No

25. MANNER OF DEATH Natural Homicide Accident Pending Suicide Cannot be determined 26a. WAS CASE REFERRED TO MEDICAL EXAMINER? Yes No 26b. IF YES Declined by Medical Examiner 27. TIME OF DEATH (Approximate) _____ 28. DID TOBACCO USE CONTRIBUTE TO DEATH? Yes Probably No Unknown 29. IF FEMALE: Pregnant at time of death Not pregnant within past year 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

BURIAL/CREMATION PERMIT
Medical Examiner: Authorization for Disposition/Transportation After the medical examiner completes and signs this burial/transport permit/cremation authorization, it constitutes authority for burial, cremation, transportation or removal from the state. A copy of this form serves as a Burial/Cremation Permit.

MEDICAL EXAMINER ONLY

30. DATE PRONOUNCED (Month/Day/Year) _____ 31a. DATE OF INJURY (Month/Day/Year) _____ 31b. TIME OF INJURY _____ 31c. INJURY AT WORK? Yes No 31d. PLACE OF INJURY--at home, farm, street, factory, office, building, etc. _____ 31e. IF TRANSPORTATION INJURY SPECIFY: Driver/Operator Passenger Pedestrian Other (Specify) _____
31f. DESCRIBE HOW INJURY OCCURRED _____ 31g. LOCATION OF INJURY (Street/Number/City/State) _____

CERTIFIER

32. CERTIFIER (Check only one)
 Certifying physician/nurse practitioner/physician assistant – 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 – 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.

33a. SIGNATURE AND TITLE OF CERTIFIER _____ 33b. LICENSE NUMBER _____ 33c. DATE SIGNED (Month/Day/Year) _____

33d. NAME AND ADDRESS OF CERTIFIER (Print legibly) _____ 36. DATE REGISTERED BY STATE _____

REGISTRAR

34. FOR LOCAL REGISTRAR (Name) _____ 35. DATE FILED (Month/Day/Year) _____

DATE CORRECTED (Mo/Day/Yr) _____ ITEM(S) CORRECTED: _____
DATE AMENDED (Mo/Day/Yr) _____ ITEM(S) AMENDED: _____