

Reg. Dist. No. _____
 Primary Reg. Dist. No. _____
 Registrar's No. _____

**Ohio Department of Health
 VITAL STATISTICS
 CERTIFICATE OF DEATH**
 Type or print in permanent black ink

State File No. _____

1. Decedent's Legal Name (Include AKA's if any).(First Middle, LAST, suffix)		2. Sex	3. Date of Death (Mo/Day/Year)
4. Social Security Number	5a. Age (Years)	5b. Under 1 Year Months Days	5c. Under 1 day Hours Minutes
6. Date of Birth(Mo/Day/Year)		7. Birthplace (City and State or Foreign Country)	
8a. Residence State		8b. County	8c. City or Town
8d. Street and Number		8e. Apt. No.	8f. Zipcode
8g. Inside City Limits?		9. Ever in US Armed Forces?	
10. Marital Status at Time of Death		11. Surviving Spouse's Name (If Wife, give name prior to first marriage)	
12. Decedents Education		13. Decedent of Hispanic Origin	
14. Decedent's Race		15. Fathers Name	
16. Mothers Name		17a. Informant's Name	
17b. Relationship to Decedent		17c. Mailing Address (Street and Number, City, State, Zip Code)	
18a. Place of Death		18b. Facility Name (If not Institution, give street & number)	
18c. City or Town, State and Zip Code		18d. County of Death	
19. Signature of Funeral Service Licensee or Other Agent		20 License Number (of licensee)	21. Name and Complete Address of Funeral Facility
22a. Method of Disposition		22b. Date of Disposition	
22c. Place of Disposition (Name of Cemetery, Crematory, or other place)		22d. Location (City/Town or State)	
23. Registrars Signature		24. Date Filed	
25a. Name of Person Issuing Burial Permit		25b. Dist. No.	25c. Date Permit Issued
26a. Certifier (Check Only One)	<input type="checkbox"/> Certifying Physician To the best of my Knowledge, death occurred at the time, date, and place; and due to the cause(s) and manner stated.		
	<input type="checkbox"/> 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.		
26b. Time of Death	26c. Date Pronounced Dead (Mo/Day/Year)		26d. Was Case referred to Coroner?
26e. Signature and Title of Certifier		26f. License number	26g. Date Signed
27. Name (First, Middle, Last) and Address of Person who Completed Cause of Death			
28. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Type or print in permanent black ink.			
Immediate Cause (Final disease or condition resulting in death)	a.	Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to the immediate cause.	b. Due to (or as Consequence of)		
Enter Underlying Cause Last (Disease or injury that initiated events resulting in a death)	c. Due to (or as Consequence of)		
	d. Due to (or as Consequence of)		
Part II. Other Significant Conditions contributing to death but not resulting in the underlying cause given in Part I.		29a. Was an Autopsy Performed?	29b. Were Autopsy Findings Available Prior to completion of Cause of Death?
30. Did Tobacco Use Contribute to Death?	31. If Female	32. Manner of Death	
33a. Date Of Injury (Mo/Day/Year)	33b. Time of Injury	33c. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)	33d. Injury at Work?
33e. Location of Injury (Street and Number or Rural Route Number, City or Town, State)			
33f. Describe How Injury Occurred:			
33g. If Transportation Injury, Specify:			

DECEDENT

Bar Code here

DISPOSITION

REGISTRAR

CERTIFIER

CAUSE OF DEATH

Bar code number here.

Bar Code here