

STATE OF ILLINOIS CERTIFICATE OF DEATH WORKSHEET

REGISTRATION
DISTRICT NO.

LOCAL FILE
NUMBER

STATE FILE NUMBER

To be Completed/Verified by
FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)				2. SEX		3. DATE OF DEATH (Month/Day/Year) (Spell Month)	
4. COUNTY OF DEATH		5a. AGE AT LAST BIRTHDAY (Years)		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Month/Day/Year)		7a. CITY OR TOWN					
7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)							
7c. PLACE OF DEATH (Check only one: see instructions)							
IF DEATH OCCURRED IN A HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival				IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long-term care facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify): _____			
8. BIRTHPLACE (City and State or Foreign Country)		9. SOCIAL SECURITY NUMBER		10. STATUS AT TIME OF DEATH see page 2 of this worksheet for acceptable choices to be entered in this field		11. SURVIVING SPOUSE/CIVIL UNION PARTNER (give full name prior to first marriage/civil union)	
12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		13a. RESIDENCE (Street and Number)		13b. APT. NO.		13c. CITY OR TOWN	
13d. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No		13e. COUNTY		13f. STATE		13g. ZIP CODE	
14. FATHER/CO-PARENT'S NAME PRIOR TO FIRST MARRIAGE/CIVIL UNION (First, Middle, Last)				15. MOTHER/CO-PARENT'S NAME PRIOR TO FIRST MARRIAGE/CIVIL UNION (First, Middle, Last)			
16a. INFORMANT'S NAME				16b. RELATIONSHIP		16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code)	
17. METHOD OF DISPOSITION: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify): _____		18. PLACE OF DISPOSITION (Name of cemetery, crematory, other)		19. LOCATION - CITY, TOWN AND STATE		20. DATE OF DISPOSITION (Month/Day/Year)	
21a. FUNERAL HOME NAME		STREET AND NUMBER		CITY OR TOWN		STATE ZIP	
21b. FUNERAL DIRECTOR'S SIGNATURE				21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER			
22. LOCAL REGISTRAR'S SIGNATURE				23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)			

To be Completed/Verified by
MEDICAL CERTIFIER

CAUSE OF DEATH (See Instructions and examples)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
24. PART I. Enter the <i>chain of events</i> - 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.							
a. IMMEDIATE CAUSE (final disease or condition resulting in death)							
Due to (or as a consequence of):							
b. Sequentially list conditions, if any, leading to the cause listed on line a.							
Due to (or as a consequence of):							
c. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST							
Due to (or as a consequence of):							
PART II. Enter other <i>significant conditions contributing to death</i> but not resulting in the underlying cause given in PART I.						25. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
						26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. DID TOBACCO USE CONTRIBUTE TO DEATH <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		28. IF FEMALE: <input type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Pregnant within one year of death but time unknown <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past 12 months		29. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation			
30. DATE OF INJURY (Month/Day/Year)		31. TIME OF INJURY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		32. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)		33. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
34. LOCATION OF INJURY		Street and Number Apartment Number		City or Town State		Zip Code	
35. DESCRIBE HOW INJURY OCCURRED:						36. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify): _____	
37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON		38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No		39. DATE PRONOUNCED (Month/Day/Year)		40. TIME OF DEATH <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
41. CERTIFIER (Check only one): <input type="checkbox"/> Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/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.							
42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24)						43. PHYSICIAN'S LICENSE NUMBER	
44. TITLE OF CERTIFIER		45. DATE CERTIFIED (Month/Day/Year)		46. SIGNATURE OF CERTIFIER			

To be Completed/Verified by FUNERAL DIRECTOR	47. DECEDENT'S EDUCATION - Check the box that best describes the highest degree or level of school completed at the time of death <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade; no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate Degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's Degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's Degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) <input type="checkbox"/> Unknown	48. 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. <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____	49. DECEDENT'S RACE - Check one or more races to indicate what the decedent considered himself or herself to be. <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native (Name of the enrolled or principle tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____
	50. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED)		51. BUSINESS/INDUSTRY (Enter type of business or industry, NOT COMPANY NAME)

Item 10 - Decedent's Status: acceptable choices for this field. Choose only 1 for item 10 on page 1 of this worksheet.

- ☐ Married
- ☐ Married but Separated
- ☐ Widowed
- ☐ Divorced from Marriage
- ☐ Never Married (includes Never in Civil Union)
- ☐ Civil union
- ☐ Civil union but separated
- ☐ Surviving partner of civil union
- ☐ Divorced from civil union
- ☐ Unknown