## Kansas Department Of Health And Environment Office of Vital Statistics

## CERTIFICATE OF DEATH

State File Number 1. DECEDENT'S LEGAL NAME (First, Middle, Last) 3. IF FEMALE, NAME PRIOR TO FIRST MARRAIGE 2. SEX 4. DATE OF DEATH (Month, Day, Year) 5. SOCIAL SECURITY NUMBER 6. DATE OF BIRTH 7a. AGE-Last Birthday 7b. UNDER 1 YEAR 7c. UNDER 1 DAY 8. PLACE OF BIRTH (City and State or Foreign Country) (Month, Day, Year) (Years) Months 9. WAS DECEDENT EVER IN 10a. PLACE OF DEATH (Check only one) U.S. ARMED FORCES? HOSPITAL | Inpatient D DOA Nursing Home Hospice Facility Assisted Living Facility ☐ ER/Outpatient ☐ Decedent's Residence ☐ Other (Specify) Yes No Unknown 10b. FACILITY NAME (If not institution, give street and number) 10c. COUNTY OF DEATH 10d. CITY OR TOWN OF DEATH 10e. ZIP CODE 11. MARITAL STATUS 12. SURVIVING SPOUSE (If wife, give name before first marriage) Married Married, but separated ☐ Widowed ☐ Divorced Never Married Unknown 13a. RESIDENCE-STREET ADDRESS & APARTMENT NO. 13b. STATE 13c. COUNTY 13d.CITY OR TOWN 13e. ZIP CODE 13f. INSIDE CITY LIMITS? Yes No Unknown 14. FATHER'S NAME (First, Middle, Last) 15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) 16a. INFORMANT'S NAME (First, Middle, Last) 16b. MAILING ADDRESS (Street and Number, City, State, Zip Code) 16c. RELATIONSHIP TO DECEDENT 17. METHOD OF DISPOSITION 18a. PLACE OF DISPOSITION (Name of cemetery, crematory, 18b. LOCATION-City or Town, and State ☐ Cremation ☐ Burial Removal from State or other place) ☐ Donation ☐ Entombment ☐ Other (Specify) 19. FUNERAL SERVICE LICENSEE & LICENSE NO. (Signature) 20. NAME OF EMBALMER & LICENSE NO. 21. NAME AND ADDRESS OF FIRM 22. CAUSE OF DEATH – 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. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines, if necessary.

Approximate Interval: Onset to Death **IMMEDIATE CAUSE** (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if b. any, leading to immediate cause listed on line a. Enter DUE TO (OR AS A CONSEQUENCE OF): the UNDERLYING CAUSE (disease or injury that initiated DUE TO (OR AS A CONSEQUENCE OF): the events resulting in death) LAST. PART II. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23b.WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? 23a.AUTOPSY 23c.WAS CORONER CONTACTED? Yes No ☐ Yes ☐ No ☐ Unknown Yes No Unknown Unknown Not Applicable 24. DID TOBACCO USE CONTRIBUTE TO DEATH? 25. IF FEMALE 26. MANNER OF DEATH Not pregnant within past year Not pregnant, but pregnant 43 days to 1 year before death ☐ Natural ☐ Homicide ☐ Yes Probably Pregnant at time of death Unknown if pregnant within the last year Accident Pending Investigation ☐ No Unknown Not pregnant, but pregnant within 42 days of death Suicide Could not be determined 27b. TIME OF INJURY 27a. DATE OF INJURY 27c. INJURY AT WORK 27d. DESCRIBE HOW INJURY OCCURRED (Month, Day, Year) Yes No 27e. PLACE OF INJURY-Residence, farm, street, factory, building, etc. (Specify) 27f. LOCATION (Street and Number or Rural Route, City or Town, State, Zip Code) 28a. DATE PRONOUNCED DEAD 28b. TIME PRONOUNCED DEAD 28c. ACTUAL OR PRESUMED TIME OF DEATH 28d. NAME OF PERSON PRONOUNCING DEATH (If applicable) 28e. LICENSE NO. (Month, Day, Year) P.M. 29a.CERTIFIER (Check only one) ☐ Certifying physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. Pronouncing & 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. 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. Signature of certifier > LICENSE NO DATE CERTIFIER SIGNED 29b. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH M.D. D.O. SPEC. DEPUTY 30. DATE FILED BY STATE REGISTRAR (Month, Day, Year)

31.ANCESTRY-What is this person's ancestry or ethnic origin? Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)	33.RACE (Check one or more boxes to indicate what race(s) the decedent considered himself or herself to be.)	34. EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death.)
32.HISPANIC ORIGIN (Check the box or boxes that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "no" box if the decedent is not Spanish/Hispanic/Latino)  No, not Spanish/Hispanic/Latino Yes, Mexican/Mexican American/Chicano	White Black or African American American Indian or Alaska Native (Name of the enrolled or principal tribes)  Asian Indian Chinese	□ 8 <sup>th</sup> grade or less □ 9 <sup>th</sup> - 12 <sup>th</sup> grade; no diploma □ High school graduate or GED □ 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) □ Posterate (e.g., BA, BB, EM, MS, MEng, MEd, MSW, MBA)
Yes, Puerto Rican Yes, Cuban Yes, Central American	☐ Filipino ☐ Japanese	Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)  Unknown
Yes, South American Yes, other Spanish/Hispanic/Latino (Specify)	☐ Korean ☐ Vietnamese ☐ Other Asian (Specify)	35. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)
☐ Unknown	Native Hawaiian	The formation of an analysis of the contract o
	Guamanian or Chamorro Samoan	36. KIND OF BUSINESS/INDUSTRY (Do not give name of company.)
	Other Pacific Islander (Specify)	Of the grant part has had, though at grant advanced to control to the grant part of
	Other (Specify)	Take to a second Company of the Comp
	Unknown	TA VALUE AND AND THE PROPERTY AND THE PARTY