

ACTION: Final
 Reg. Dist. No. _____
 Primary Reg. Dist. No. _____
 Registrar's No. _____

EXISTING DATE: 12/20/2010 10:21 AM
 Appendix Ohio Department of Health
 3701-5-02 **VITAL STATISTICS** State File No. _____
CERTIFICATE OF DEATH
 Type or print in permanent black ink

1. Decedent's Legal Name (Include AKA's if any),(First Middle, LAST, suffix)		2. Sex		3. Date of Death (Mo/Day/Year)			
DECEDENT	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)		
Bar Code here	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)			
REGISTRAR	23. Registrars Signature			24. Date Filed			
	25a. Name of Person Issuing Burial Permit			25b. Dist. No.		25c. Date Permit Issued	
CURSHER	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							
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.					Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)	a.					
	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:							

APPENDIX B
3701-5-02

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APPENDIX (p71087) (s012706) (d305619) (a0261891)

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