

GEORGIA DEATH CERTIFICATE

A. BIRTH CERTIFICATE NUMBER

B. STATE FILE NUMBER

DECEDENT'S INFORMATION	1. DECEDENT'S LEGAL FULL NAME (FIRST, MIDDLE, LAST)			1a. LAST NAME AT BIRTH (IF FEMALE)		2. SEX	2a. DATE OF DEATH (MO/DAY/YR)		
	3. SOCIAL SECURITY NUMBER		4a. AGE (YEARS)	4b. UNDER 1 YEAR		4c. UNDER 1 DAY		5. DATE OF BIRTH (MO/DAY/YR)	
				MONTHS	DAYS	HOURS	MINUTES		
	6. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY)		7a. STREET AND NUMBER OF RESIDENCE			7b. ZIP CODE	7c. CITY OR TOWN OF RESIDENCE		
	7d. COUNTY OF RESIDENCE		7e. STATE OF RESIDENCE		7f. COUNTRY		7g. INSIDE CITY LIMITS ☐ Yes ☐ No ☐ Unknown	8. ARMED FORCES ☐ Yes ☐ No ☐ Unknown	
	8a. OCCUPATION		8b. NATURE OF BUSINESS			8c. EMPLOYER			
	9. MARITAL STATUS ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown		10. SPOUSE'S NAME (IF WIFE, GIVE NAME PRIOR TO FIRST MARRIAGE)			11. FATHER'S NAME (FIRST, MIDDLE, LAST)			
	12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST)		13. DECEDENT'S EDUCATION (HIGHEST LEVEL) ☐ 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) ☐ Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown					14a. INFORMANT'S NAME (FIRST, MIDDLE, LAST)	
	14b. RELATIONSHIP TO DECEDENT		14c. MAILING ADDRESS (STREET AND NUMBER, CITY, COUNTY, STATE, ZIP CODE)						
	15. HISPANIC ORIGIN ☐ No, not Spanish/Hispanic/Latino ☐ Yes, Puerto Rican ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (specify) _____ ☐ Unknown		16. DECEDENT'S RACE ☐ White ☐ Japanese ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Black/African American ☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Guamanian/Chamorro ☐ Samoan ☐ American Indian/Alaska Native ☐ Other Asian ☐ Other Pacific Islander ☐ Other ☐ Unknown						
17a. IF DEATH OCCURRED IN HOSPITAL ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival			17b. IF DEATH OCCURRED OTHER THAN HOSPITAL ☐ Hospice Facility ☐ Nursing Home/Long Term Care Facility ☐ Decedent's Home ☐ Other ☐ Unknown						
18. FACILITY NAME		19. FACILITY ADDRESS (STREET AND NUMBER, CITY, STATE, ZIP CODE)				20. COUNTY OF DEATH			
DISPOSITION	21. METHOD OF DISPOSITION ☐ Burial ☐ Donation ☐ Removal from State ☐ Cremation ☐ Entombment ☐ Other		22. PLACE OF DISPOSITION (NAME AND COMPLETE ADDRESS)				23. DATE OF DISPOSITION (MO/DAY/YR)		
	24a. EMBALMER'S NAME & CERTIFIED INITIALS						24b. LICENSE NUMBER		
	25. FUNERAL HOME NAME		25a. FUNERAL HOME ADDRESS (STREET AND NUMBER, CITY, COUNTY, STATE, ZIP CODE)						
PRONOUNCER	26. FUNERAL DIRECTOR'S NAME (PRINT)		26a. SIGNATURE OF FUNERAL DIRECTOR				26b. LICENSE NUMBER		
	27. DATE PRONOUNCED DEAD (MO/DAY/YR)	28. TIME PRONOUNCED DEATH	29a. PRONOUNCER'S NAME AND TITLE (PRINT)						
	29b. PRONOUNCER'S LICENSE NUMBER						30. ACTUAL OR PRESUMED TIME OF DEATH		
CAUSE OF DEATH	31. Part I. Enter the <u>chain of events</u> -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. 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						Approximate interval between onset and death		
	Part II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in Part I						32. WAS AUTOPSY PERFORMED ☐ Yes ☐ No ☐ Unknown		
	33. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No ☐ Unknown		33a. WAS AN INJURY OF ANY KIND INDICATED IN THE CAUSE OF DEATH FOR PART I OR PART II WITH THE DECEDENT ☐ Yes ☐ No ☐ Unknown			34. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER ☐ Yes ☐ No ☐ Unknown			
	35. TOBACCO USE CONTRIBUTE TO DEATH ☐ Yes ☐ No ☐ Unknown ☐ Probably		36. IF FEMALE ☐ Not Applicable ☐ Not pregnant within the past year ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at the time of death ☐ Unknown if pregnant within the past year			37. MANNER OF DEATH ☐ Accident ☐ Natural ☐ Could not be determined ☐ Pending Investigation ☐ Homicide ☐ Suicide			
	38. DATE OF INJURY (MO/DAY/YR)	39. TIME OF INJURY		40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant wooded area)			41. INJURY AT WORK ☐ Yes ☐ No ☐ Unknown		
	42. LOCATION OF INJURY		STREET AND NUMBER		CITY	STATE	COUNTY	ZIP CODE	
	43. DESCRIBE HOW INJURY OCCURRED					44. IF TRANSPORTATION INJURY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other			
	45. To the best of my knowledge death occurred at the time, date, place, and due to the cause(s) stated. <u>Medical Certifier (Name, Title, License No.) (PRINT AND SIGN)</u>			46. On the basis of examination and/or investigation, in my opinion death occurred at the time date, place, and due to the cause(s) stated. <u>Medical Examiner/Coroner (Name, Title, License No.) (PRINT AND SIGN)</u>					
	45a. DATE SIGNED (MO/DAY/YR)		45b. HOUR OF DEATH		46a. DATE SIGNED (MO/DAY/YR)		46b. HOUR OF DEATH		
	47. PERSON COMPLETING CAUSE OF DEATH (NAME, ADDRESS, COUNTY, ZIP CODE)								
48. REGISTRAR SIGNATURE(PRINT AND SIGN)				49. DATE FILED (REGISTRAR) (MO/DAY/YR)					