

TYPE OR
PRINT IN
PERMANENT
BLACK INK.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-

I.D. TAG NO.

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY	1. Legal Name (Include AKAs, if any) First Middle Last Suffix					2. Death Date (MON DD YYYY)		
	3. Sex (M/F)	4a. Age - Last Birthday	4b. Under 1 Year Months : Days	4c. Under 1 Day Hours : Minutes	5. Social Security Number		6. County of Death	
	7. Birthdate (MON DD YYYY)		8a. Birthplace (City/Town, or County)		8b. (State or Foreign Country)		9. Decedent's Education	
	10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.)			11. Decedent's Race(s)		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8)				14. City/Town			
	15. Residence County		16. State or Foreign Country		17. Zip Code + 4		18. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	19. Marital Status at Time of Death			20. Spouse's Name (If married or widowed, give name prior to first marriage.)				
	21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.")				22. Kind of Business/Industry (DO NOT USE COMPANY NAME.)			
	23. Father's Name (First, Middle, Last, Suffix)				24. Mother's Name Prior to First Marriage (First, Middle, Last)			
	25. Informant's Name		26. Telephone Number	27. Relation to Decedent	28. Mailing Address (Number & Street, City/Town, State, Zip + 4)			
	29. Place of Death			30. Facility Name				
	31. Location of Death (Give address.)			32. City/Town or Location of Death		33. State	34. Zip Code + 4	
	35. Method of Disposition		36. Place of Disposition (Name of cemetery, crematory, or other place)		37. Location			
	38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4)							
	39. Date of Disposition (MON DD YYYY)		40. Funeral Director's Signature			41. OR License Number		
	42. Registrar's Signature			43. Date Received (MON DD YYYY)		44. Local File Number		
	45. Record Amendment							
	TO BE COMPLETED BY MEDICAL CERTIFIER	46. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Were autopsy findings available to complete the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		49. Time of Death		
		50. 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.						Approximate Interval: Onset to Death
		Final disease or condition resulting in death -> Sequentially list conditions, if any, leading to the cause listed on line a. ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).		IMMEDIATE CAUSE ↓ a. Due to (or as a consequence of) ↓ b. Due to (or as a consequence of) ↓ c. Due to (or as a consequence of) ↓ d. Due to (or as a consequence of) ↓				
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:								
52. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		53. If Female <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death			54. Did tobacco use contribute to death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown			
55. Date of Injury (MON DD YYYY)		56. Time of Injury	57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)			58. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
59. Location of Injury (Number & Street, City/Town, State, Zip + 4)								
60. Describe how injury occurred.				61. If transportation injury, specify. <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____				
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4)								
63. Name and Title of Attending Physician if Other than Certifier								
64. Title of Certifier			65. License Number		66. Date Signed (MON DD YYYY)			
67. Medical Certifier - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				68. Medical Examiner - 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.				
69. Record Amendment								