

# ALABAMA CERTIFICATE OF DEATH

STATE FILE NO. **101**

TYPE IN PERMANENT DARK INK.

1. DECEASED LEGAL NAME (First, Middle, Last) (Type last name all capitals)		2. LAST NAME PRIOR TO FIRST MARRIAGE		3. COUNTY OF DEATH	
4. CITY, TOWN, OR LOCATION OF DEATH AND ZIP CODE		5. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. PLACE OF DEATH (Facility Name) – Hospital or Other Institution – (if not in either, give street and number)	
7. IF HOSPITAL (Specify Inpatient, ER, Outpatient, or DOA)		8. SEX <input type="checkbox"/> Unknown <input type="checkbox"/> Female <input type="checkbox"/> Male		9. SOCIAL SECURITY NUMBER	
11. AGE – Last Birthday (Years)		12. DATE OF BIRTH (Month, Day, Year)		13. MARITAL STATUS (Specify Married, Never Married, Widowed, Divorced)	
14. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. SURVIVING SPOUSE (NAME PRIOR TO FIRST MARRIAGE)		16. DECEASED RESIDENCE-STATE	
18. CITY, TOWN, OR LOCATION AND ZIP CODE		19. STREET ADDRESS (Apt, Lot, Unit - if applicable)		20. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. FATHER/PARENT NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)		22. MOTHER/PARENT NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)			
23. INFORMANT NAME AND RELATIONSHIP TO DECEASED			24. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, County, Zip Code, Apt, Lot)		
25. DATE OF DISPOSITION (Month, Day, Year)		26. METHOD OF DISPOSITION: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Hospital Disposal <input type="checkbox"/> Medical Donation <input type="checkbox"/> Other(Specify): _____			
27. CEMETERY OR CREMATORY (Name)		28. LOCATION (City or Town, State)			
29. FUNERAL HOME (Name and Address)		30. FUNERAL HOME LICENSE NUMBER			
31. FUNERAL DIRECTOR OR OTHER AGENT– SIGNATURE		32. DATE SIGNED (Month, Day, Year)		33. FUNERAL DIRECTOR LICENSE NUMBER	
34. _____ Certifying Physician _____ Certifying Registered Nurse Practitioner _____ Certifying Nurse Midwife "To the best of my knowledge, death occurred at the time and date, and due to the cause(s) and manner stated."  _____ 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."  SIGNATURE: _____					35. DATE SIGNED (Month, Day, Year)
36. DATE OF DEATH (Month, Day, Year)		37. TIME OF DEATH	38. DATE PRONOUNCED DEAD (Month, Day, Year)		39. TIME PRONOUNCED DEAD
40. NAME, ADDRESS, CITY, STATE, AND ZIP CODE OF PERSON CERTIFYING CAUSE OF DEATH (Item 44)				41. CERTIFIER LICENSE NUMBER	
42. REGISTRAR – SIGNATURE		ITEMS 42-43 FOR STATE USE ONLY		43. DATE FILED (Month, Day, Year)	

**MEDICAL CERTIFICATION**

44. <b>PART I. CAUSE OF DEATH</b> 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. Enter only one cause on a line.  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 <b>UNDERLYING CAUSE</b> (disease or injury that initiated the events resulting in death) <b>LAST</b> c. _____ Due to (or as a consequence of):  d. _____				Approximate interval: Onset to death  _____  _____	
45. <b>PART II.</b> Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.			46. <b>MANNER OF DEATH</b> <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined		
47. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		48. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year			
49. DATE OF INJURY (Month, Day, Year)		50. TIME OF INJURY	51. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)		52. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
53. LOCATION OF INJURY (Street or R.F.D. No., City or Town, County, State)			54. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		
55. DESCRIBE HOW INJURY OCCURRED:		56. AUTOPSY/TOXICOLOGY PERFORMED? Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Toxicology <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		57. WERE FINDINGS CONSIDERED? Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Toxicology <input type="checkbox"/> Yes <input type="checkbox"/> No	

**THIS IS A LEGAL RECORD AND MUST BE FILED WITHIN FIVE (5) DAYS AFTER DEATH**

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**FUNERAL HOME USE ONLY – DO NOT DETACH**

58. HOSPICE CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		60. DECEASED 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 Alaska Native (Name of the enrolled or principal 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) _____ <input type="checkbox"/> Unknown		61. DECEASED 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"/> Trade school <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	
59. DECEASED OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent was 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) _____ <input type="checkbox"/> Unknown		62. DECEASED USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED).		63. KIND OF BUSINESS/INDUSTRY	

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