KENTUCKY CERTIFICATE OF DEATH

116 _____

To Be Completed By: Funeral Director (Must Be Typed)

1a. DECEDENT'S LEGAL NAME (*First, Middle, Last) (Include AKA's if any)*

1b. IF FEMALE, DECEDENT'S LAST NAME PRIOR TO FIRST MARRIAGE

2. SEX

3. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month)

4. SOCIAL SECURITY NUMBER

5a. AGE-LAST BIRTHDAY (Years)

5b. Under 1 Year: Months / Days

5c. Under 1 Day: Hours / Minutes

6. DATE OF BIRTH (Mo/Day/Yr)

7. COUNTY OF DEATH

8. PLACE OF DEATH (*Check only one*)
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ Dead on Arrival **OTHER:** ☐ Hospice Facility ☐ Nursing Home/Long Term Care Facility ☐ Residence ☐ Other (Specify)

9. FACILITY NAME *(If not institution, give street and number)*

10. CITY OR TOWN, STATE AND ZIP CODE

11. BIRTHPLACE (City and State or Foreign Country)

12. MARITAL STATUS
☐ Married ☐ Widowed ☐ Never Married
☐ Married but Separated ☐ Divorced ☐ Unknown

13. SURVIVING SPOUSE (If wife, give name prior to first marriage)

14. DECEDENT'S USUAL OCCUPATION (Kind of work done during most of working life.) (Do not use retired)

15. KIND OF BUSINESS/INDUSTRY

16. WAS DECEDENT EVER IN U.S. ARMED FORCES?
☐ Yes ☐ No

17a. RESIDENCE- State

17b. COUNTY

17c. CITY OR TOWN

17d. STREET AND NUMBER

17e. ZIP CODE

17f. INSIDE CITY LIMITS?
☐ Yes ☐ No

18. DECEDENT'S EDUCATION
(Check the box that best describes the highest degree or level of school completed at the time of death.)
☐ 8th Grade or Less
☐ 9th-12th Grade; No Diploma
☐ High School Graduate or GED Completed
☐ Some College Credit but No Degree
☐ Associates Degree (e.g., AA, AS)
☐ Bachelor's Degree (e.g., BA, AB, BS)
☐ Master's Degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)

19. DECEDENT OF HISPANIC ORIGIN? (Check the box 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
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify) _____

20. DECEDENT'S RACE
(Check one or more races to indicate what the decedent considered himself or herself to be)
☐ White
☐ Black or African American
☐ Native Hawaiian
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Guamanian or Chamorro
☐ Korean
☐ Vietnamese
☐ Samoan
☐ Other Asian (Specify)_____
☐ Other Pacific Islander (Specify)_____
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
☐ Other (Specify)_____

21. FATHER'S NAME (First, Middle, Last)

22. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

23a. INFORMANT'S NAME

23b. RELATIONSHIP TO DECEDENT

23c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

24. METHOD OF DISPOSITION (*Check only one*):
☐ Burial ☐ Cremation ☐ Donation ☐ Entombment
☐ Removal from State ☐ Other (Specify) _____

25. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)

26. LOCATION – City, Town and State

27. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such) DATE SIGNED (Mo/Day/Yr)

_____ _____
(Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.118

28. KY LICENSE NUMBER (of licensee)

29. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

To Be Completed By: Medical Certifier

30. DATE PRONOUNCED DEAD (Mo/Day/Yr)

31. ACTUAL OR PRESUMED TIME OF DEATH

32. WAS MEDICAL EXAMINER OR CORONER CONTACTED?
☐ Yes ☐ No

CAUSE OF DEATH

33. 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 each line.

Approximate Interval Between Onset and Death

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.
b. _____
DUE TO (OR AS A CONSEQUENCE OF):

Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I

34. MANNER OF DEATH
☐ Natural ☐ Accident
☐ Homicide ☐ Pending Investigation
☐ Suicide ☐ Could not be Determined

35. WAS AN AUTOPSY PERFORMED?
☐ Yes ☐ No

36. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?
☐ Yes ☐ No

37. DID TOBACCO USE CONTRIBUTE TO DEATH?
☐ Yes ☐ Probably
☐ No ☐ Unknown

38. IF FEMALE:
☐ Not pregnant within past year
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Pregnant at time of death
☐ Unknown if pregnant within past year

39. DATE OF INJURY (Mo/Day/Yr) (Spell Month)

40. TIME OF INJURY

41. INJURY AT WORK?
☐ Yes ☐ No

42. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)

43. IF TRANSPORTATION INJURY, SPECIFY:
☐ Driver/Operator ☐ Pedestrian
☐ Passenger ☐ Other (Specify)_____

44. DESCRIBE HOW INJURY OCCURRED:

45. LOCATION OF INJURY (Street and Number, City or Town, State, Zip Code)

46. TO BE COMPLETED BY CERTIFIER:
To the best of my knowledge, death occurred at the time, date, and place, and due to cause(s) and manner stated.

SIGNATURE_____
(Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.118

47. DATE CERTIFIED *(Mo/Day/Yr)*

48. LICENSE NUMBER

49. TITLE OF CERTIFIER

50. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (ITEM 33)

51. REGISTRAR'S SIGNATURE

52. DATE FILED (Mo/Day/Yr)