

Contact Sheet – Death Certificate

Funeral Home: _____
(name and address)

Funeral Director: _____ Telephone Number _____
(name)

Decedent Information

Name of Decedent: _____ Male Female

Date of Birth: _____ Social Security Number: _____
(last four digits)

Date of Death: _____ Place of Death: _____
(city or county)

Location of Death: Home Hospital Emergency Room Other _____
(specify)

Resident of Decedent: _____
(street, city, state, zip code)

Decedent's Medications: _____

Known Pharmacy: _____

Date last seen by a physician _____ Physician contact information _____
(name and telephone number)

Recent Illness: Yes No If yes, describe: _____

Last person who saw decedent alive: _____ Telephone number _____
(name)

Persons Contacted

Profession: Primary Physician, Specialist, ER Physician, Surgeon, Law Enforcement, EMS, OCME, Physician's Staff, etc.

Name: _____ Phone Number: _____ Profession: _____	Name: _____ Phone Number: _____ Profession: _____	Name: _____ Phone Number: _____ Profession: _____
Name: _____ Phone Number: _____ Profession: _____	Name: _____ Phone Number: _____ Profession: _____	Name: _____ Phone Number: _____ Profession: _____

Decedent Name: _____

Please record information that would be helpful to the medical certifier.

Funeral Director Notes/Comments

Law Enforcement Notes/Comments

Medical Examiner Notes/Comments
