

DISTRICT PUBLIC PROSECUTORS OFFICE
CERTIFICATE OF DEATH

File No.: B _____

(To be completed by the certificate-issuing agency)						Health Agency's Designation					
1. Decedent's Name (First, Middle, last)		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Personal Identification No.							
				<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			<input type="text"/>	<input type="text"/>
4. Registered Permanent Residence (Street and number, city, town, country)								County/City		District/ precinct	
5. Date of Birth		Year <input type="text"/> Month <input type="text"/> Day <input type="text"/> Hour <input type="text"/> Minute <input type="text"/> AM <input type="checkbox"/> PM <input type="checkbox"/> (Hour/minute data are required for decedents less than 1 week old)						Year <input type="text"/> Month <input type="text"/> Day <input type="text"/>			
6. Date of Death		Year <input type="text"/> Month <input type="text"/> Day <input type="text"/> Hour <input type="text"/> Minute <input type="text"/> AM <input type="checkbox"/> PM <input type="checkbox"/>						Year <input type="text"/> Month <input type="text"/> Day <input type="text"/>			
7. Location and Place of Death		Location of Death (Street and number, city, town, country)									
		Place of Death <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Midwifery Center <input type="checkbox"/> Residence <input type="checkbox"/> Other									
8. Manner of Death		<input type="checkbox"/> Nature/Illness <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined									
9. Decedent's Occupation		Usual Occupation						Profession -- Designation			
		Kind of Business/Assignment									
10. Marital status		<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown									
11. Cause of Death A. Immediate Cause: a. _____ Underlying Cause: b. _____ (Disease/injury initiated events resulting in death) c. _____ B. Other Significant Conditions: _____ (Not resulting in the underlying cause shown above)								Designation for cause of Death			
This is to certify that the above statement is true. Pursuant to Article 218, section 2 of the Criminal Procedure, the examination was coordinated by a prosecutor's investigator (or a police officer) under prosecutor's supervision. Prosecutor's Investigator (Police Officer) Medical Examiner (Coroner Investigator) (Physician) (Signature or Official Name Stamp---with Agency's Official Seal) Date: _____ Year <input type="text"/> Month <input type="text"/> Day <input type="text"/>								Pronouncing/Certifying Physician Designation			
								Form Completed by (Name Stamp)			

Unless noted otherwise, the body may be cremated.

No charge for Examination performed

- a. Examination has been completed. The body may be returned for burial service.
- b. In six copy: one kept with the file; one for the medical examiner's office; four to accompany the body for household registration and burial service processes.
- c. The first page may be copied. Copied should be brought to the Service Center of the Prosecutors Office for authentication (Personal Identification Card and stamp are required).
- d. Health Agency's Designation to be completed by responsible health agency.