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| Name Known to Physician: | Date of Death: |
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DH-PHS-PROD-09

**STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Demographic Information**

Type or Print in Black Ink

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|--|--|--|---|--|--|--|---|---|--|--|
| To Be Completed/Verified By: FUNERAL DIRECTOR OR PERSON ACTING AS SUCH | 1a. DECEDENT'S LEGAL NAME (First, Middle, Last, Suffix) | | | | | | | | | |
| | 1b. ALIASES (Any other names the decedent used or was known as) | | | | 1c. DECEDENT'S LAST NAME AT BIRTH | | | | | |
| | 2. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female | | 3. SOCIAL SECURITY NUMBER | | 4a. AGE-LAST BIRTHDAY (Years) | | 4b. IF UNDER 1 YEAR Months Days | | 4c. IF UNDER 1 DAY Hours Minutes | |
| | 5. DATE OF BIRTH (Month, Day, Year) | | | | 6. BIRTHPLACE (City and State or Foreign Country - include Province if Canada) | | | | | |
| | 7a. RESIDENCE STREET AND NUMBER (Include Apartment Number) | | | | 7b. CITY OR TOWN OF RESIDENCE | | 7c. STATE OR FOREIGN COUNTRY | | | |
| | 8a. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 8b. VETERAN OF ANY WAR? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 8c. IF SO, WHAT WAR(S)? | | | | | |
| | 9. MARITAL STATUS AT TIME OF DEATH: <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union dissolution <input type="checkbox"/> Never Married or in Civil Union <input type="checkbox"/> Unknown | | | | 10a. BIRTH NAME OF SURVIVING SPOUSE / CIVIL UNION PARTNER | | | 10b. SEX OF SURVIVING SPOUSE/PARTNER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown | | |
| | 11. FATHER'S OR PARENT'S BIRTH NAME (First, Middle, Last) | | | | 12. MOTHER'S OR PARENT'S BIRTH NAME (First, Middle, Last) | | | | | |
| | 13a. INFORMANT'S NAME (First, Middle, Last) | | | | 13b. RELATIONSHIP TO DECEDENT | | | | | |
| | 13c. INFORMANT'S MAILING ADDRESS (Street and Number, City or Town, State, Zip Code) | | | | | | | | | |
| | 14. DECEDENT'S EDUCATION LEVEL: (Check the box that best describes the highest degree or level of school completed at the time of death.) <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> 9 th – 12 th grade; no diploma <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) | | | | 15. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.) <input type="checkbox"/> No, not Spanish/Hispanic/Latino/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino/Latina (Specify) _____ | | | | | |
| | 16. DECEDENT'S RACE: (Check one or more races to indicate what the decedent considered himself or herself to be.) <input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black or African American <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) <input type="checkbox"/> Filipino <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Samoan _____ <input type="checkbox"/> Japanese _____ <input type="checkbox"/> Other Pacific Islander (Specify) _____ _____ _____ _____ <input type="checkbox"/> Other (Specify) _____ | | | | | | | | | |
| | 17. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED) | | | | 18. KIND OF BUSINESS/INDUSTRY | | 19. DID DECEDENT RECEIVE HOSPICE CARE? (In past 30 days) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| | 20. PLACE OF DEATH If death occurred in a hospital: (Indicate only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive Care Unit <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival If death occurred somewhere other than a hospital: <input type="checkbox"/> Nursing Home / Long Term Care Facility <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (specify) _____ | | | | | | | | | |
| | 21a. FACILITY NAME (If not institution, give street and number) | | | | 21b. CITY OR TOWN | | 21c. STATE | | | |
| 22a. METHOD OF DISPOSITION: <input type="checkbox"/> Temporary Storage <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (specify) | | | | | | | | | | |
| 22b. PLACE OF TEMPORARY STORAGE (Name of cemetery, other place) | | | | 22c. LOCATION OF TEMPORARY STORAGE (City or Town, State) | | | | | | |
| 22d. PLACE OF FINAL DISPOSITION (Name of cemetery, crematory, other place) | | | | 22e. LOCATION OF FINAL DISPOSITION (City or Town, State) | | | | | | |
| 23a. NAME OF FUNERAL FACILITY OR AUTHORIZED PERSON | | | | 23b. ADDRESS OF FUNERAL FACILITY OR AUTHORIZED PERSON (Street and Number, City, State, Zip Code) | | | | | | |
| 24. SIGNATURE OF FUNERAL SERVICE LICENSEE OR AUTHORIZED PERSON | | | | 25. VERMONT LICENSE NUMBER | | 26. DATE OF DISPOSITION (Month, Day, Year) | | | | |

If attached to a completed Preliminary Report of Death – Medical Certification, this document shall be acceptable for issuance of burial transit and removal permits. This is not a permanent record. A town clerk may not issue certified copies of this record.

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| Name Known to Physician: | Date of Death: |
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**STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Medical Certification**

Type or Print in Black Ink

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|--|---|--|---|
| 19. DID DECEDENT RECEIVE HOSPICE CARE? (In past 30 days) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 20. PLACE OF DEATH (Indicate only one) | | If death occurred in a hospital: | |
| <input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive Care Unit | | If death occurred somewhere other than a hospital: | |
| <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival | | <input type="checkbox"/> Nursing Home / Long Term Care Facility <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home | |
| <input type="checkbox"/> Other (specify) _____ | | | |
| 21a. FACILITY NAME (If not institution, give street and number) | | 21b. CITY OR TOWN | 21c. STATE |
| 27. MANNER OF DEATH: <i>Note: All deaths that are not "Natural" should be referred to a Medical Examiner. Call 1-888-552-2952.</i> | | | |
| <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could Not Be Determined | | | |
| 28. CAUSE PART I. Enter the <u>chain of events</u> – 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 a line. Add additional lines if necessary. | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____ Due to (or as a consequence of): | | | APPROXIMATE INTERVAL: ONSET TO DEATH |
| Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST . | | | |
| b. _____ Due to (or as a consequence of): | | | |
| c. _____ Due to (or as a consequence of): | | | |
| d. _____ | | | |
| 29. CAUSE PART II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I. | | | |
| 30. DID TOBACCO USE CONTRIBUTE TO DEATH? | | 31. IF FEMALE: | |
| <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown | | <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 of death | |
| 32a. WAS MEDICAL EXAMINER CONTACTED? | 32b. M.E. CASE NUMBER | 33. WAS AN AUTOPSY PERFORMED? | 34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF AN INJURY IS PART OF THE CAUSE OF DEATH (Pt. I OR II) THE DEATH SHOULD BE CERTIFIED BY A MEDICAL EXAMINER. CALL 1-888-552-2952 | | | |
| 35. DATE OF INJURY (Month, Day, Year) | 36. TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM | 37. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) | 38. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 39. LOCATION OF INJURY (Street and Number, City or Town, State) | | | |
| 40. DESCRIBE HOW INJURY OCCURRED | | 41. IF TRANSPORTATION INJURY, SPECIFY: | |
| | | <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (specify) _____ | |
| 42a. ACTUAL OR PRESUMED DATE OF DEATH (Month, Day, Year) | 42b. ACTUAL OR PRESUMED TIME OF DEATH <input type="checkbox"/> AM <input type="checkbox"/> PM | 42c. DATE PRONOUNCED DEAD (Month, Day, Year) | 42d. TIME PRONOUNCED DEAD <input type="checkbox"/> AM <input type="checkbox"/> PM |
| 43a. SIGNATURE OF CERTIFIER – To the best of my knowledge, on the basis of case history, examination, and/or investigation, death occurred at the time, date, and place and due to the cause(s) and manner stated. | | | 43b. DATE CERTIFIED (Month, Day, Year) |
| 43c. NAME OF CERTIFIER (Type or Print) | | | 43d. LICENSE NUMBER |
| 43e. ADDRESS OF CERTIFYING PHYSICIAN (Street and Number, City or Town, State, Zip Code) | | | 44. CONTACT PHONE NUMBER () |
| 45. TITLE OF CERTIFIER: <input type="checkbox"/> Physician <input type="checkbox"/> Pathologist <input type="checkbox"/> Medical Examiner | | 46. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) | |

To Be Completed/Verified By: MEDICAL CERTIFIER

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