# Preliminary Report of Death – Demographic Information

**Name Known to Physician:**

**Date of Death:**

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| **STATE OF VERMONT** |
| **DEPARTMENT OF HEALTH** |

**Preliminary Report of Death – Demographic Information**

**Type or Print in Black Ink**

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.</td>
<td><strong>DECEDEENT’S LEGAL NAME</strong> (First, Middle, Last, Suffix)</td>
</tr>
<tr>
<td>1b.</td>
<td><strong>ALIASES</strong> (Any other names the decedent used or was known as)</td>
</tr>
<tr>
<td>1c.</td>
<td><strong>DECEDEENT’S LAST NAME AT BIRTH</strong></td>
</tr>
</tbody>
</table>
| 2. | **SEX:**  
- Male  
- Female |
| 3. | **SOCIAL SECURITY NUMBER** |
| 4a. | **AGE-LAST BIRTHDAY** (Years) |
| 4b. | **IF UNDER 1 YEAR** (Months, Days, Hours, Minutes) |
| 4c. | **IF UNDER 1 DAY** (Days, 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. | **EVEN IN U.S. ARMED FORCES?**  
- Yes  
- No |
| 8b. | **VETERAN OF ANY WAR?**  
- Yes  
- No |
| 8c. | **IF SO, WHAT WAR(S)?** |
| 9. | **MARITAL STATUS AT TIME OF DEATH:**  
- Married  
- Widowed  
- Divorced  
- Civil Union dissolution  
- Never Married or in Civil Union  
- Unknown |
| 10a. | **BIRTH NAME OF SURVIVING SPOUSE / CIVIL UNION PARTNER**  
- Male  
- Female  
- Unknown |
| 10b. | **SEX OF SURVIVING SPOUSE/PARTNER**  
- Male  
- Female  
- 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 DECEDEENT** |
| 13c. | **INFORMANT’S MAILING ADDRESS** (Street and Number, City or Town, State, Zip Code) |
| 14. | **DECEDEENT’S EDUCATION LEVEL:** (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  
- Associate degree (e.g., AA, AS)  
- Bachelor’s degree (e.g., BA, AB, BS)  
- Master’s degree (e.g., MA, MS, ME, Eng, Med, MSW, MBA)  
- Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)  
- No degree  
- Other (Specify)  
- Unkown |
| 15. | **DECEDEENT’S RACE:** (Check one or more races to indicate what the decedent considered himself or herself to be.)  
- White  
- Black or African American  
- American Indian or Alaska Native (Name of the enrolled or principal tribe)  
- Asian Indian  
- Chinese  
- Filipino  
- Japanese  
- Native Hawaiian  
- Guamanian or Chamorro  
- Samoan  
- Other Pacific Islander (Specify)  
- Other (Specify)  
- Unknown |
| 16. | **DECEDEENT’S OCCUPATION** (Indicate type of work done during most of working life. DO NOT USE RETIRED) |
| 17. | **DECEDEENT’S USUAL OCCUPATION** (Indicate type of work done during most of working life. DO NOT USE RETIRED) |
| 18. | **KIND OF BUSINESS/INDUSTRY** |
| 19. | **DID DECEDEENT RECEIVE HOSPICE CARE?**  
- Yes  
- No  
- Unknown |
| 20. | **PLACE OF DEATH**  
- If death occurred in a hospital:  
- Inpatient  
- Intensive Care Unit  
- Emergency Room/Outpatient  
- Dead on Arrival  
- Nursing Home / Long Term Care Facility  
- Hospice Facility  
- Decedent's Home  
- Other (Specify)  |
| 21a. | **FACILITY NAME** (If not institution, give street and number) |
| 21b. | **CITY OR TOWN** |
| 21c. | **STATE** |
| 22a. | **METHOD OF DISPOSITION:**  
- Temporary Storage  
- Burial  
- Cremation  
- Donation  
- Embalming  
- Removal from State  
- 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) |

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*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.*
STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Medical Certification

19. DID DECEDENT RECEIVE HOSPICE CARE? (In past 30 days) □ Yes □ No □ Unknown

20. PLACE OF DEATH
   If death occurred in a hospital: (Indicate only one) □ Inpatient □ Intensive Care Unit
   □ Nursing Home / Long Term Care Facility □ Hospice Facility □ Decedent’s Home
   □ Emergency Room/Outpatient □ Dead on Arrival □ Other (specify) ____________________________
   If death occurred somewhere other than a hospital: _____________________________________________

21a. FACILITY NAME (If not institution, give street and number) 21b. CITY OR TOWN 21c. STATE

27. MANNER OF DEATH:
   Note: All deaths that are not ‘Natural’ should be referred to a Medical Examiner. Call 1-888-552-2952.
   □ Natural □ Accident □ Suicide □ Homicide □ Pending Investigation □ Could Not Be Determined

28. CAUSE – 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.

PART I
   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):
   b. ________________________ ____________________________                __________________
   Due to (or as a consequence of):
   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.

30. DID TOBACCO USE CONTRIBUTE TO DEATH? □ Yes □ No □ Probably

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

32a. WAS MEDICAL EXAMINER CONTACTED? □ Yes □ No

32b. M.E. CASE NUMBER

33. WAS AN AUTOPSY PERFORMED? □ Yes □ No

34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH? □ Yes □ 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 □ AM □ PM

37. PLACE OF INJURY (e.g. Decedent’s home, construction site, restaurant, wooded area)

38. INJURY AT WORK? □ Yes □ No

39. LOCATION OF INJURY (Street and Number, City or Town, State)

40. DESCRIBE HOW INJURY OCCURRED

41. IF TRANSPORTATION INJURY, SPECIFY:
   □ Driver/Operator □ Passenger □ Other (specify) ____________________________
   □ Pedestrian

42a. ACTUAL OR PRESUMED DATE OF DEATH (Month, Day, Year)

42b. ACTUAL OR PRESUMED TIME OF DEATH □ AM □ PM

42c. DATE PRONOUNCED DEAD (Month, Day, Year)

42d. TIME PRONOUNCED DEAD □ AM □ 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.

43c. NAME OF CERTIFIER (Type or Print)

43d. LICENSE NUMBER

43b. DATE CERTIFIED (Month, Day, Year)

43e. ADDRESS OF CERTIFIER (Street and Number, City or Town, State, Zip Code)

44. CONTACT PHONE NUMBER ( )

45. TITLE OF CERTIFIER □ Physician □ Pathologist □ Medical Examiner
   □ Physician Assistant □ Advanced Practice Registered Nurse

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