

TYPE OR
PRINT IN
PERMANENT
BLACK INK.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-

I.D. TAG NO.

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY	1. Legal Name (Include AKAs, if any)				2. Death Date (MON DD YYYY)	
	3. Sex (MF)	4a. Age — Last Birthday	4b. Under 1 Year	4c. Under 1 Day	5. Social Security Number	
	7. Birthdate (MON DD YYYY)	8a. Birthplace (City/Town, or County)		8b. (State or Foreign Country)		9. Decedent's Education
	10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.)			11. Decedent's Race(s)		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No
	13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8)				14. City/Town	
	15. Residence County		16. State or Foreign Country		17. Zip Code + 4	18. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	19. Marital Status at Time of Death			20. Spouse's Name (If married or widowed, give name prior to first marriage.)		
	21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.")				22. Kind of Business/Industry (DO NOT USE COMPANY NAME.)	
	23. Father's Name (First, Middle, Last, Suffix)			24. Mother's Name Prior to First Marriage (First, Middle, Last)		
	25. Informant's Name		26. Telephone Number	27. Relation to Decedent	28. Mailing Address (Number & Street, City/Town, State, Zip + 4)	
29. Place of Death			30. Facility Name			
31. Location of Death (Give address.)			32. City/Town or Location of Death	33. State	34. Zip Code + 4	
35. Method of Disposition		36. Place of Disposition (Name of cemetery, crematory, or other place)		37. Location		
38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4)						
39. Date of Disposition (MON DD YYYY)		40. Funeral Director's Signature		41. OR License Number		
42. Registrar's Signature			43. Date Received (MON DD YYYY)		44. Local File Number	
45. Record Amendment						
TO BE COMPLETED BY MEDICAL CERTIFIER	46. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Were autopsy findings available to complete the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		49. Time of Death	
	50. 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.					
	Final disease or condition resulting in death →	IMMEDIATE CAUSE ↓				
	Sequentially list conditions, if any, leading to the cause listed on line a. ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events 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.	Due to (or as a consequence of) ↓			
	51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:					
	52. Manner of Death		53. If Female		54. Did tobacco use contribute to death?	
	<input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		<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 before death		<input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	
55. Date of Injury (MON DD YYYY)	56. Time of Injury	57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)		58. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
59. Location of Injury (Number & Street, City/Town, State, Zip + 4)						
60. Describe how injury occurred.				61. If transportation injury, specify. <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4)						
63. Name and Title of Attending Physician if Other than Certifier						
64. Title of Certifier			65. License Number		66. Date Signed (MON DD YYYY)	
67. Medical Certifier - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				68. Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.		
69. Record Amendment						