CASE # ______

Mortuary: ______

BATCH ______

Hospice: ☐ YES ☐ NO Hospice Agency: ______

FUNERAL DIRECTOR ______

FAMILY SERVICE COUNSELOR ______

______ # OF CERTIFIEDS

______ SALES CONTRACT #

City of Birth: ______

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 1/03)

STATE FILE NUMBER ______ LOCAL REGISTRATION NUMBER ______

DECEDENT'S PERSONAL DATA

1 NAME OF DECEDENT - - - FIRST (Given)	2 MIDDLE	3 LAST (Family)

AKA ALSO KNOWN AS - - - Include full AKA (FIRST, MIDDLE, LAST)	4 DATE OF BIRTH mm/dd/ccyy	5 AGE Yrs.	IF UNDER ONE YEAR Months / Days	IF UNDER 24 HOURS Hours / Minutes	6 SEX

9 BIRTH STATE/FOREIGN COUNTRY	10 SOCIAL SECURITY NUMBER	11 EVER IN U.S. ARMED FORCES? ☐ YES ☐ NO ☐ UNK	12 MARITAL STATUS (at time of Death)	7 DATE OF DEATH mm/dd/ccyy	8 HOUR (24 Hours)

13 EDUCATION - - - Highest Level/Degree (see worksheet on back)	14/15 WAS DECEDENT SPANISH/HISPANIC/LATINO? (If yes, see worksheet on back) ☐ YES ☐ NO	16 DECEDENT'S RACE - - - Up to 3 races may be listed (see worksheet on back)

17 USUAL OCCUPATION - - - Type of work for most of life. DO NOT USE RETIRED	18 KIND OF BUSINESS OR INDUSTRY (e.g. grocery store, road construction, employment agency, etc.)	19 YEARS IN OCCUPATION

USUAL RESIDENCE

20 DECEDENT'S RESIDENCE (Street and number or location)				
21 CITY	22 COUNTY/PROVINCE	23 ZIP CODE	24 YEARS IN COUNTY	25 STATE/FOREIGN COUNTRY

INFORMATION

26 INFORMANT'S NAME, RELATIONSHIP	27 INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP)

SPOUSE AND PARENT INFORMATION

28 NAME OF SURVIVING SPOUSE - - - FIRST	29 MIDDLE	30 LAST (Maiden Name)	
31 NAME OF FATHER - - - FIRST	32 MIDDLE	33 LAST	34 BIRTH STATE
35 NAME OF MOTHER - - - FIRST	36 MIDDLE	37 LAST (Maiden Name)	38 BIRTH STATE

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39 DISPOSITION DATE mm/dd/ccyy	40 PLACE OF FINAL DISPOSITION		
41 TYPE OF DISPOSITION(S)	42 SIGNATURE OF EMBALMER		43 LICENSE NUMBER
44 NAME OF FUNERAL ESTABLISHMENT	45 LICENSE NUMBER	46 SIGNATURE OF LOCAL REGISTRAR	47 DATE mm/dd/ccyy

PLACE OF DEATH

101 PLACE OF DEATH	102 IF HOSPITAL, SPECIFY ONE ☐ IP ☐ ER/OP ☐ DOA	103 IF OTHER THAN HOSPITAL, SPECIFY ONE ☐ Hospice ☐ Nursing Home/LTC ☐ Decedent's Home ☐ Other
104 COUNTY	105 FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location)	106 CITY

PHYSICIAN'S CERTIFICATION

114 I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATE FROM THE CAUSES STATE — Decedent Attended Since / Decedent Last Seen Alive		115 SIGNATURE AND TITLE OF CERTIFIER	116 LICENSE NUMBER	117 DATE mm/dd/ccyy
(A) mm/dd/ccyy	(B) mm/dd/ccyy	118 TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE		

By signing you are verifying that the information for the Death Certificate is TRUE & CORRECT.
Any corrections after the certificate is filed, will be at the expense of the family.

______ Authorized Signature

SPECIAL INSTRUCTIONS

______

______

______

______

______

Informant's E-mail Address: ______

Informant's Phone ______

______ COUNSELOR

DATE OF BIRTH ______ SS# ______

Yearly No. ______ Monthly No. ______ Page No. ______