

STATE OF COLORADO
CERTIFICATE OF DEATH

STATE FILE NUMBER

FUNERAL DIRECTOR

PHYSICIAN/CORONER

1. DECEDENT'S NAME (First, Middle, Last)				2. SEX		3. DATE OF DEATH (Month, Day, Year)			
4. SOCIAL SECURITY NUMBER		5a. AGE - (Years)	5b. UNDER 1 YEAR Mos Days	5c. UNDER 1 DAY Hrs Mins		6. DATE OF BIRTH Month Day Year		7. BIRTHPLACE (City and State or Foreign Country)	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		9a. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other (Specify) OTHER: <input type="checkbox"/> Assisted Living/Nursing Home <input type="checkbox"/> Hospice <input type="checkbox"/> Decedent's Residence							
9b. FACILITY NAME (If not institution, give street and number)				9c. CITY, TOWN, OR LOCATION OF DEATH			9d. COUNTY OF DEATH		
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired)			10b. KIND OF BUSINESS/INDUSTRY		11. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown		12. SPOUSE (If wife, give maiden name)		
13a. RESIDENCE - STATE		13b. COUNTY	13c. CITY, TOWN, OR LOCATION			13d. STREET AND NUMBER			
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (If "Yes", specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:		15. RACE: American Indian, Black, White, etc. (Specify)		16. EDUCATION: (Specify only highest grade completed) Elementary or secondary (0 - 12) College (13-16 or 17+)			
17. FATHER - NAME (First, Middle, Last)			18. MOTHER - NAME (First, Middle, Maiden)			19. INFORMANT - NAME and relationship to deceased			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial/Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		<input type="checkbox"/> Resomation <input type="checkbox"/> Removal from State	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)			20c. LOCATION - City or Town, State			
21a. SIGNATURE OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH Signature				21b. NAME AND ADDRESS OF FACILITY Evergreen Mortuary 26624 N. Turkey Creek Road Evergreen, CO 80439					
22a. REGISTRAR'S SIGNATURE Signature						22b. DATE FILED (Month, Day, Year)			
23. TIME OF DEATH <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Milt		24. DATE AND TIME PRONOUNCED DEAD Month Day Year Time				25. WAS CORONER NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
TO BE COMPLETED BY SIGNING PHYSICIAN 26a. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature				TO BE COMPLETED BY CORONER 27a. 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 as stated. Signature					
26b. DATE SIGNED (Month, Day, Year)				27b. DATE SIGNED (Month, Day, Year)					
26c. NAME, AND MAILING ADDRESS OF SIGNING PHYSICIAN				27c. NAME AND COUNTY					
29. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined				30. DID TOBACCO USE CONTRIBUTE TO DEATH <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		31. IF FEMALE: <input type="checkbox"/> Not pregnant within last 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. DATE OF INJURY (Month, Day, Year)		32b. TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Milt	32c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	32d. DESCRIBE HOW INJURY OCCURRED					
32e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			32f. LOCATION INJURED (Street and Number or Rural Route Number, City, County, State)						
33. IMMEDIATE CAUSE - enter only one cause per line for (a), (b), and (c). Do not enter mode of dying (e.g. Cardiac or Respiratory Arrest) alone.						Interval between onset and death			
Part 1. Conditions if any which gave rise to immediate cause stating the underlying cause last (c). (a) _____ DUE TO OR AS A CONSEQUENCE OF:						Interval between onset and death			
(b) _____ DUE TO OR AS A CONSEQUENCE OF:						Interval between onset and death			
(c) _____									
Part 2. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause in Part 1						34. AUTOPSY <input type="checkbox"/> Yes <input type="checkbox"/> No	35. If YES, were findings considered in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		