

I'm not a robot!

IOWA FUNERAL PLANNING				
Iowa Death Certificate Worksheet				
Decedent's Full Name:				
First	Middle	Last		
Date of Birth:		Social Security #:		
Decedent's Address:				
Street address (not a PO box)			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <small>(Inside City Limits?)</small>	
City	State	Zip	County	
Decedent's marital status: SELECT FROM dropdown				
Spouse's Full Name: <small>Mark if spouse is deceased:</small> First Middle Maiden				
Father's Full Name: First Middle Last				
Mother's Full Name: First Middle Maiden				
Decedent's State or Country of birth:		Veteran's Branch of Service	SELECT FROM dropdown <small>(If Applicable)</small>	
Decedent's level of education: SELECT FROM dropdown				
Decedent's Hispanic Origin: SELECT FROM dropdown				
Decedent's Race: SELECT FROM dropdown				
Decedent's Occupation:		Kind of business or industry:		
The Informant on the death certificate is the person or family member who will be handling the affairs of the deceased. The information below is listed on the death certificate.				
Informant's Full Name:				
First	Middle	Last		
Informant's Address:				
Street address (not a PO box)			Relationship to Deceased	
City	State	Zip		
Informant's preferred phone: _____ Informant email: _____				

Ministry of Consumer and Business Services

Office of the Registrar General

 Ontario

Medical Certificate of Death - Form 16

You must use the Stillbirth Registration Form 8 when registering stillbirths. This form must be completed by the attending physician, coroner, or designated person before a burial permit can be issued. Please PRINT clearly in blue or black ink as it is a permanent legal record.

Hospital code number

INFORMATION ABOUT THE DECEASED

1. Name of deceased (last, first, middle)	2. Date of death [month - by name, day, year (in full)]					
3. Sex (M or F)	4. Age	5. If under 1 yr. Months	6. If under 1 day Hours	7. Gestation age	8. Birth weight	
9. Place of death (name of facility or location)				nursing home	residence	other
10. City, town, village or township			Regional municipality, county or district			

CAUSE OF DEATH

CAUSE OF DEATH	11. Part I	I	Approximate interval between onset & death		
	Immediate cause of death	(a) due to, or as a consequence of			
	Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b) due to, or as a consequence of			
	Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	(c) due to, or as a consequence of	(d)		
12. If deceased was a female, did the death occur:	during pregnancy (including abortion and ectopic pregnancy)	within 42 days thereafter	between 43 days and 1 year thereafter		
13. Was the deceased dead on arrival at the hospital?	Yes <input type="checkbox"/> No <input type="checkbox"/>	14. Was there a surgical procedure within 28 days of death?	Yes <input type="checkbox"/> No <input type="checkbox"/>	15. Date of surgery (m/d/y)	
16. Reason for surgery and operative findings					
17. Autopsy being held?	Yes <input type="checkbox"/> No <input type="checkbox"/>	18. Does the cause of death stated above take account of autopsy findings?	Yes <input type="checkbox"/> No <input type="checkbox"/>	19. May further information relating to the cause of death be available later?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Accidental or violent death (if applicable)	20. If accident, suicide, homicide or undetermined (specify)	21. Place of injury (e.g. home, farm, highway, etc.)	22. Date of injury (m/d/y)		
	23. How did injury occur? (describe circumstances)				

CERTIFICATION

By signing below, you certify that the information on this form is correct to the best of your knowledge.

24. Your signature (physician, coroner, RN(E.C.), other): X	25. Date (m/d/y)
26. Your name (last, first, middle):	27. Your title: <input type="checkbox"/> Physician <input type="checkbox"/> Coroner <input type="checkbox"/> RN(EC) <input type="checkbox"/> other (specify)
28. Your address (street number and name, city, province, postal code):	

TO BE COMPLETED BY THE DIVISION REGISTRAR

By signing below, I am satisfied that the information in this Medical certificate of death and the Statement of death is correct and sufficient and I agree to register the death.

Signature X	Date (m/d/y)	Registration number	Div. reg. code no.
For the use of the Office of the Registrar General only			

Personal information contained in this form is collected under the authority of the Vital Statistics Act, R.S.O. 1990, c. V.5 and will be used to register and record the births, still births, deaths, marriages, adoptions, deaths from natural causes or accidents, provide certified copies, documents, certificates, search notices, subpoenas and for statistical, research, medical, environmental, adoption and adoption disclosure purposes. Questions about this collection should be directed to the Deputy Registrar General at P.O. Box 4600, Thunder Bay, ON P7B 6L8. Telephone 1-800-461-2156 or 416-325-8305.

1128(H)(1)(b)

No.

Folud - 6
Form - 6

Government of India
ಭಾರತ ಸರ್ಕಾರ

GOVERNMENT OF KARNATAKA
ಖಾತೆ ಮತ್ತು ಮರಣದ ಮೂಲ ರಿಜಿಸ್ಟ್ರಿ
Chief Registrar of Births and Deaths

ಬಿಬಿ ಪ್ರಮಾಣ ಪತ್ರ

(ನಿರ್ದಿಷ್ಟ ನಿಯಮ, 1969 ಅಥವಾ 12/17 ನಾಲ್ಕು ವರ್ಷಗಳ ನಿರ್ದಿಷ್ಟ ನಿಯಮ, 1999 ಅಥವಾ 8/13 ನಾಲ್ಕು ನಿಯಮ)

DEATH CERTIFICATE

(Issued under Section 12/17 of the RBD Act, 1969 and Rule 8/13 of the KRBD Rules, 1999)

ಇಡೀ ಮರಣದ ದಿನಾಂಕ: ತಿಥಿ: ಸಾಲು: ಶಿಕ್ಷಣ
 ಮರಣದ ಸ್ಥಾನ: (ನಗರ/ಉಪನಗರ) ಮಹಿಳೆ/ಹುದ್ದೆ ಸ್ಥಾನ: ಮರಣದ
 ಸ್ಥಾನದ ವರ್ಣನೆ: ಮರಣದಿನಾಂಕ: ಮರಣದಿನಾಂಕ:

This is to certify that the following information has been taken from the original record of death which is the register for (village/town)
 taluk of district of Karnataka State.

(1) Name	(2) Sex
(3) Date of Death	(4) Place of Death
(5) Name of Mother	(6) Name of the Father/Husband.....
(7) Address of the deceased at the time of death:	(8) Permanent address of the deceased
(9) Registration No	(10) Date of Registration
(11) Remarks(if any)	(12) Date of issue
(13) Signature of the issuing authority	(14) Address of the issuing authority

Classify Seal

"ಖಾತೆ ಮತ್ತು ಮರಣದ ರಿಜಿಸ್ಟ್ರಿ, ಕರ್ನಾಟಕ"
 "Ensure registration of every birth and death"

ಈ ಪತ್ರ ಮರಣದ ಕಾಲಾನ್ತರದಲ್ಲಿ ಮರಣದ ಕಾಳಿಯ ನಿಯಮ, 17(1)ದ ನಿಯಮದ ಮೂಲಕ.

No disclosure shall be made of particulars regarding the cause of death as entered in the Register. See proviso to Section 17(1).

STATE OF ILLINOIS CERTIFICATE OF DEATH		STATE FILE NUMBER	
LOCAL FILE NUMBER		2 SEX	3 DATE OF DEATH (Month/Day/Year) (Split Box)
1. DECEDENT'S LEGAL NAME (include M.I.s if any) (First, Middle, Last)			
4. COUNTY OF DEATH		5a. AGE AT LAST BIRTHDAY (Years) Months	5b. UNDER 1 YEAR Months
6. CITY OR TOWN		6. HOSPITAL OR OTHER INSTITUTION NAME if not at other, give street and number	
7. PLACE OF DEATH (Check all that apply as instructed)			
If DEATH OCCURRED IN A HOSPITAL			
<input type="checkbox"/> Hospital <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Hospital Facility <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Death in Hospital <input type="checkbox"/> Death at Home Other (Specify)			
8. BIRTHPLACE (City and State or Foreign Country)		9. SOCIAL SECURITY NUMBER	
10. RESIDENCE (Street and Number)		11. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never married	
12a. COUNTY 12b. STATE 12c. ZIP CODE		13. PATIENT'S NAME (First, Middle, Last)	
14. INFORMANT'S NAME		15. MOTHER'S NAME PRIOR TO MARRIAGE (First, Middle, Last)	
16. RELATIONSHIP		18a. MAILING ADDRESS (Street, City or Town, State, Zip Code)	
17. MEDIUM OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify)		18. LOCATION: CITY, TOWN AND STATE 19. DATE OF DEPOSITION (Month/Day/Year)	
20. FUNERAL HOME NAME		21. STREET NUMBER	
22. FUNERAL DIRECTOR'S SIGNATURE		23. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER	
24. LOCAL REGISTRAR'S SIGNATURE		25. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)	

1A. You should then go back through the others which led to the possible cause of death until it reached the underlying cause of death that started this chain of events. The lowest completed .emon out li ottos o otnacca osulcni eresse ehcna ebbervod CMG oremun out II .osse a otnacca ihccolb a elatipac id erettel ni emon out li erapmats e etrom id otacifitrec li eramrif oirassecen "Ä otacifitrec la odnof ni ilgatted irtla .itad ied enoizaterpretni'l e evitacnumoc Äticapac el ,erudecorp el ,ocinilc emase'l onorpoc ehc drachsalf 0002 ertlo eneitnco ehc ECSO drachsalf id atlocar artson alla otassereti eresse ehcna itsertoP .etneizap led atassap acidem airots aretni'l eracnele itservod iuc ni etrap ehclauq ad "Ä noN .etinomlop id otrom "Ä ehc etneizap nu ni acimehcsi aitapoidrac al eresse ebbertop oipmese nU .etrom al erednetta'llen olour nu otuva ah etnemlibaborp am ,etrom id elasuac azneuqes elapicnirp alled etrap onavecaf non ehc inoizidnoc ertla eratnemucod id etnesnoc II etrom alla otuibirtnco reva orebbertop ehc inoizidnoc - II etraP .inna 08 id 'Äip onnah ehc itneizap ni olos otasu eresse "Äup otseuq :etrom id asuac acinu emoc Ätiligarf/onaizna amoc otnemiruase id ocaidrac otserra aissehcac ainetsa aissifsA .aizitsegnoc acaidrac azneiciffusni erazzilit KO "Ä ,aivattuT .)airotaripser/otagef/etnemaner/acaidrac azneiciffusni oipmese da(a1 acinu emoc →ä seruliaFÄ →ä :a1 emoc erevircs ioup non ehc esoc enuLA .etrom id inumoc esuac id attart is ehc onamreffa isetnerap us iop rep ehc aenil assets allus ais elriresni oirassecen "Ä ,isac itseuq ni e etrom alla etnematterid otatrop onnah ehc etarapes inoizidnoc eud eresse onossop ic ,eznatsothic enucla nI ."orcncac" ehc otsottuip "elapicnirp ocnorb ortsed led amonicraconeda'l" ehc eramreffa eresse ebbertop oipmese nU .iah ehc inoizamrofni el etad elibissop ocificeps 'Äip li iis ,etrom alled asuac al amreffa is odnauQ .A1 aenil al olos eratelpmoc elibattecca "Ä ,isac itseuq nI .edioncarabus aigarrome'nu emoc ,etrom alla etnematterid atrop ehc enoizidnoc anu olos ereva onossop itrom enuclA .etnatsottos etrom id asuac al erenetnco idniuq ebbervod 1 etrap alleN otrom otrom "Ä etneizap li eS .)elanosrep ozziridni out li non(eladepso'lled ozziridni'l ereneg ni "Ä aznediser aL .)aigrurihc e SBBM anicideM .se da(CMG etavorppa ehcifilaq el Document the name of the consultant on the small line at the bottom of the certificate (this is easily lost). Counterfoil There is a countermission on the left side that is left in the death certificate book. It is necessary to document the patient's name, the cause of death (part 1) and the conditions potentially contributing to death (part 2). You also need to document your personal details again. Other

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