Arizona Department of Health Services
Office of Vital Records
Death Registration Worksheet

This form is for the collection of the data needed to complete the Arizona Certificate of Death

This is not a death certificate.

Name:

Personal Information:

Legal First Name _____ Legal Middle Name _____ Legal Last Name _____ Suffix _____

AKA's if any _____ Gender: (Circle one) M F Unknown

Date of Birth: ___/___/___ Date of Death: ___/___/___ ☐Actual ☐Found

Age in: _____Years or _____Months or _____Days or _____Hours or _____Minutes

U.S. Social Security Number _____-_____-_____ ☐None ☐Unknown

Place of Death:

City, Town, or Location _____ County _____ Zip Code _____

Place of Death: ☐Dead on Arrival, ☐Decedent's Residence, ☐ER/Outpatient, ☐Hospice Facility, ☐Inpatient,

☐Nursing Home/Long Term Care, ☐Other (Specify)_____

Place of Death Facility _____

Specify Other Institution or Specify Street and Number _____

Marital Status: ☐Divorced, ☐Married, ☐Married but Separated, ☐Never Married, ☐Not Obtainable, ☐Unknown, ☐Widowed

First Name of Surviving Spouse _____ Middle Name of Surviving Spouse _____ Last Name of Surviving Spouse _____ Suffix _____

Last Name of Surviving Spouse Prior to First Marriage _____

Education (Select one):

☐8th grade or less
☐9th through 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, BS)
☐Master's degree (e.g.: MA, MS, MEng, MEd, MSW, MBA)
☐Doctorate (e.g.: PhD, EdD, or Professional Degree e.g.: MD, DO)
☐Refused
☐Not Obtainable
☐Unknown
☐Not Classifiable

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Name:

Decedent's Race (Select all that apply):	Decedent's Hispanic Origin: Check the box that best corresponds with the decedent's ethnic identity as given by the informant.
□White □Black or African-American □American Indian or Alaska Native: Primary or Enrolled Tribe: _____ Second Tribe (Optional): _____ Additional Tribe: _____ Additional Tribe: _____ □Asian Indian □Chinese □Filipino □Japanese □Korean □Vietnamese □Other Asian (Specify) _____ □Native Hawaiian □Guamanian or Chamorro □Samoan □Other Pacific Islander (Specify)_____ □Other (Specify) _____ □Unknown □Refused □Not Obtainable	□Not Spanish, Hispanic or Latino □Mexican, Mexican American or Chicano □Puerto Rican □Cuban □Other (Specify) _____ □Unknown □Refused □Not Obtainable

Birth Information:

Birth Country _____ Birth State _____ Birth County _____ Birth City _____

Decedent's Residence Address:

Decedent's Street Address _____ Unit # _____ City _____ State _____ Zip Code _____

Residence County _____ Residence Country _____ How Long in Arizona _____ (Days, Years, etc.)

□Yes □No □Unknown In City Limits □Yes □No □Unk On Arizona Reservation If yes, name of Arizona Reservation _____

Decedent's Occupation _____ Decedent's Industry _____ □Yes □No □Unknown U.S. Armed Forces

Father's First Name _____ Middle Name _____ Last Name _____ Suffix _____

Mother's First Name _____ Middle Name _____ Mother's Last Name Prior to First Marriage _____

Informant:

First Name _____ Middle Name _____ Last Name _____ Suffix _____

Relationship to Deceased _____

Informant's Mailing Address (including county) _____ Zip Code _____

To the best of my knowledge, the above information on pages 1 and 2 of this worksheet is true and correct.

Informant's Signature _____ Date Signed _____

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Name:

Disposition:

_____/_____/_____
Date of Final Disposition

Method(s) of Disposition

- ☐ Burial
- ☐ Cremation
- ☐ Donation
- ☐ Donation/Burial
- ☐ Donation/Cremation
- ☐ Donation/Entombment
- ☐ Entombment
- ☐ Removal From State
- ☐ Removal/Burial
- ☐ Removal/Cremation
- ☐ Removal/Donation
- ☐ Removal/Donation/Burial
- ☐ Removal/Donation/Cremation
- ☐ Removal/Donation/Entombment
- ☐ Removal/Entombment
- ☐ Removal/Other (Specify Other)_____
- ☐ Unknown
- ☐ Other (Specify):_____

_____
Name, City & State of First Disposition Facility or Crematory

_____
Name, City & State of Second Disposition Facility or Cemetery

_____
Name and Address of Funeral Home

Funeral Director: _____ _____
Name License Number

_____ _____
Signature of Funeral Director Date Signed

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Death Registration Worksheet – Page 4 - Medical Certification

Name:

____/____/____ Date of Death | Actual or Found Circle one | ____ □AM □PM □Military Time of Death | Actual or Found Circle one

Cause of Death Information: Was M.E. Contacted? □ Yes □ No

Part 1A ____ Immediate Cause of Death | ____ Duration

Part 1B ____ Due to or as a Consequence of | ____ Duration

Part 1C ____ Due to or as a Consequence of | ____ Duration

Part 1D ____ Due to or as a Consequence of | ____ Duration

Part 2 ____

Was an autopsy performed? □ Yes □ No. Were autopsy findings available to complete the cause of death? □ Yes □ No.

Did tobacco use contribute to death?

□ Yes
□ No
□ Probably
□ Unknown

If the decedent was female between the ages of 5 and 75, select one of the following:

□ Not pregnant but pregnant 43 days to one year before death
□ Not pregnant but pregnant within 42 days of death
□ Not pregnant within past year
□ Pregnant at time of death
□ Unknown if pregnant within past year

Did death involve an injury of any kind? □Yes □No □Unknown. If yes, complete the following:

Date of injury: ____/____/____ □ Actual, □ Could not be Determined

Time of injury: ____ □AM □PM □ Actual, □ Could not be Determined

Did injury occur at work? □ Yes, □No, □ Unknown

____
Address of place of injury (Street address, city, county, state, country & Zip)

Describe how injury occurred: ____

____

MEDICAL EXAMINER ONLY

Place of Injury:

□ Farm
□ Home
□ Industrial or Construction Area
□ Residential Institution
□ School, Other Institution & Public Administrative Area
□ Sports & Athletics Area
□ Street & Highway
□ Trade & Service Area
□ Unknown
□ Other (Specify) ____

If traffic accident, the decedent was:

□ Driver/Operator
□ Not Applicable
□ Passenger
□ Pedestrian
□ Other ____
□ Unknown

Manner of Death:

□ Accident
□ Homicide
□ Natural Death
□ Pending Investigation
□ Suicide
□ Undetermined

□ **Certifying Physician or Nurse Practitioner** –To the best of my knowledge, death occurred due to the cause(s) and manner stated.

□ **Medical Examiner, Tribal Investigator** - 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.

____
Signature and Date

____
Print Name