

✓ **Please fill out (Items 1-25)**

STATE OF TEXAS	CERTIFICATE OF DEATH	STATE FILE NUMBER
1. LEGAL NAME OF DECEASED (Include AKA's if any) (First, Middle, Last) _____ (Maiden)		2. DATE OF DEATH – ACTUAL OR PRESUMED _____
3. SEX _____	4. DATE OF BIRTH _____	5. AGE-Last Birthday (Years) _____
		6. BIRTHPLACE (City & State or Foreign Country) _____
		7. SOCIAL SECURITY NUMBER _____
8. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		9. SURVIVING SPOUSE (If wife, give name prior to first marriage) _____
10a. RESIDENCE STREET ADDRESS _____		10b. APT NO _____
10d. COUNTY _____		10e. STATE _____
10f. ZIP CODE _____		10g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. FATHER'S NAME _____		12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE _____
13. PLACE OF DEATH (CHECK ONLY ONE)		
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify) _____
14. COUNTY OF DEATH _____	15. CITY/TOWN, ZIP (If outside city limits, give precinct no) _____	16. FACILITY NAME (If not institution, give street address) _____
17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED _____		18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code) _____
19. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify) _____		20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH _____
21. _____ <input type="checkbox"/> Unknown		Section _____
		Block _____
		Lot _____
		Space _____
22. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) _____		23. LOCATION (City/Town, and State) _____
24. NAME OF FUNERAL FACILITY _____		25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) _____
26. CERTIFIER (Check only one): <input type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/Justice of the Peace – 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.		
27. SIGNATURE OF CERTIFIER _____		28. DATE CERTIFIED (Mo/Day/Yr) _____
		29. LICENSE NUMBER _____
		30. TIME OF DEATH (Actual or presumed) _____
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) _____		32. TITLE OF CERTIFIER _____
33. PART 1. 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. ENTER ONLY ONE CAUSE ON EACH LINE.		Approximate interval: Onset to death _____
IMMEDIATE CAUSE (Final disease or condition -----> resulting in death) a. _____ Due to (or as a consequence of): _____		
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST. c. _____ Due to (or as a consequence of): _____		
PART 2. ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I. d. _____ Due to (or as a consequence of): _____		
34. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No		35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No
36. 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"/> Could not be determined	37. DID TOBACCO CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year
39. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		
40a. DATE OF INJURY (Mo/Day/Yr) _____	40b. TIME OF INJURY _____	40c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
40d. PLACE OF INJURY (e.g., Decedent's home; construction site, restaurant, wooded area) _____		
40e. LOCATION (Street and Number, City, State, Zip Code) _____		40f. COUNTY OF INJURY _____
41. DESCRIBE HOW INJURY OCCURRED _____		
42a. REGISTRAR FILE NO. _____	42b. DATE RECEIVED BY LOCAL REGISTRAR _____	42c. REGISTRAR _____

✓ **Please fill out (Items 43-49)**

INFORMATION ON BACK OF THE FORM MUST BE COMPLETED IF APPLICABLE

----- INFORMATION BELOW IS FOR STATISTICAL PURPOSES ONLY AND IS NOT TO BE INCLUDED ON CERTIFIED COPIES -----

43. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th – 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	44. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino) <input type="checkbox"/> No, not Spanish, Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____	45. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____
46. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		47. EVER A PEACE OFFICER IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
48. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED)		49. TYPE OF BUSINESS/INDUSTRY _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES – VITAL STATISTICS UNIT

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine of up to \$10,000. (Health and Safety Code, Sec. 195, 1989)

VS-112 REV 1/2006

IF DECEASED SERVED IN U.S. ARMED FORCES, FILL OUT THE FOLLOWING:

Is the deceased reported to have been in such service?	Name of organization in which service was rendered?
Serial number of discharge papers or adjusted service certificate?	Name of next of kin or of next friend?
Post Office Address?	

Signature: _____ **Date:** _____
 (Signature of funeral home representative or informant)

Please indicate the number of certified copies you would like to order from the Texas Department of Health: Certified Copies Requested: _____

**Return Information for Certified Copies:
 To whom shall the certified copies be returned (see #6)?**

 (Funeral Home or Family Member Name)

 (Street Address / P.O. Box)

City _____ State _____ Zip _____

Phone Number _____ / _____ Email Address _____

Additional Information & Instructions:

1. Form Submission:

Please completely fill out this form and send it back to our office as soon as possible. americanmortuaryservice@gmail.com or fax to (214) 941-5150

Note: We cannot begin the process of obtaining a Burial Transit Permit or filing the Texas Certificate of Death until we receive this completed form.

2. Electronic Death Certificate Filing:

Once this form is received, our staff will enter the data into the state electronic death certificate filing system and assign a certifying physician (Pending medical examiner death certificates can take up to three months to be medically certified).

3. Medical Data Completion:

We will receive electronic confirmation once the certifying physician has completed the medical data portion of the certificate (Items 26-42c).

4. Final Review and Approval:

Our staff will email a final copy to your office to review for any typographical errors. Your office must approve the final copy by signature, confirming there are no typographical errors, before we file the certificate with the Texas Department of Health.

5. Certificate Filing and Certified Copies:

After our office receives the final approval (as per step 4), we will electronically file the certificate with the state and order the certified copies as requested on this form.

6. Certified Copy Delivery:

Certified copies will be sent via U.S. Postal Service (certified mail) and require a signature upon delivery to the designated person listed on this form (Above).

7. ALL open charges / invoice(s) must be paid in full before the certified death certificates will be mailed to the designated person listed above. Thank you for your understanding in this matter.

Final Processing Information:

The process may take several weeks to complete, depending on multiple factors:

- *The time it takes for your staff to send the death certificate information obtained from the family.*
- *The time it takes the certifying physician to complete the medical portion (see #2).*
- *The time for your office to grant final approval for filing with the state (see #4).*
- *The state's processing time and postage required to receive the certified copies from the state of Texas.*
- *U.S. Postal Service mailing time for delivering certified copies to your office or the family, as specified above.*

If you have any additional questions, please contact our office at (214) 941-5000.