TYPE IN PERMANENT BLACK INK

FLORIDA CERTIFICATE OF DEATH

MO97

LOCAL FILE NO.

DEMOGRAPHIC INFORMATION TO BE COMPLETED BY: FUNERAL DIRECTOR

1. DECEDENT'S NAME *(First, Middle, Last, Suffix)* | 2. SEX

3. DATE OF BIRTH *(Month, Day, Year)* | 4a. AGE-Last Birthday *(Years)* | 4b. UNDER 1 YEAR *Months* *Days* | 4c. UNDER 1 DAY *Hours* *Minutes* | 5. DATE OF DEATH *(Month, Day, Year)*

6. SOCIAL SECURITY NUMBER | 7. BIRTHPLACE *(City and State or Foreign Country)* | 8. COUNTY OF DEATH

9. PLACE OF DEATH *(Check only one)*
HOSPITAL: __ Inpatient __ Emergency Room/Outpatient __ Dead On Arrival
NON-HOSPITAL: __ Hospice facility __ Nursing Home/Long Term Care Facility __ Decedent's Home __ Other *(Specify)*

10. FACILITY NAME *(If not institution, give street address)* | 11a. CITY, TOWN, OR LOCATION OF DEATH | 11b. INSIDE CITY LIMITS? __Yes __No

12. MARITAL STATUS *(Specify)*
__Married __Married, but Separated __Widowed __Divorced __Never Married
13. SURVIVING SPOUSE'S NAME *(If wife, give maiden name)*

14a. RESIDENCE - STATE | 14b. COUNTY | 14c. CITY, TOWN, OR LOCATION

14d. STREET ADDRESS | 14e. APT. NO. | 14f. ZIP CODE | 14g. INSIDE CITY LIMITS? __Yes __No

15a. DECEDENT'S USUAL OCCUPATION *(Indicate type of work done during most of working life.)* Do not use "Retired" | 15b. KIND OF BUSINESS/INDUSTRY

16. DECEDENT'S RACE *(Specify the race/races to indicate what decedent considered himself/herself to be. More than one race may be specified.)*
__ White __Black or African American __ American Indian or Alaskan Native *(Specify tribe)*
__ Asian Indian __Chinese __Filipino __Japanese __Korean __ Vietnamese __ Other Asian *(Specify)*
__ Native Hawaiian __ Guamanian or Chamorro __Samoan __ Other Pacific Isl. *(Specify)* __ Other *(Specify)*

17. DECEDENT OF HISPANIC OR HAITIAN ORIGIN? *(Specify if decedent was of Hispanic or Haitian Origin.)* __Yes *(If Yes, specify)* __No
__Mexican __ Puerto Rican __ Cuban __ Central/South American
__ Other Hispanic *(Specify)* Haitian

18. DECEDENT'S EDUCATION *(Specify the decedent's highest grade or level of school completed at time of death.)*
__ 8th or less __ High school but no diploma __ High school diploma or GED
__ College but no degree College degree *(Specify):* __ Associate __ Bachelor's __ Master's __ Doctorate

19. WAS DECEDENT EVER IN U.S. ARMED FORCES? __Yes __No

20. FATHER'S NAME *(First, Middle, Last, Suffix)* | 21. MOTHER'S NAME *(First, Middle, Maiden Surname)*

22a. INFORMANT'S NAME | 22b. RELATIONSHIP TO DECEDENT | 23a. INFORMANT'S MAILING - STATE

23b. CITY OR TOWN | 23c. STREET ADDRESS | 23d. ZIP CODE

24. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place)* | 25a. LOCATION - STATE | 25a. LOCATION - CITY OR TOWN

26a. METHOD OF DISPOSITION __ Burial __ Entombment __ Cremation __ Donation __ Removal from State __ Other *(Specify)*

26b. IF CREMATION, DONATION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? __Yes __No | 27a. LICENSE NUMBER *(of Licensee)* | 27b. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶

28. NAME OF FUNERAL FACILITY
All County Funeral Home & Crematory
29a. FACILITY'S MAILING - STATE
Florida

29b. CITY OR TOWN
Lake Worth
29c. STREET ADDRESS
1107 Lake Avenue
29d. ZIP CODE
33460-

30. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) | TIME OF DEATH

DATE:_____

Please proofread the Death Certificate & fax back any corrections or add any blanks not complete.

NOTE: ANY BLOCKS LEFT BLANK WILL BE FILLED IN AS "UNOBTAINABLE"

The original certificate will be filed with the Vital Statistics Office and will become a permanent record. Upon signing below, you assume full responsibility for any corrections that need to be made once filed with Vital Statistics. We will order your copies once full payment has been received. Although we understand the urgency of these documents, it may take up to (14) business days for the entire filing process to be completed. An expedite fee of $75.00 may decrease the filing process up to seven (7) days or less.

IF THIS IS NOT RECEIVED BY THE DATE & TIME BELOW, THIS WILL BE FILED WITH VITAL STATISTICS, AS IS.

THIS MUST BE RETURNED BY:_____ **TIME**_____

ALL DEATH CERTIFICATES WILL BE SENT CERTIFIED MAIL, RETURN RECEIPT.
ALL COUNTY FUNERAL HOME ASSUMES NO RESPONSIBILITY FOR LOST MAIL.
LOST MAIL CAN BE TRACED BY THE POSTAL SERVICE 30 DAYS AFTER MAILING.

All information is correct X_____
(OR)
Make Noted Corrections X_____

Number of Death Certificates with cause of death _____ **without cause of death** _____

(If no designation is made for Death Certificates, all certified copies will be made showing cause of death)

Please call when Death Certificates are ready X_____
Please initial and write phone number
(OR)
Please Mail to: _____

_____

SIGNATURE X_____ **DATE**_____