**Section 500.APPENDIX F Death Records**

**Section 500.ILLUSTRATION C Medical Certificate of Death**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **DECEDENT’S BIRTH** **NO.** | REGISTRATIONDISTRICT NO | **State of Illinois** | STATE FILENUMBER |
|  |
|  | REGISTEREDNUMBER | **MEDICAL CERTIFICATE OF DEATH** |  |
|  |
|  | *Type, or Print in* | DECEASED - *NAME* | FIRST | MIDDLE | LAST | SEX | DATE OF DEATH  | (MONTH, DAY, YEAR) |
| **PERMANENT INK** | 1. |  |  |  | 2. | 3. |
|  | *See Funeral Director’s, Hospital, or Physician’s Handbook for INSTRUCTIONS* | COUNTY OF DEATH | AGE - LASTBIRTHDAY (YRS) | UNDER 1 YEAR | UNDER 1 DAY | DATE OF BIRTH (MONTH, DAY, YEAR) |
|  | MOS | DAYS | HOURS | MIN |  |
|  |
|  | 4. | 5a. | 5b. |  | 5c. |  | 5d. |
|  |  | CITY, TOWN, TWP, OR ROAD DISTRICT NUMBER | HOSPITAL OR OTHER INSTUTITION – NAME (IF NOT IN EITHER GIVE STREET AND NUMBER) | IF HOSPITAL OR INST INDICATE D.O.A OP EMER RM INPATIENT (SPECIFY) |
| A.  | 6a. | 6b. | 6c. |
|  | DECEASED | BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY) | MARRIED, NEVER MARRIEDWIDOWED, DIVORCED (SPECIFY) | NAME OF SURVIVING SPOUSE (MAIDEN NAME IF WIFE) | WAS DECEASED EVER IN USARMED FORCES? (YES/NO) |
|  |
|  |  | 7. | 8a. | 8b. | 9. |
| B  | SOCIAL SECURITY NUMBER | USUAL OCCUPATION | KIND OF BUSINESS OR INDUSTRY | EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED) |
|  | C.  | 10. | 11a. | 11b. | Elementary, Secondary (0-12)12. | College (1-4 or 5 +) |
| D  | RESIDENCE (STREET AND NUMBER) | CITY, TOWN OR ROAD DISTRICT NO. | INSIDE CITY(YES/NO) | COUNTY |
|  |  |  |
| E  | 13a. | 13b. | 13c. | 13d. |
| PRINTED BY THE AUTHORITY OF THE STATE OF ILLINOIS |  | STATE | ZIP CODE | RACE (WHITE, BLACK, AMERICANINDIAN etc.) (SPECIFY) | OF HISPANIC ORIGIN? (SPECIFY NO OR YES – IF YES, SPECIFY CUBAN, MEXICAN PUERTO RICAN etc.) |
|  |  |
|  | 13e. | 13f. | 14a. | 14b. | [ ]  | NO | [ ]  | YES | SPECIFY: |
| PARENTS | FATHER - *NAME* | FIRST | MIDDLE | LAST | MOTHER - *NAME* | FIRST | MIDDLE | LAST |
| 15. | 16. |
|  | INFORMANT'S NAME (TYPE OR PRINT) | RELATIONSHIP | MAILING ADDRESS (STREET AND NO. OR R.F.D, CITY OR TOWN, STATE, ZIP) |
| 1  | 17a. | 17b. | 17c. |
| 2  | 18. PART I. Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 3  | **Immediate Cause (Final****disease or condition****resulting in death)** | **›** | **→** |  |  |  |
|   | { |  |  |
|   | (a) |  |
|   | **CONDITIONS IF ANY****WHICH GIVE RISE TO IMMEDIATE CAUSE (a) STATING THE** **UNDERLYING CAUSE LAST** | DUE TO, OR AS A CONSEQUENCE OF |  |
| CAUSE |  | (b) |  |
|  | DUE TO, OR AS A CONSEQUENCE OF |  |
|  |  |  |  |
|  |  | (c) |  |
| 4  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | AUTOPSY(YES/NO) | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
|  | COMPLETION OF CAUSE OF DEATH? (YES/NO) |
| 5  |  | 19a. | 19b. |
| N  | DATE OF OPERATION, IF ANY | MAJOR FINDINGS OF OPERATION | IF FEMALE WAS THERE A PREGNANCY |
|  |  | IN PAST THREE MONTHS? |
| P  | 20a. | 20b. | 20c. YES [ ]  NO [ ]  |
|   | I (DID) (DID NOT) ATTEND THE DECEASED  | (MONTH, DAY, YEAR) | WAS CORONER OR MEDICALEXAMINER NOTIFIED? (YES/NO) | HOUR OF DEATH |
|   | AND LAST SAW HIM/HER ALIVE ON |
|  | 21a. | 21b. | 21c. | M |
|  |  | TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED | DATE SIGNED | (MONTH, DAY, YEAR) |
| CERTIFIER |  |
| 22a. SIGNATURE ► | 22b. |
|  |  | NAME AND ADDRESS OF CERTIFIER | (TYPE OR PRINT) | ILLINOIS LICENSE NUMBER |
|  |  | 22c. | 22d. |
|  |  | NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER  | (TYPE OR PRINT) | **NOTE: IF AN INJURY WAS INVOLVED IN THIS DEATH THE CORONER OR MEDICAL EXAMINER MUST BE NOTIFIED.** |
|  |  | 23. |
|  |  | BURIAL, CREMATION, REMOVAL (SPECIFY) | CEMETERY OR CREMATORY-*NAME* | LOCATION  | CITY OR TOWN | STATE | DATE  | (MONTH, DAY, YEAR) |
|  |  | 24b. |  |  |
|  |  | 24a. | 24c. | 24d. |
|  |  | FUNERAL HOME | NAME | STREET AND NUMBER OR R.F.D. | CITY OR TOWN | STATE | ZIP |
|  | DISPOSITION | 25a. |
|  |  | FUNERAL DIRECTOR'S SIGNATURE | FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER |
|  |  | 25b.► | 25c. |
|  |  | LOCAL REGISTRAR'S SIGNATURE | DATE FILED BY LOCAL REGISTRAR (MONTH, DAY, YEAR) |
|  |  | 26a.► | 26b. |
|  |  | **VR200 (Rev 1/89)** | **Illinois Department of Public Health – Office of Vital Records** | **(BASED ON 1989 US STANDARD CERTIFICATE)** |

(Source: Added at 15 Ill. Reg. 11706, effective August 1, 1991)