**Section 500.APPENDIX F Death Records**

**Section 500.ILLUSTRATION B Medical Examiner's – Coroner's Certificate of Death**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | **PERMANENT CERTIFICATE** | REGISTRATION DISTRICT NO. | **STATE OF ILLINOIS** | **STATE FILE****NUMBER** |
| **MEDICAL EXAMINER'S – CORONER'S** |
| [ ]  | **TEMPORARY CERTIFICATE** | REGISTERED NUMBER | **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 Coroner's or Funeral Director's Handbook for INSTRUCTIONS*** | COUNTY OF DEATH | AGE-LAST BIRTHDAY (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 DOA OP EMER RM INPATIENT (SPECIFY) |
| A.  | 6a. | 6b. | 6c. |
|  |  | BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY) | MARRIED, NEVER MARRIED WIDOWED, DIVORCED (SPECIFY) | NAME OF SURVIVING SPOUSE (MAIDEN NAME IF WIFE) | WAS DECEASED EVER IN US ARMED FORCES? (YES/NO) |
| DECEASED |  |  |  |
| 7. | 8a. | 8b. | 9. |
| B C D E  | SOCIAL SECURITY NUMBER | USUAL OCCUPATION | KIND OF BUSINESS OR INDUSTRY | EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED) |
|  | 10. | 11a. | 11b. | Elementary, Secondary (0-12) | College (1-4 or 5 +) |
| 12. |
| RESIDENCE (STREET AND NUMBER) | CITY, TOWN OR ROAD DISTRICT NO. | INSIDE CITY (YES/NO) | COUNTY |
|  |  |  |
| 13a. | 13b. | 13c. | 13d. |
| PRINTED BY THE AUTHORITY OF THE STATE OF ILLINOIS | STATE | ZIP CODE | RACE (WHITE, BLACK, AMERICAN INDIAN, 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) |
| 17a. | 17b. | 17c. |
| 1. 2. 3. 4. 5.  | 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 |
| Immediate Cause (Final disease or condition resulting in death) |  |  |
| { | (a) |  |
| CONDITIONS IF ANY WHICH GIVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDER-LYING CAUSE LAST. |  | DUE TO, OR AS A CONSEQUENCE OF |
|  |  |
| (b) |
| DUE TO, OR AS A CONSEQUENCE OF |  |
| CAUSE | (c) |
| N. P.   H,G RIF UNK  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | ATUOPSY (YES/NO) | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (YES/NO) |
| 19a. | 19b. |
| NATURAL, ACCIDENT, HOMICIDE, SUICIDE, UNDETERMINED, (SPECIFY) | DATE OF INJURY (MONTH DAY YEAR) | HOUR | HOW INJURY OCCURRED (ENTER NATURE OF INJURY MENTIONED IN PART I OR PART II, ITEM 18) |
|  |
| 20a. | 20b. | 20c. | M. | 20d. |
| INJURY AT WORK (YES/NO) | PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.) (SPECIFY) | LOCATION (CITY, VIL. OR TOWN OR TWP. OR RD. DIST. NO ., COUTY, STATE) | IF FEMALE WAS THERE A PREGNANCY IN PAST THREE MONTHS? |
| 20e. | 20f. | 20g. | 20h. YES [ ]  NO [ ]  |
|  | I CERTIFY THAT IN MY OPINION BASED UPON MY INVESTIGATION AND/OR THE INQUISITION. THIS DEATH OCCURRED ON THE DATE, AT THE PLACE AND DUE TO THE CAUSE(S) STATED, AND THAT……………….... | THE DECEDENT WAS PRONOUNCED DEAD ON | AT |
| MONTH | DAY | YEAR |
| 21a. | 21b. | 21c. | M. |
|  |  | CORONER'S-MEDICAL EXAMINER'S SIGNATURE | DATE SIGNED | (MONTH, DAY, YEAR) |
|  | CERTIFIER | 22a.► | 22b. |
|  |  | CORONER'S PHYSICIAN'S SIGNATURE | DATE SIGNED | (MONTH, DAY, YEAR) |
| 23a.► | 23b. |
|  |  | BURIAL, CREMATION, REMOVAL (SPECIFY) | CEMETERY OR CREMATORY-NAME | LOCATION  | CITY OR TOWN | STATE | DATE  | (MONTH, DAY, YEAR) |
|  |  |
| 24a. | 24b. | 24c. | 24d. |
| FUNERAL HOME | *NAME* | STREET AND NUMBER OF RFD | CITY OR TOWN | STATE | ZIP |
|  | DISPOSITION | 25a. |
|  |  | FUNERAL DIRECTOR'S SIGNATURE | FUNERAL DIRECTOR'S ILLINOS LICENSE NUMBER |
| 25b.► | 25c. |
| LOCAL REGISTRAR'S SIGNATURE | DATE FILED BY LOCAL REGISTRAR | (MONTH, DAY, YEAR) |
| 26a.► | 26b. |
| VR202 (Rev 1/89) | Illinois Department of Public Health – Office of Vital Records | (BASED ON 1988 US STANDARD CERTIFICATE) |

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