

COMMONWEALTH OF VIRGINIA - CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS - RICHMOND

	REGISTRATION AREA NUMBER	CERTIFICATE NUMBER	STATE FILE NUMBER
DECEDENT	1. FULL NAME OF DECEDENT (first) (middle) (last) (suffix)		
	2. SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> NOT DETERMINED <input type="checkbox"/>	3. DATE OF DEATH <input type="checkbox"/> ACTUAL <input type="checkbox"/> PRESUMED <input type="checkbox"/> <input type="checkbox"/> APPROXIMATE <input type="checkbox"/> FOUND ON	4. DATE OF BIRTH
	6. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	7. BIRTHPLACE (U.S. STATE OR FOREIGN COUNTRY)	8. SOCIAL SECURITY NUMBER IF NO SSN, CHECK APPROPRIATE BOX NONE <input type="checkbox"/> NOT OBTAINABLE <input type="checkbox"/> UNKNOWN <input type="checkbox"/>
USUAL RESIDENCE OF DECEDENT	9. STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.)		10. CITY OR TOWN OF RESIDENCE INSIDE CITY OR TOWN LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO
	11. COUNTY OF DECEDENT'S RESIDENCE (if independent city, leave blank)	12. U.S. STATE (OR FOREIGN COUNTRY) OF DECEDENT'S RESIDENCE	12a. ZIP CODE
PERSONAL DATA OF DECEDENT	13. RACE OF DECEDENT (CHECK ONE OR MORE) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> FILIPINO <input type="checkbox"/> KOREAN <input type="checkbox"/> OTHER PACIFIC ISLANDER(SPECIFY) _____ <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> SAMOAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN (SPECIFY) _____ <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> JAPANESE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (SPECIFY) _____ <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE(SPECIFY) _____		
	14. DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> CENTRAL OR SOUTH AMERICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> MEXICAN <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> OTHER (SPECIFY) _____ <input type="checkbox"/> UNKNOWN		
	15. EDUCATION (HIGHEST GRADE COMPLETED) <input type="checkbox"/> ASSOCIATE DEGREE <input type="checkbox"/> BACHELOR'S DEGREE <input type="checkbox"/> MASTER'S DEGREE <input type="checkbox"/> DOCTORATE/PROFESSIONAL DEGREE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> ELEMENTARY/SECONDARY (0-12) <input type="checkbox"/> HIGH SCHOOL DIPLOMA <input type="checkbox"/> GED <input type="checkbox"/> YEARS OF COLLEGE _____		
	16. CITIZEN OF WHAT COUNTRY	17. USUAL OR LAST OCCUPATION	18. KIND OF BUSINESS OR INDUSTRY
	19. MARITAL STATUS <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		20. IF MARRIED, SEPARATED OR WIDOWED, NAME OF SPOUSE (if divorced leave blank)
	21. NAME OF DECEDENT'S FATHER (FIRST, MIDDLE, LAST, SUFFIX)		22. MOTHER'S FULL MAIDEN NAME (FIRST, MIDDLE, LAST)
INFORMANT'S DETAILS	23. INFORMANT'S RELATIONSHIP OR SOURCE OF INFORMATION		24. FULL NAME OF INFORMANT OR NAME OF SOURCE
	25. NAME OF HOSPITAL OR INSTITUTION OF DEATH (if none, so state)		
PLACE OF DEATH	26. SPECIFY IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> NURSING HOME <input type="checkbox"/> LONG TERM CARE FACILITY <input type="checkbox"/> DECEDENT'S HOME <input type="checkbox"/> CORRECTIONAL FACILITY <input type="checkbox"/> OTHER (SPECIFY) _____		25a. SELECT ONE IF DEATH OCCURRED IN HOSPITAL DOA <input type="checkbox"/> OUT PAT. EMER RM <input type="checkbox"/> INPATIENT <input type="checkbox"/>
	27. CITY OR TOWN OF DEATH	28. STREET ADDRESS OR RT. NO OF PLACE OF DEATH	28a. ZIP CODE
	28b. COUNTY OF DEATH (if independent city, leave blank)		
ONLY THE FOLLOWING MAY LEGALLY FILE A DEATH CERTIFICATE	29. METHOD OF DISPOSITION <input type="checkbox"/> BURIAL <input type="checkbox"/> ENTOMBMENT / MAUSOLEUM <input type="checkbox"/> CREMATION / INCINERATION <input type="checkbox"/> BURIAL AT SEA <input type="checkbox"/> DONATION <input type="checkbox"/> OTHER (SPECIFY) _____ <input type="checkbox"/> REMOVAL FROM STATE (IF KNOWN, PLEASE ALSO CHECK FINAL METHOD OF DISPOSITION WHEN REMOVING FROM STATE, FROM OPTIONS SHOWN)		
	30. PLACE OF DISPOSITION - NAME OF CEMETERY OR CREMATORY		
	31. PLACE OF DISPOSITION - STREET ADDRESS OF CEMETERY OR CREMATORY	31a. CITY / COUNTY	31b. STATE
	31c. ZIP CODE	31d. COUNTRY	
LICENSED FUNERAL DIRECTOR/LICENSSEE	32. SIGNATURE OF FUNERAL DIRECTOR/LICENSSEE, VSAP OR NEXT OF KIN (ACTUAL SIGNATURE)		32a. DIRECTOR/LICENSSEE'S NO. 0502901190
	32b. NAME OF FUNERAL HOME OR FACILITY JANAZAH SERVICES LLC		
STATE ANATOMICAL BOARD	33. NAME OF FUNERAL DIRECTOR / LICENSSEE, VSAP OR NEXT OF KIN (TYPE OR PRINT) MIRIAM ROSE ABDRAHMAAN, FSP		33a. STREET ADDRESS OF FUNERAL HOME / FACILITY, VSAP OR NEXT OF KIN (Include street address, city, state and zip code) 14640 FLINT LEE RD CHANTILLY VA 20151
	34. TIME OF DEATH: To the best of my knowledge, death occurred at _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> ACTUAL <input type="checkbox"/> APPROXIMATE <input type="checkbox"/> PRESUMED <input type="checkbox"/> FOUND ON		
CAUSE OF DEATH TO PHYSICIAN: Complete and sign medical certification (item 35-40a) and return both copies to funeral director as soon as possible after determination of cause. NOTE: If "Pending" # must be indicated, so state in part I and notify registrar of final decision as soon as possible	35. 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.		INTERVAL BETWEEN ONSET AND DEATH
	IMMEDIATE CAUSE OF DEATH → (A) (Final disease or condition resulting in death) _____ DUE TO (OR AS A CONSEQUENCE OF)		
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST (B) _____ DUE TO (OR AS A CONSEQUENCE OF)		
	(C) _____ DUE TO (OR AS A CONSEQUENCE OF)		
	(D) _____ DUE TO (OR AS A CONSEQUENCE OF)		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
INJURY INFORMATION To be filled out only for MILITARY DEATHS	36. WAS THE MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	36a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	36b. WERE FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
	37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> POSSIBLY <input type="checkbox"/> UNKNOWN		
	38. IF FEMALE: <input type="checkbox"/> PREGNANT AT TIME OF DEATH <input type="checkbox"/> UNKNOWN IF PREGNANT WITHIN THE PAST YEAR <input type="checkbox"/> NOT PREGNANT, BUT PREGNANT WITHIN 42 DAYS OF DEATH <input type="checkbox"/> NOT PREGNANT WITHIN PAST YEAR <input type="checkbox"/> NOT PREGNANT, BUT PREGNANT WITHIN 43 DAYS TO 1 YEAR BEFORE DEATH <input type="checkbox"/> NOT APPLICABLE (if decedent's age is 0-5 or 75 years)		
	39. IF EXTERNAL, TO WHAT EXTENT IT CONTRIBUTED TO CAUSE OF DEATH? <input type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING		40. WAS THIS A MILITARY DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
	40a. IF MILITARY DEATH, SELECT MANNER OF DEATH NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> UNDETERMINED <input type="checkbox"/> PENDING <input type="checkbox"/>		
ITEMS 41 TO 47 IN THIS SECTION SHOULD ONLY BE COMPLETED FOR MILITARY DEATHS			
41. DATE OF INJURY	42. TIME OF INJURY _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	43. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	44. PLACE OF INJURY (home, farm, factory, street, office, bldg, etc.)
45. LOCATION OF INJURY - STREET ADDRESS (INCLUDE HOUSE AND/OR APT. # OR ROUTE NO.)		45a. CITY / COUNTY	45b. STATE
45c. ZIP CODE		45d. COUNTRY	
46. IF TRANSPORTATION INJURY, SPECIFY <input type="checkbox"/> DRIVER/OPERATOR <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> OTHER (SPECIFY) _____			
47. DESCRIBE HOW INJURY RELATING TO DEATH OCCURRED			
MEDICAL CERTIFICATION	48. SIGNATURE OF PERSON COMPLETING THE CAUSE OF DEATH		48a. TITLE <input type="checkbox"/> MEDICAL DOCTOR <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> DOCTOR OF OSTEOPATHY (D.O.) <input type="checkbox"/> NURSE PRACTITIONER <input type="checkbox"/> OTHER _____
	49. NAME OF PERSON PROVIDING THE MEDICAL CERTIFICATION OF DEATH (Type or Print)		49a. ADDRESS OF PERSON PROVIDING THE MEDICAL CERTIFICATION OF DEATH (Type or Print)
	49b. MEDICAL LICENSE NO.		
50. ARE YOU A DESIGNEE? <input type="checkbox"/> YES <input type="checkbox"/> NO	51. IF YES, PLEASE PROVIDE THE NAME OF AUTHORIZING OR ABSENT PHYSICIAN		51a. ADDRESS OF AUTHORIZING PHYSICIAN
52. SIGNATURE OF REGISTRAR		52a. PRINTED NAME OF REGISTRAR	52b. DATE RECORD FILED.
53. RESERVED FOR REGISTRAR'S USE			

VOID-APPROVAL FORM ONLY