



**CATHOLIC FUNERAL
& CEMETERY SERVICES**
OF THE DIOCESE OF SACRAMENTO

Death Certificate Information

1. Name of Decedent-First		2. Middle		3. Last (Family)	
AKA - Also Known As - Include Full AKA (First, Middle, Last)			4. Date of Birth	5. Age - Years	If Under One Year Months Days
9. Birth State/ Country		10. Social Security Number	11. Ever in US Armed Forces <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		12. Marital Status
13. Education - Highest Level / Degree			14/15. Was Decedent Spanish/Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Decedent Race - Up to three races may be listed.
17. Usual Occupation - Type of work most of life (not "retired")			18. Kind of Business (e.g. grocery, road construction, etc.)		19. Years in Occupation
20. Decedent's Residence (Street and number of location)					
21. City		22. County		23. Zip Code	
24. Years in County		25. State/Country			
26. Informant's Name		27. Relationship		27. Informant's Mailing Address (Street, number, rural route no, city, state, zip)	
28. Name of Surviving Spouse - First		29. Middle		30. Last (Maiden Name)	
31. Name of Father - First		32. Middle		33. Last	
34. Birth State/Ctry		35. Name of Mother - First		36. Middle	
37. Last (Maiden Name)		38. Birth State/Ctry		39. Disposition Date	
40. Place of Final Disposition		41. Type of Disposition			
42. Embalming <input type="checkbox"/> Yes <input type="checkbox"/> No		42. Cremation <input type="checkbox"/>			
44. Name of Funeral Establishment			45. License Number		113A. If female, pregnant in last year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
101. Place of Death		102. If hospital, specify one <input type="checkbox"/> IP <input type="checkbox"/> ER/OP <input type="checkbox"/> DOA		103. If other than hospital, specify one <input type="checkbox"/> Hospice <input type="checkbox"/> Nursing Hm/LTC <input type="checkbox"/> At Home <input type="checkbox"/> Other	
104. County		105. Facility Address (street and number) or Location Where Found			106. City
Doctor's Name		Doctor's Phone		Doctor's Fax	
Vitals Verified By (print)		Signature X			
Notes					

Check one: C CA NC (for office use only)

Stationary Contact's Email: _____

Death Certificate Disposition Information

Number of DCs _____	Release DCs to _____
Number to be held for: _____	Relationship _____
Insurance _____	Address _____
	Phone _____