Name Known to Physician:	**Date of Death:**

VDH-HSI-PROD-2023

STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Demographic Information

Type or Print in Black Ink

To Be Completed/Verified By: FUNERAL DIRECTOR OR PERSON ACTING AS SUCH

1a. DECEDENT'S LEGAL NAME *(First, Middle, Last, Suffix)*

1b. ALIASES *(Any other names the decedent used or was known as)*

1c. DECEDENT'S LAST NAME AT BIRTH

2. SEX: ☐ Male ☐ Female

3. SOCIAL SECURITY NUMBER

4a. AGE-LAST BIRTHDAY *(Years)*

4b. IF UNDER 1 YEAR: Months | Days

4c. IF UNDER 1 DAY: Hours | Minutes

5. DATE OF BIRTH *(Month, Day, Year)*

6. BIRTHPLACE *(City and State or Foreign Country - include Province if Canada)*

7a. RESIDENCE STREET AND NUMBER *(Include Apartment Number)*

7b. CITY OR TOWN OF RESIDENCE

7c. STATE OR FOREIGN COUNTRY

8a. EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No

8b. VETERAN OF ANY WAR? ☐ Yes ☐ No

8c. IF SO, WHAT WAR(S)?

9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Civil Union ☐ Widowed ☐ Divorced ☐ Civil Union dissolution ☐ Never Married or in Civil Union ☐ Unknown

10a. BIRTH NAME OF SURVIVING SPOUSE / CIVIL UNION PARTNER

10b. SEX OF SURVIVING SPOUSE/PARTNER ☐ Male ☐ Female ☐ Unknown

11. FATHER'S OR PARENT'S BIRTH NAME *(First, Middle, Last)*

12. MOTHER'S OR PARENT'S BIRTH NAME (*First, Middle, Last)*

13a. INFORMANT'S NAME *(First, Middle, Last)*

13b. RELATIONSHIP TO DECEDENT

13c. INFORMANT'S MAILING ADDRESS *(Street and Number, City or Town, State, Zip Code)*

14. DECEDENT'S EDUCATION LEVEL: *(Check the box that best describes the highest degree or level of school completed at the time of death.)*

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

15. DECEDENT OF HISPANIC ORIGIN? *(Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.)*

- ☐ No, not Spanish/Hispanic/Latino/Latina
- ☐ Yes, Mexican, Mexican American, Chicano/Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino/Latina (Specify) ____________________

16. DECEDENT'S RACE: (*Check one or more races to indicate what the decedent considered himself or herself to be.)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) ______________________________
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) __________________
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) __________________________
- ☐ Other (Specify) _________________________________

17. DECEDENT'S USUAL OCCUPATION *(Indicate type of work done during most of working life. DO NOT USE RETIRED)*

18. KIND OF BUSINESS/INDUSTRY

19. DID DECEDENT RECEIVE HOSPICE CARE? *(In past 30 days)* ☐ Yes ☐ No ☐ Unknown

20. PLACE OF DEATH *(Indicate only one)*

If death occurred in a hospital: ☐ Inpatient ☐ Intensive Care Unit ☐ Emergency Room/Outpatient ☐ Dead on Arrival

If death occurred somewhere other than a hospital: ☐ Nursing Home / Long Term Care Facility ☐ Hospice Facility ☐ Decedent's Home ☐ Other (specify) ____

21a. FACILITY NAME *(If not institution, give street and number)*

21b. CITY OR TOWN

21c. STATE

22a. METHOD OF DISPOSITION: ☐ Temporary Storage ☐ Burial ☐ Cremation ☐ NOR ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (specify)

22b. PLACE OF TEMPORARY STORAGE *(Name of cemetery, other place)*

22c. LOCATION OF TEMPORARY STORAGE (*City or Town, State*)

22d. PLACE OF FINAL DISPOSITION *(Name of cemetery, disposition facility, other place)*

22e. LOCATION OF FINAL DISPOSITION *(City or Town, State)*

23a. NAME OF FUNERAL FACILITY OR AUTHORIZED PERSON

23b. ADDRESS OF FUNERAL FACILITY OR AUTHORIZED PERSON *(Street and Number, City, State, Zip Code)*

24. SIGNATURE OF FUNERAL SERVICE LICENSEE OR AUTHORIZED PERSON

25. VERMONT LICENSE NUMBER

26. DATE OF DISPOSITION *(Month, Day, Year)*

If attached to a completed *Preliminary Report of Death – Medical Certification*, this document shall be acceptable for issuance of burial transit and removal permits. This is not a permanent record. A town clerk may not issue certified copies of this record.

Name Known to Physician: | **Date of Death:**

STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Medical Certification

Type or Print in Black Ink

To Be Completed/Verified By: MEDICAL CERTIFIER

19. DID DECEDENT RECEIVE HOSPICE CARE? *(In past 30 days)* ☐ Yes ☐ No ☐ Unknown

20. PLACE OF DEATH *(Indicate only one)*
If death occurred in a hospital: ☐ Inpatient ☐ Intensive Care Unit ☐ Emergency Room/Outpatient ☐ Dead on Arrival
If death occurred somewhere other than a hospital: ☐ Nursing Home / Long Term Care Facility ☐ Hospice Facility ☐ Decedent's Home ☐ Other (specify) ______

21a. FACILITY NAME *(If not institution, give street and number)*	21b. CITY OR TOWN	21c. STATE

27. MANNER OF DEATH: *Note: All deaths that are not "Natural" should be referred to a Medical Examiner. Call 1-888-552-2952.*
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could Not Be Determined

28. CAUSE **PART I.** *Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.*

APPROXIMATE INTERVAL: ONSET TO DEATH

IMMEDIATE CAUSE *(Final disease or condition resulting in death.)* → a. ______ ______
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the ***UNDERLYING CAUSE*** *(disease or injury that initiated the events resulting in death)* ***LAST.***

b. ______ ______
Due to (or as a consequence of):

c. ______ ______
Due to (or as a consequence of):

d. ______ ______

29. CAUSE **PART II.** *Enter other significant conditions contributing to death but not resulting in the underlying cause given in* ***PART I.***

30. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

31. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year

32a. WAS MEDICAL EXAMINER CONTACTED? ☐ Yes ☐ No	32b. M.E. CASE NUMBER	33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No	34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH? ☐ Yes ☐ No

IF AN INJURY IS PART OF THE CAUSE OF DEATH (Pt. I OR II) THE DEATH SHOULD BE CERTIFIED BY A MEDICAL EXAMINER. CALL 1-888-552-2952

35. DATE OF INJURY *(Month, Day, Year)*	36. TIME OF INJURY ☐ AM ☐ PM	37. PLACE OF INJURY *(e.g. Decedent's home, construction site, restaurant, wooded area)*	38. INJURY AT WORK? ☐ Yes ☐ No

39. LOCATION OF INJURY *(Street and Number, City or Town, State)*

40. DESCRIBE HOW INJURY OCCURRED

41. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (specify) ______

42a. ACTUAL OR PRESUMED DATE OF DEATH *(Month, Day, Year)*	42b. ACTUAL OR PRESUMED TIME OF DEATH ☐ AM ☐ PM	42c. DATE PRONOUNCED DEAD *(Month, Day, Year)*	42d. TIME PRONOUNCED DEAD ☐ AM ☐ PM

43a. SIGNATURE OF CERTIFIER – To the best of my knowledge, on the basis of case history, examination, and/or investigation, death occurred at the time, date, and place and due to the cause(s) and manner stated.	43b. DATE CERTIFIED *(Month, Day, Year)*

43c. NAME OF CERTIFIER *(Type or Print)*	43d. LICENSE NUMBER

43e. ADDRESS OF CERTIFIER *(Street and Number, City or Town, State, Zip Code)*	44. CONTACT PHONE NUMBER ( )

45. TITLE OF CERTIFIER: ☐ Physician ☐ Pathologist ☐ Medical Examiner ☐ Physician Assistant ☐ Advanced Practice Registered Nurse	46. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER *(Type or Print)*

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