Death Certificate

Next of Kin/Informant Name:____Relationship :____________________
Address: ____
Email: ____ Phone: (___) _______________________

Personal Record

Name: ____ SSN: ________________________
Address:____ City:__________________________ State ___ ZIP _________
Date of Death ____/____/_______ | ___ Male ___ Female
Race (Check all that apply):
□ Caucasian □ African American □ American Indian or □ Alaska Native - Name of Tribe: ________________________
Hispanic:: □ Mexican □ Mexican/American □ Chicano □ Puerto Rican □ Cuban Asian: □ Chinese □ Filipino □ Japanese
□ Korean □ Vietnamese Guamanian: □ Chamaorro □Samoan
City & State of Death __________________________County of Death:________________ Inside City Limits: __ Yes __ No
Place of Death (Hospital, Hospice, Inpatient, ER, DOA, At Home, etc.): ____
Name of Hospital or Other Facility Where Death Occurred: ____
Address of Hospital or Other Facility Where Death Occurred: ____
Physician Name: ____Phone: ( ) _____ - ________
Marital Status: ___ Single | ___ Married | ___ Separated |___ Divorced | ___Widowed | ___ Never Married | ___Unknown
Birth Date ____/____/_____ Birthplace: ___________________________________County of Birth: ______________________
Spouse's Name:____ Maiden Name _______________________________
Marriage Date ____/____/____ Marriage Place ________________________________Spouse Death Date ____/____/____
Prior Spouse ____Maiden Name ________________________________
Marriage Date ____/____/____ Marriage Place ________________________________Spouse Death Date ____/____/____
Mother's Name: _________________________ Mother's Maiden Name: _________________Mother's DOD ___/____/____
Father' Name: ________________________________ Father's DOD ___/____/____

Personal History

Occupation: ______________________________Industry: ______________________ Number of Years in Occupation: _____
Employer/Company Name ____________________________________Employer City & State: __________________________
Education: School (# of years 0-12) ____ College (# of years) ____
Elementary School Name, City & State: ____ Years Attended: ___________
Middle School Name, City & State: ____ Years Attended: ___________
High School Name, City & State:____ Years Attended: ___________
College Name City & State: ____ Years Attended: ___________
Degree(s): Check all that apply: □ Associate □ B.A. □ B.S. □ MBA □ M.A. □ M.S. □ PhD. □ DSW □ M.D. □ DDS □ DMD
□ J.D. □ LL.M □ S.J.D. Other ________
Field(s) of Study: ____
Military Branch ___________ Rank ______________Serial Number ___________________ War/Conflict _________________
Enlist. Date___/___/____ Place ______________________ Discharge Date ___/___/____ Place ___________________________
Decorations ____ American Flag: Draped ______ Folded_________
Religion _______________________ Place of Worship ____
Organizations/Memberships ____
____
Other: ____
____

Please email a photo and the written obituary to Arika Perry at aperry@sunsetevansville.com.