

## DECEASED INFORMATION

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ SEX : M  F

D.O.B: \_\_\_\_\_ CITY & STATE OF BIRTH: \_\_\_\_\_ SSN# \_\_\_\_\_

ETHNICITY: \_\_\_\_\_ COUNTRY OF ORIGIN: \_\_\_\_\_

LEVEL OF EDUCATION: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SURVIVING SPOUSE: \_\_\_\_\_

WAR VETERAN: Yes  No  IF YES, THEN WHICH WAR? \_\_\_\_\_

NAME OF FATHER: \_\_\_\_\_ NAME OF MOTHER: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ APT/FLOOR# \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

## DECEASED'S DEATH & PHYSICIAN INFORMATION

DATE OF DEATH: \_\_\_\_\_ HOUR/TIME OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_ CONTRIBUTING CAUSE: \_\_\_\_\_

NAME OF FACILITY OF DEATH: \_\_\_\_\_ DATE OF ADMISSION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WAS DECEASED TRANSFERRED FROM ANOTHER FACILITY? Yes  No  IF YES, \_\_\_\_\_

PHYSICIAN/DOCTOR'S NAME: \_\_\_\_\_ PH# \_\_\_\_\_

CONTACT ADDRESS: \_\_\_\_\_

## BURIAL INFORMATION

DATE OF BURIAL: \_\_\_\_\_ MASJID NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CEMETRY NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

SECTION: \_\_\_\_\_ PLOT: \_\_\_\_\_ RANGE: \_\_\_\_\_ GRAVE: \_\_\_\_\_

## INFORMANT'S INFORMATION

INFORMANT'S FULL NAME: \_\_\_\_\_ RELATION TO DECEASED: \_\_\_\_\_

PH# \_\_\_\_\_ MAILING ADDRESS: \_\_\_\_\_

**ADDITIONAL NOTES (FOR OFFICIAL USE ONLY!):**