

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK.  
FOR  
INSTRUCTIONS  
SEE HANDBOOK.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
**CERTIFICATE OF DEATH**

STATE FILE NUMBER

**124 -**

REGISTRATION DISTRICT NO.

REGISTRAR'S NUMBER

1. DECEDENT'S NAME (First, Middle, Last)		2. SEX		3. DATE OF DEATH (Month, Day, Year)				
4. SOCIAL SECURITY NO.		5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR MONTHS    DAYS		5c. UNDER 1 DAY HOURS    MINUTES		6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		9a. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <b>OTHER:</b> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
9b. FACILITY NAME (If not institution, give street and number)				9c. CITY, TOWN, OR LOCATION OF DEATH			9d. COUNTY OF DEATH	
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify)		11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name)		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. RESIDENCE - STATE		13b. COUNTY		13c. CITY, TOWN, OR LOCATION			13d. ZIP CODE	
13e. STREET AND NUMBER				13f. INSIDE CITY LIMITS <input type="checkbox"/> Yes <input type="checkbox"/> No		13g. YEARS AT PRESENT ADDRESS <input type="checkbox"/> Under 5 <input type="checkbox"/> 5-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20 or more		
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:				15. RACE - American Indian, Black, White, etc. (Specify)		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)    College (1-4 or 5+)		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)				
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
20a. BURIAL, CREMATION, OTHER (Specify)		20b. DATE OF DISPOSITION (Month, Day, Year)		20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)		20d. LOCATION (City or Town, State)		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH			22a. NAME AND ADDRESS OF FACILITY			22b. FUNERAL ESTABLISHMENT LICENSE NUMBER		
23. 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. List only one cause on each line. IMMEDIATE CAUSE → a. DUE TO (OR AS A CONSEQUENCE OF): (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY M <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. DESCRIBE HOW INJURY OCCURRED			
28a. (Specify) <input type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> MEDICAL EXAMINER/CORONER			28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) ▶			28c. DATE SIGNED (Month, Day, Year)	28d. TIME OF DEATH	
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)				29b. MO. LICENSE NUMBER		30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input type="checkbox"/> No		
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			32. REGISTRAR'S SIGNATURE ▶			33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year)		

**DECEDENT**

VS 300

MO 580-2211 (4-07)

NAME OF DECEDENT FOR USE BY PHYSICIAN OR INSTITUTION

**PARENTS**

**INFORMANT**

**DISPOSITION**

**CAUSE OF DEATH**

**CERTIFIER**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the deceased named above was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_ Signed \_\_\_\_\_

Name of Decedent \_\_\_\_\_ Licensed Embalmer No. \_\_\_\_\_

**NOTE:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his/her OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.) If embalmed by a STUDENT, he/she also shall sign in his/her OWN HANDWRITING. If this body is not embalmed, fact should be so stated above.

P.O. Address \_\_\_\_\_