

U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO.		STATE FILE NO.			
1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) Carole Penny Marshall		2. SEX	3. SOCIAL SECURITY NUMBER		
4a. AGE-Last Birthday (Years)	4b. UNDER 1 YEAR Months Days	4c. UNDER 1 DAY Minutes	5. DATE OF BIRTH (Mo/Day/Yr)	6. BIRTHPLACE (City and State or Foreign Country)	
7a. RESIDENCE-STATE		7b. COUNTY		7c. CITY OR TOWN	
7d. STREET AND NUMBER		7e. APT. NO.	7f. ZIP CODE	7g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)		
11. FATHER'S NAME (First, Middle, Last)			12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)		
13a. INFORMANT'S NAME		13b. RELATIONSHIP TO DECEDENT		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)	
14. PLACE OF DEATH (Check only one: see instructions)					
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival			IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify):		
15. FACILITY NAME (if not institution, give street & number)			16. CITY OR TOWN, STATE, AND ZIP CODE		17. COUNTY OF DEATH
18. METHOD OF DISPOSITION: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify):		19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)			
20. LOCATION-CITY, TOWN, AND STATE			21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY		
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT				23. LICENSE NUMBER (Of licensee)	
ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH			24. DATE PRONOUNCED DEAD (Mo/Day/Yr) 12/17/2018	25. TIME PRONOUNCED DEAD 2:10	
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable) <i>[Signature]</i>			27. LICENSE NUMBER 6772469	28. DATE SIGNED (Mo/Day/Yr)	
29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month) December 17/2018		30. ACTUAL OR PRESUMED TIME OF DEATH 2:10		31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
CAUSE OF DEATH (See instructions and examples)					
32. 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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Acute Myocardial Infarction 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. Severe Atherosclerotic coronary disease Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					Approximate interval: Onset to death 2 Hours 7 Years
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I Diabetes Mellitus Type I					33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		36. IF FEMALE: <input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined	
38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)	39. TIME OF INJURY	40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area)		41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
42. LOCATION OF INJURY: State: _____ City or Town: _____		Street & Number: _____ Apartment No.: _____ Zip Code: _____			
43. DESCRIBE HOW INJURY OCCURRED:				44. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)	
45. CERTIFIER (Check only one): <input type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Pronouncing & Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. Signature of certifier: <i>[Signature]</i>					
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32) Khalid Aleisa, Olaya Street, 13311					
47. TITLE OF CERTIFIER Medical doctor		48. LICENSE NUMBER 6772469		49. DATE CERTIFIED (Mo/Day/Yr) 10/11/2018	
50. FOR REGISTRAR ONLY- DATE FILED (Mo/Day/Yr)					
51. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death. <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		52. 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. <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		53. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____	
54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED)					
55. KIND OF BUSINESS/INDUSTRY					

NAME OF DECEDENT For use by physician or institution

To Be Completed/Verified By: FUNERAL DIRECTOR:

To Be Completed By: MEDICAL CERTIFIER: