

**Vital Statistics Worksheet - American Cremation Service**

REVISED 12/31/13

- American San Diego (619) 283-5842
- American Kearny Mesa (858) 277-7875
- American Carlsbad (760) 729-9182
- American Escondido (760) 480-8483
- American Cathedral City (760) 324-4700
- American El Cajon (619) 447-4282
- FAX (619) 283-5846
- FAX (858) 277-7840
- FAX (760) 729-8847
- FAX (760) 489-2870
- FAX (760) 324-9090
- FAX (619) 447-4285

Please complete death certificate worksheet and return to appropriate office above. If you have any questions, please feel free to contact the appropriate office above. Information provided on this form will be used verbatim on the death certificate. In accordance with CA law, a death certificate must be filed within 7 days of the date of death, as long as the medical section has been completed by the doctor and accepted by the Health and Human Services Department. Any information not supplied by the informant **MUST** be listed as unknown. **We reserve the right to change the Occupation or Industry items to conform with the State of California Guidelines.**

|  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| NAME OF DECEDENT - FIRST   |  | MIDDLE  |  | LAST   |  | DATE OF BIRTH  |  | SEX   |  |
| AKA ALSO KNOWN AS - Include full AKA (FIRST, MIDDLE, LAST) and list only one (1)   |  |   |  |  |  |  |  |   |  |
| BIRTH STATE/FOREIGN COUNTRY  |  | SOCIAL SECURITY NUMBER  |  | EVER IN US ARMED FORCES?<br>O YES O NO O UNK                       |  | MARRITAL STATUS (at time of death)<br>O NEVER MARRIED O MARRIED O DIVORCED<br>O WIDOWED O SRDP |  | DECEDEDENT'S RACE (up to three (3) may be listed) |  |
| EDUCATION (highest level/degree)<br>O YES _____ O NO _____   |  | WAS DECEDENT LATINO? (if yes, specify: Mexican, Nicaraguan, etc.) |  | KIND OF BUSINESS OR INDUSTRY List only one (1) (e.g. construction) |  | YEARS IN OCCUPATION  |  |   |  |
| DECEDENT'S RESIDENCE (street number or location)   |  | CITY  |  | COUNTY   |  | ZIP CODE   |  | STATE/FOREIGN COUNTRY                             |  |
| PERSON SUPPLYING INFORMATION, RELATIONSHIP, AND MAILING ADDRESS  |  |   |  |  |  |  |  |   |  |
| PRIMARY DOCTOR WHO WILL COMPLETE DEATH CERTIFICATE (list all and include contact information)  |  |   |  |  |  |  |  |   |  |
| NAME OF SURVIVING SPOUSE - FIRST   |  | MIDDLE  |  | LAST (MAIDEN name if applicable)                                   |  |  |  |   |  |
| NAME OF DECEDENT'S FATHER - FIRST  |  | MIDDLE  |  | LAST   |  |  |  | BIRTH STATE                                       |  |
| NAME OF DECEDENT'S MOTHER - FIRST  |  | MIDDLE  |  | LAST (MAIDEN name)   |  |  |  | BIRTH STATE                                       |  |
| FINAL RESTING PLACE OF DECEDENT OR CREMATED REMAINS If residence or cemetery, please supply full name and address.   |  |   |  | CIRCLE ONE:<br>CREMATION   |  | BURIAL   |  | EMBALMING?<br>NO                                  |  |
| I hereby attest that I provided the foregoing information and believe that said information is true and correct to the best of my knowledge. I have <b>read and reviewed</b> it for accuracy and understand there will be a minimum charge of <b>\$75.00</b> plus the cost of replacement of certified copies of the death certificate and/or permit, to be paid by the informant, to amend the death certificate after certified copies are issued. |  |   |  |  |  | SIGNATURE OF INFORMANT   |  | DATE AND TIME                                     |  |
| If the doctor has not provided information in a reasonable time, you may reach me at:  |  |   |  |  |  | Phone:   |  | Email:  |  |