

Name Known to Physician:	Date of Death:
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VDH-HSI-PROD-2023

STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Demographic Information

Type or Print in Black Ink

To Be Completed/Verified By: FUNERAL DIRECTOR OR PERSON ACTING AS SUCH	1a. DECEDENT'S LEGAL NAME (First, Middle, Last, Suffix)									
	1b. ALIASES (Any other names the decedent used or was known as)				1c. DECEDENT'S LAST NAME AT BIRTH					
	2. SEX: ☐ Male ☐ Female		3. SOCIAL SECURITY NUMBER		4a. AGE-LAST BIRTHDAY (Years)		4b. IF UNDER 1 YEAR Months Days		4c. IF UNDER 1 DAY Hours Minutes	
	5. DATE OF BIRTH (Month, Day, Year)				6. BIRTHPLACE (City and State or Foreign Country - include Province if Canada)					
	7a. RESIDENCE STREET AND NUMBER (Include Apartment Number)				7b. CITY OR TOWN OF RESIDENCE		7c. STATE OR FOREIGN COUNTRY			
	8a. EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No		8b. VETERAN OF ANY WAR? ☐ Yes ☐ No		8c. IF SO, WHAT WAR(S)?					
	9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Civil Union ☐ Widowed ☐ Divorced ☐ Civil Union dissolution ☐ Never Married or in Civil Union ☐ Unknown				10a. BIRTH NAME OF SURVIVING SPOUSE / CIVIL UNION PARTNER		10b. SEX OF SURVIVING SPOUSE/PARTNER ☐ Male ☐ Female ☐ Unknown			
	11. FATHER'S OR PARENT'S BIRTH NAME (First, Middle, Last)				12. MOTHER'S OR PARENT'S BIRTH NAME (First, Middle, Last)					
	13a. INFORMANT'S NAME (First, Middle, Last)				13b. RELATIONSHIP TO DECEDENT					
	13c. INFORMANT'S MAILING ADDRESS (Street and Number, City or Town, State, Zip Code)									
	14. DECEDENT'S EDUCATION LEVEL: (Check the box that best describes the highest degree or level of school completed at the time of death.) ☐ 8 th grade or less ☐ 9 th – 12 th grade; no diploma ☐ High school graduate or GED completed ☐ Some college credit, but no degree				15. 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.) ☐ No, not Spanish/Hispanic/Latino/Latina ☐ Yes, Mexican, Mexican American, Chicano/Chicana ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino/Latina (Specify) _____					
	16. DECEDENT'S RACE: (Check one or more races to indicate what the decedent considered himself or herself to be.) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (Specify) _____ ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (Specify) _____ ☐ Other (Specify) _____									
	17. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED)				18. KIND OF BUSINESS/INDUSTRY		19. DID DECEDENT RECEIVE HOSPICE CARE? (In past 30 days) ☐ Yes ☐ No ☐ Unknown			
	20. PLACE OF DEATH (Indicate only one) ☐ Inpatient ☐ Intensive Care Unit ☐ Emergency Room/Outpatient ☐ Dead on Arrival				If death occurred somewhere other than a hospital: ☐ Nursing Home / Long Term Care Facility ☐ Hospice Facility ☐ Decedent's Home ☐ Other (specify) _____					
	21a. FACILITY NAME (If not institution, give street and number)				21b. CITY OR TOWN		21c. STATE			
22a. METHOD OF DISPOSITION: ☐ Temporary Storage ☐ Burial ☐ Cremation ☐ NOR ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (specify)										
22b. PLACE OF TEMPORARY STORAGE (Name of cemetery, other place)				22c. LOCATION OF TEMPORARY STORAGE (City or Town, State)						
22d. PLACE OF FINAL DISPOSITION (Name of cemetery, disposition facility, other place)				22e. LOCATION OF FINAL DISPOSITION (City or Town, State)						
23a. NAME OF FUNERAL FACILITY OR AUTHORIZED PERSON		23b. ADDRESS OF FUNERAL FACILITY OR AUTHORIZED PERSON (Street and Number, City, State, Zip Code)								
24. SIGNATURE OF FUNERAL SERVICE LICENSEE OR AUTHORIZED PERSON				25. VERMONT LICENSE NUMBER		26. DATE OF DISPOSITION (Month, Day, Year)				

If attached to a completed Preliminary Report of Death – Medical Certification, this document shall be acceptable for issuance of burial transit and removal permits. This is not a permanent record. A town clerk may not issue certified copies of this record.

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**STATE OF VERMONT
DEPARTMENT OF HEALTH
Preliminary Report of Death – Medical Certification**

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19. DID DECEDENT RECEIVE HOSPICE CARE? (In past 30 days) ☐ Yes ☐ No ☐ Unknown			
20. PLACE OF DEATH If death occurred in a hospital: <i>(Indicate only one)</i> ☐ Inpatient ☐ Intensive Care Unit ☐ Emergency Room/Outpatient ☐ Dead on Arrival If death occurred somewhere other than a hospital: ☐ Nursing Home / Long Term Care Facility ☐ Hospice Facility ☐ Decedent's Home ☐ Other (specify) _____			
21a. FACILITY NAME (If not institution, give street and number)		21b. CITY OR TOWN	21c. STATE
27. MANNER OF DEATH: Note: All deaths that are not "Natural" should be referred to a Medical Examiner. Call 1-888-552-2952. ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could Not Be Determined			
28. CAUSE PART I. Enter the <u>chain of events</u> — 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. _____ 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. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____			APPROXIMATE INTERVAL: ONSET TO DEATH _____ _____ _____
29. CAUSE PART II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I.			
30. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown		31. IF FEMALE: ☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Unknown if pregnant within the past year ☐ Not pregnant, but pregnant within 42 days of death	
32a. WAS MEDICAL EXAMINER CONTACTED? ☐ Yes ☐ No	32b. M.E. CASE NUMBER	33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No	34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH? ☐ Yes ☐ No
IF AN INJURY IS PART OF THE CAUSE OF DEATH (Pt. I OR II) THE DEATH SHOULD BE CERTIFIED BY A MEDICAL EXAMINER. CALL 1-888-552-2952			
35. DATE OF INJURY (Month, Day, Year)	36. TIME OF INJURY ☐ AM ☐ PM	37. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)	38. INJURY AT WORK? ☐ Yes ☐ No
39. LOCATION OF INJURY (Street and Number, City or Town, State)			
40. DESCRIBE HOW INJURY OCCURRED		41. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (specify) _____	
42a. ACTUAL OR PRESUMED DATE OF DEATH (Month, Day, Year)	42b. ACTUAL OR PRESUMED TIME OF DEATH ☐ AM ☐ PM	42c. DATE PRONOUNCED DEAD (Month, Day, Year)	42d. TIME PRONOUNCED DEAD ☐ AM ☐ PM
43a. SIGNATURE OF CERTIFIER – To the best of my knowledge, on the basis of case history, examination, and/or investigation, death occurred at the time, date, and place and due to the cause(s) and manner stated.			43b. DATE CERTIFIED (Month, Day, Year)
43c. NAME OF CERTIFIER (Type or Print)			43d. LICENSE NUMBER
43e. ADDRESS OF CERTIFIER (Street and Number, City or Town, State, Zip Code)			44. CONTACT PHONE NUMBER ()
45. TITLE OF CERTIFIER: ☐ Physician ☐ Pathologist ☐ Medical Examiner ☐ Physician Assistant ☐ Advanced Practice Registered Nurse		46. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	

To Be Completed/Verified By: MEDICAL CERTIFIER

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