NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
N.C. VITAL RECORDS

CERTIFICATE OF DEATH

REGISTRATION **DISTRICT NO.** ______ LOCAL NO. ______ COUNTY OF DEATH ______ STATE FILE NO. ______

DECEDENT

TYPE/PRINT IN PERMANENT BLACK, BLUE-BLACK OR BLUE INK

NAME OF DECEDENT (For use by Physician, Institution or Medical Examiner)

DECEDENT'S LEGAL NAME
1a. FIRST aka | 1b. MIDDLE aka | 1c. LAST aka | 1d. SUFFIX | 1e. LAST NAME PRIOR TO FIRST MARRIAGE

2. SEX | 3a. AGE-LAST BIRTHDAY (Yrs) | 3b. UNDER 1 YEAR Months Days | 3c. UNDER 1 DAY Hours Minutes | 4. DATE OF BIRTH (Month/Day/Year) | 5. BIRTHPLACE (County/State or Foreign Country) | 6. DATE OF DEATH (Month/Day/Year)

PLACE OF DEATH (Check only one)
7a. IF DEATH OCCURRED IN A HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA
7b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify) ______

7c. FACILITY NAME (If not institution, give street and number) | 7d. CITY OR TOWN | 7e. COUNTY OF DEATH

8. MARITAL STATUS ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never married ☐ Unknown
9. SURVIVING SPOUSE (If wife, give name prior to first marriage)
10a. DECEDENT'S USUAL OCCUPATION (Do not use retired)
10b. KIND OF BUSINESS/INDUSTRY

11. SOCIAL SECURITY NUMBER | 12a. RESIDENCE–STATE OR FOREIGN COUNTRY | 12b. COUNTY | 12c. CITY OR TOWN

12d. STREET AND NUMBER | 12e. INSIDE CITY LIMITS ☐ Yes ☐ No | 12f. ZIP CODE | 13. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No

14. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death)
- ☐ 8th grade or less
- ☐ 9th–12th grade; no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

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
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (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 ☐ Japanese
- ☐ Chinese ☐ Korean
- ☐ Filipino ☐ Vietnamese
- ☐ Other Asian (Specify) ______
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) ______
- ☐ Other (Specify) ______

PARENTS

17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

19a. INFORMANT'S NAME | 19b. RELATIONSHIP TO DECEDENT | 19c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

DISPOSITION

20a. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify) ______
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)
20c. LOCATION (City or Town and State)

21a. SIGNATURE OF FUNERAL DIRECTOR | 21b. LICENSE NUMBER | 21c. NAME OF EMBALMER | 21d. LICENSE NUMBER

22. NAME AND ADDRESS OF FUNERAL HOME

MEDICAL CERTIFICATION

BURIAL/CREMATION PERMIT

Medical Examiner: Authorization for Disposition/Transportation
After the medical examiner completes and signs this burial transit permit/cremation authorization, it constitutes authority for burial, cremation, transportation or removal from the state.
A copy of this form serves as a Burial/Cremation Permit.

23. 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 on lines b, c and/or d. Enter only one cause on a line. DO NOT ABBREVIATE.

Approximate interval: Onset to death

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. ______

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

24a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No
24b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

25. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending ☐ Suicide ☐ Cannot be determined
26a. WAS CASE REFERRED TO MEDICAL EXAMINER? ☐ Yes ☐ No
26b. IF YES ☐ Declined by Medical Examiner
27. TIME OF DEATH (Approximate)
28. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown
29. IF FEMALE:
- ☐ Pregnant at time of death
- ☐ Not pregnant within past year
- ☐ Not pregnant, but pregnant within 42 days of death
- ☐ Not pregnant, but pregnant 43 days to 1 year before death
- ☐ Unknown if pregnant within the past year

MEDICAL EXAMINER ONLY

30. DATE PRONOUNCED (Month/Day/Year) | 31a. DATE OF INJURY (Month/Day/Year) | 31b. TIME OF INJURY | 31c. INJURY AT WORK? ☐ Yes ☐ No | 31d. PLACE OF INJURY–at home, farm, street, factory, office, building, etc.
31e. IF TRANSPORTATION INJURY SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)
31f. DESCRIBE HOW INJURY OCCURRED | 31g. LOCATION OF INJURY (Street/Number/City/State)

CERTIFIER

32. CERTIFIER (Check only one)
☐ Certifying physician/nurse practitioner/physician assistant – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Medical Examiner – 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.

33a. SIGNATURE AND TITLE OF CERTIFIER | 33b. LICENSE NUMBER | 33c. DATE SIGNED (Month/Day/Year)

33d. NAME AND ADDRESS OF CERTIFIER (Print legibly) | 36. DATE REGISTERED BY STATE

REGISTRAR

34. FOR LOCAL REGISTRAR (Name) | 35. DATE FILED (Month/Day/Year)

DATE CORRECTED (Mo/Day/Yr) | ITEM(S) CORRECTED:
DATE AMENDED (Mo/Day/Yr) | ITEM(S) AMENDED:

DHHS 1872
(REVISED 08/13)
N.C. VITAL RECORDS
(REVIEW 08/16)

NOTIFICATION OF DEATH

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NC VITAL RECORDS

LOCAL REGISTRAR'S COPY

	First	Middle	Last	
Name of Deceased				Date of Death

	Name of Institution or Street Address	City	County
Place Death			

	Name	Address
Attending Physician ☐ Medical Examiner* ☐		

	Name	Telephone No.	Address
Funeral Home			

Signature of Authorized Representative	Date Signed

*FOR MEDICAL EXAMINER CASES ONLY — I certify that the body of the above-named decedent has been released by the above-named medical examiner for final disposition.

Signature: ______________________________
Funeral Director or Authorized Representative

IMPORTANT NOTICE

The funeral director who first assumes custody of a body must:

1. File a Notification of Death with the local registrar of the district in which death occurred within 24 hours after taking possession of the body, and
2. File a death certificate within 5 days after death.

See back of this form for instructions pertaining to burial transit permits for Medical Examiner cases and removals from the state.

THIS FORM MAY BE FAXED TO LOCAL REGISTRAR.

FOR LOCAL REGISTRAR'S USE ONLY

	Date Due	Date Received	Date Filed with Register of Deeds
Notification of Death			
Death Certificate			

Follow-up Efforts and Activities (Note parties and dates contacted)

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0142

STATEMENT OF DEATH BY FUNERAL DIRECTOR

NAME OF DECEASED	SOCIAL SECURITY NUMBER
	Please complete the items below, and return the form in the enclosed addressed, postage paid envelope. Your assistance and cooperation are appreciated.

PRIVACY ACT/PAPERWORK ACT NOTICE: The information on this form is authorized by Section 404.715 and 404.720 of the Federal Regulations (20 CFR 404.715 and 404.720). While your response is voluntary, we need your assistance to make an accurate and timely determination concerning the death of the individual named above, and to determine if there are survivors who may be eligible for Social Security benefits.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3.5 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

1. NAME OF DECEASED		2. SOCIAL SECURITY NUMBER
3. DATE OF DEATH	4. DATE OF BIRTH *(if known)*	5. Check (x) whether the deceased was ☐ Male ☐ Female

6. NAME OF WIDOW OR WIDOWER *(if known)*

7. ADDRESS (No. and Street, P.O. Box) OF WIDOW OR WIDOWER *(if known)*

CITY	STATE	ZIP CODE	TELEPHONE NUMBER (if Available) area code

I hereby certify that I am an authorized funeral director and prepared for final disposition the body of the person named above. I understand this statement may be used in connection with an application for Social Security benefits. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

NAME AND ADDRESS OF FUNERAL DIRECTOR OR FIRM	SIGNATURE OF FUNERAL DIRECTOR OR AUTHORIZED REPRESENTATIVE	
City of Oaks Cremation, LLC 8384 Six Forks Road, SUite 204 Raleigh, NC 27615	TELEPHONE NUMBER (919) 438- 1649 area code	DATE

FOR SOCIAL SECURITY USE ONLY - DO NOT WRITE IN THIS SPACE