At-need Death Certificate Information Form- DCSVA

Name of Decedent			Social Security Number
Date of Death	Time of Death (24hr)	Facility Type HOSPITAL NON-HOSPITAL	❑ Inpatient ❑ E R / Outpatient ❑ Dead On Arrival ❑ Hospice Facility ❑ Nursing Home ❑ Decedent's Home ❑ Other (specify):
Facility or Place of Death *(if not institution, give street address)*			Autopsy ❑ Yes ❑ No Pacemaker ❑ Yes ❑ No
City of Death	County of Death	State of Death	

Date of Birth	Place of Birth *(City, State or Foreign Country)*	Citizen of What Country

Age	Gender ❑ Male ❑ Female	US Veteran? ❑ Yes ❑ No	Branch &Years of Service *(if Veteran)*

Marital Status ❑ Married ❑ Married, but Separated ❑ Widowed ❑ Divorced ❑ Never Married

Spouse*(First, Middle, Married Name)*	*Spouse's Maiden Name*

Decedent's Race or Races (More *than one race may be specified)*

❑ White ❑ Black or African American ❑ American Indian or Alaskan Native (Specify tribe)

❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other Asian (specify)_____

❑ Native Hawaiian ❑ Guamanian or Chamorro ❑ Samoan ❑ Other Pacific Islander (specify)_____

❑ Other (Specify)_____

Of Hispanic or Haitian origin? ❑ Yes (if Yes, specify) ❑ No	❑ Mexican ❑ Puerto Rican ❑ Cuban ❑ Central/South American ❑ Other (specify) ❑ Haitian

Education:

Highest Grammar Grade Completed _____ ❑ High School, no diploma ❑ High School diploma or GED

Years of College Completed_____ Highest College degree (Specify): ❑ Associate ❑ Bachelor's ❑ Master's ❑ Doctorate

Decedent's Occupation (Kind of work done the longest)	Industry (Description & Company Name)	
Father's Name (First, Middle, Last)	Mother's Name (First, Middle, Last)	**Mothers Maiden Surname**

Decedent's Last Legal Residence Address *(Street Address - No PO Box)*	Apt No.	City Limits? ❑ Yes ❑ No
Decedent's City of Residence	Decedent's County of Residence	
State / Zip Code	(NOTE: In the case of patients in a nursing or convalescent home, the place where the deceased lived prior to admission should be used.)	

Contact Name *(Person Providing this Information)*	Relationship to Decedent
Contact Mailing Address *(Street, City, State, Zip* Code)	
Contact information *(Telephone, Cell Phone, etc)*	Contact (Email)
Number of Certified Death Certificates Requested	Address To Send Certified Death Certificates To

Approved: _____

Please review carefully before approving this information. You will be responsible for any amendment fees and attorney/court costs necessary due to incorrect information listed on this form.

Call: 703-584-4927 - Fax: 703-677-8745 - Email: Forms@DirectCremationServicesofVirginia.com