Medical Examiner Department

Public Interment Program

Decedent Information

PIP Case Number: _____

1. Deceased: _____ (first, middle, last) 2. Sex: Male 3. Age: _____

4. Race: White

   Other *(Specify)* _____

5. Decedent of Hispanic or Haitian origin? ☐ Yes (If yes, please specify) ☐ No

   ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Central/South American ☐ Other Hispanic (Specify) ☐ Haitian

6. Date of Death: _____ 7. Time of Death: _____ A.M. _____ P.M.

8. Date of Birth: _____ 9. Social Security No.: _____

10. Place of Birth: _____ City/State

11. Marital Status: _____ (married, married but separated, never married, single, divorced, widowed) 12. Surviving Spouse: _____

13. Was decedent in the U.S. Armed Forces: ☐ Yes ☐ No

14. Place of Death: _____ Hospital/E.R., nursing home, residence, other (please specify)

15. Was death inside city limits: ☐ Yes ☐ No

16. City, town or location of death: _____

17. Decedent's Usual Occupation: _____ 18. Kind of Business: _____

19. Residence: _____ 20. County: _____

21. Street and Number: _____

22. _____ Father's Name 23. _____ Mother's Name

24. Informant's name and mailing address: _____

25. Attending physician: (*certifier*) _____

    Phone: _____

    Address: _____

    City, State, Zip Code: _____

26. Form Completed by: _____ Name _____ Title _____ Phone