

Medical Examiner Department

Public Interment Program



Decedent Information

COUNTI	
PIP Case Number:	

1.	Deceased:					2. \$	Sex:		3. Age:	
				(first,	middle, last)					
4.	Race: White	Black	Other	(Alas	skan, Asian, An	nerican	Indian or	Unknown)		
5.	Decedent of Hispanic Mexican	or Haitian o Cuban	rigin? Puerto Rican		Yes (If yes, plea Central/South			No Other	Hispanic (Specify)	Haitian
6.	Date of Death:			7.	Time of Dea	ıth: _		A.M	·	P.M.
8.	Date of Birth:			9.	Social Secu	rity No	o.: _			
10.	Place of Birth:					<u></u>				
					(City/St	ate			
11.	Marital Status:(married, married but separated, new		vorced, widowed)	12.	Surviving Sp	oouse	: _			
13.	Was decedent in the	U.S. Armed	Forces:		Yes	1	No	14.	Highest Grad	de Completed
15.	Place of Death:									
	Hospital/E.R., nursing home, residence, other (please specify)									
16.	Was death inside city	/ limits:	Yes		No					
17.	City, town or location	of death:								
18.	Decedent's Usual Oc	al Occupation:19. Kind of Business:								
20.	Residence Address:								Zip Code:	
21.	State:						Cou	ınty:		
22.						23.				
		ther's Name			-				er's Maiden N	
24.	Informant's name:									
	Informant's Address:									
25.	Attending physician:	(certifier)	First Name:				L	ast Name	e:	
	Phone Number:					Fax N	Number:			
	Address:									
00	Farm Carriella									
∠ڻ.	Form Completed by:	Name					Γitle			Phone