

TYPE OR
PRINT IN
PERMANENT
BLACK INK.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-

I.D. TAG NO.

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

TO BE COMPLETED BY MEDICAL CERTIFIER

1. Legal Name (Include AKAs, if any) First Middle Last Suffix					2. Death Date (MON DD YYYY)	
3. Sex (M/F)	4a. Age - Last Birthday	4b. Under 1 Year	4c. Under 1 Day	5. Social Security Number		6. County of Death
	Months	Days	Hours	Minutes		
7. Birthdate (MON DD YYYY)		8a. Birthplace (City/Town, or County)		8b. (State or Foreign Country)		9. Decedent's Education
10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.)			11. Decedent's Race(s)			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8)				14. City/Town		
15. Residence County		16. State or Foreign Country		17. Zip Code + 4		18. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. Marital Status at Time of Death			20. Spouse's Name (If married or widowed, give name prior to first marriage.)			
21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.")				22. Kind of Business/Industry (DO NOT USE COMPANY NAME.)		
23. Father's Name (First, Middle, Last, Suffix)			24. Mother's Name Prior to First Marriage (First, Middle, Last)			
25. Informant's Name		26. Telephone Number	27. Relation to Decedent	28. Mailing Address (Number & Street, City/Town, State, Zip + 4)		
29. Place of Death			30. Facility Name			
31. Location of Death (Give address.)			32. City/Town or Location of Death		33. State	34. Zip Code + 4
35. Method of Disposition		36. Place of Disposition (Name of cemetery, crematory, or other place)		37. Location		
38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4)						
39. Date of Disposition (MON DD YYYY)		40. Funeral Director's Signature			41. OR License Number	
42. Registrar's Signature			43. Date Received (MON DD YYYY)		44. Local File Number	
45. Record Amendment						
46. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		47. Autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Were autopsy findings available to complete the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		49. Time of Death	
CAUSE OF DEATH (See instructions and examples.)						
50. 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. DO NOT ABBREVIATE.						Approximate Interval: Onset to Death
Final disease or condition resulting in death →		IMMEDIATE CAUSE ↓				
Sequentially list conditions, if any, leading to the cause listed on line a.		a.				
ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).		Due to (or as a consequence of) ↓				
		b.				
		Due to (or as a consequence of) ↓				
		c.				
		Due to (or as a consequence of) ↓				
		d.				
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:						
52. Manner of Death		53. If Female			54. Did tobacco use contribute to death?	
<input type="checkbox"/> Natural <input type="checkbox"/> Homicide		<input type="checkbox"/> Not pregnant within past year	<input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death	<input type="checkbox"/> Yes	<input type="checkbox"/> Probably	
<input type="checkbox"/> Accident <input type="checkbox"/> Undetermined		<input type="checkbox"/> Pregnant at time of death	<input type="checkbox"/> Unknown if pregnant within the past year	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Suicide <input type="checkbox"/> Pending		<input type="checkbox"/> Not pregnant, but pregnant within 42 days before death				
55. Date of Injury (MON DD YYYY)		56. Time of Injury	57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)			58. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
59. Location of Injury (Number & Street, City/Town, State, Zip + 4)						
60. Describe how injury occurred.				61. If transportation injury, specify. <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4)						
63. Name and Title of Attending Physician if Other than Certifier						
64. Title of Certifier			65. License Number		66. Date Certified (MON DD YYYY)	
67. Medical Certifier - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				68. 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.		
69. Record Amendment						

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CERTIFICATE OF DEATH

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I.D. TAG NO.

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY	1. Legal Name (Include AKAs, if any) First Middle Last Suffix					2. Death Date (MON DD YYYY)	
	3. Sex (M/F)	4a. Age - Last Birthday	4b. Under 1 Year Months Days	4c. Under 1 Day Hours Minutes	5. Social Security Number		6. County of Death
	7. Birthdate (MON DD YYYY)		8a. Birthplace (City/Town, or County)		8b. (State or Foreign Country)		9. Decedent's Education
	10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.)			11. Decedent's Race(s)		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8)				14. City/Town		
	15. Residence County		16. State or Foreign Country		17. Zip Code + 4		18. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	19. Marital Status at Time of Death			20. Spouse's Name (If married or widowed, give name prior to first marriage.)			
	21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.")				22. Kind of Business/Industry (DO NOT USE COMPANY NAME.)		
	23. Father's Name (First, Middle, Last, Suffix)				24. Mother's Name Prior to First Marriage (First, Middle, Last)		
	25. Informant's Name		26. Telephone Number	27. Relation to Decedent	28. Mailing Address (Number & Street, City/Town, State, Zip + 4)		
29. Place of Death			30. Facility Name				
31. Location of Death (Give address.)			32. City/Town or Location of Death		33. State	34. Zip Code + 4	
35. Method of Disposition		36. Place of Disposition (Name of cemetery, crematory, or other place)		37. Location			
38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4)							
39. Date of Disposition (MON DD YYYY)		40. Funeral Director's Signature			41. OR License Number		
42. Registrar's Signature			43. Date Received (MON DD YYYY)		44. Local File Number		
45. Record Amendment							
TO BE COMPLETED BY MEDICAL CERTIFIER	46. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Were autopsy findings available to complete the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		49. Time of Death		
	CAUSE OF DEATH (See instructions and examples.)						
	50. 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. DO NOT ABBREVIATE.					Approximate Interval: Onset to Death	
	Final disease or condition resulting in death → Sequentially list conditions, if any, leading to the cause listed on line a. ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).		IMMEDIATE CAUSE ↓ a. Due to (or as a consequence of) ↓ b. Due to (or as a consequence of) ↓ c. Due to (or as a consequence of) ↓ d. Due to (or as a consequence of) ↓				
	51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:						
	52. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		53. If Female <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death			54. Did tobacco use contribute to death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	55. Date of Injury (MON DD YYYY)	56. Time of Injury	57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)			58. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	59. Location of Injury (Number & Street, City/Town, State, Zip + 4)						
	60. Describe how injury occurred.				61. If transportation injury, specify. <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		
	62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4)						
63. Name and Title of Attending Physician if Other than Certifier							
64. Title of Certifier			65. License Number		66. Date Certified (MON DD YYYY)		
67. Medical Certifier - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				68. 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.			
69. Record Amendment							

CHECK APPROPRIATE BOX BELOW — Complete Both Copies

- AUTHORIZATION FOR FINAL DISPOSITION**
This form, when signed above by the funeral service licensee (Item 40) and by the medical certifier (67 or 68), shall serve as a disposal-transit permit for the remains of the decedent named hereon.
- ALTERNATIVE AUTHORIZATION FOR FINAL DISPOSITION**
This form, when completed and signed below by the funeral service licensee, shall serve as a disposal-transit permit for the remains of the decedent named hereon.
I have contacted Dr. _____ on (date) _____ at (time) _____ and the doctor has agreed to sign a certification of the cause of death as soon as possible.

FUNERAL SERVICE LICENSEE SIGNATURE _____ License # _____

INSTRUCTIONS: The person in charge of the place of final disposition shall date and sign both copies of the disposition form. Forward the first copy to the registrar of the county where death occurred within 10 days after the date of final disposition. The second copy will be retained by the cemetery or crematory.

DATE OF DISPOSITION _____ SEXTON'S SIGNATURE _____

**SEND THIS FORM TO THE REGISTRAR OF THE COUNTY OF DEATH.
ADDRESSES ARE ON THE REVERSE SIDE.**

Baker Co. Health Dept.
Vital Records Section
3330 Pocahtontas Road
Baker City, OR 97814
(541) 523-8211

Benton Co. Health Dept.
Vital Records Section
530 NW 27th Street
P.O. Box 579
Corvallis, OR 97339-0579
(541) 766-6835
(541) 766-6186 (Fax)

Clackamas Co. Health Services
Vital Records Section
2051 Kaen Road
Oregon City, OR 97045
(503) 655-8406

Clatsop Co. Health and
Human Services
Vital Records Section
820 Exchange Street, Suite 100
Astoria, OR 97103
(503) 325-8500

Columbia Co. Vital Records
County Clerk's Office
Court House
230 Strand Street
St Helens, OR 97051
(503) 397-3796

Coos Co. Health Dept.
Vital Records Section
1975 McPherson
North Bend, OR 97459
(541) 756-2020, ext. 646

Crook Co. Health Dept.
Vital Records Section
203 NE Court Street
Prineville, OR 97754
(541) 447-5165

Curry Co. Health Dept.
Vital Records Section
94235 Moore Street
P.O. Box 746
Gold Beach, OR 97444
(541) 247-3300

Deschutes Co. Health Dept.
Vital Records Section
2577 NE Courtney Drive
Bend, OR 97701
(541) 322-7400

Douglas Co. Health Dept.
Vital Records Section
621 W. Madrone, Room 109
Roseburg, OR 97470-3010
(541) 440-3513

Gilliam Co. Vital Records
County Clerk's Office
P.O. Box 427
Condon, OR 97823
(541) 384-2311

Grant Co. Health Dept.
Vital Records Section
528 E. Main St., Suite E
John Day, OR 97845-1240
(541) 575-0429

Harney Co. Health Dept.
Vital Records Section
420 N. Fairview
Burns, OR 97720
(541) 573-2271

Hood River Co. Health Dept.
Vital Records Section
1109 June Street
Hood River, OR 97031
(541) 386-1115

Jackson Co. Health and
Human Services
1005 E. Main Street, Bldg. A
Medford, OR 97504
(541) 774-8210
(541) 774-8157 (Fax)

Jefferson Co. Health Dept.
Vital Records Section
715 SW 4th Street, Suite C
Madras, OR 97741
(541) 475-4456

Josephine Co. Health Dept.
Vital Records Section
715 NW Dimmick
Grants Pass, OR 97526
(541) 474-5328

Klamath Co. Health Dept.
Vital Records Section
403 Pine Street
Klamath Falls, OR 97601
(541) 882-8846

Lake Co. Health Dept.
Vital Records Section
100 North "D" Street, Suite 100
Lakeview, OR 97630
(541) 947-6045

Lane Co. Health and
Human Services
Vital Records Section
125 E. 8th Avenue
Eugene, OR 97401
(541) 682-4306
(541) 682-9825 (Fax)

Lincoln Co. Health and
Human Services
36 SW Nye Street
Newport, OR 97365-3821
(541) 265-4127

Linn Co. Health Dept.
Vital Records Section
P.O. Box 100
Albany, OR 97321
(541) 967-3888
(541) 924-6904 (Fax)

Malheur Co. Health Dept.
Vital Records Section
1108 SW 4th Street
Ontario, OR 97914
(541) 889-7279
(541) 889-8468 (Fax)

Marion Co. Health Dept.
Vital Statistics
2111 Front St., NE, Suite 3-110
Salem, OR 97303-0621
(503) 588-5406

Morrow County Clerk's Office
P.O. Box 338
Heppner, OR 97836
(541) 676-5601

Multnomah Co. Health Dept.
Vital Records Section
3653 SE 34th Avenue
Portland, OR 97202
(503) 988-3745
(503) 988-4041 (Fax)

Polk Co. Health Dept.
Vital Records Section
182 SW Academy St., Suite 302
Dallas, OR 97338
(503) 623-8175

Sherman County
See: Wasco-Sherman Co.

Tillamook Co. Health Dept.
Vital Records Section
P.O. Box 489
Tillamook, OR 97141
(503) 842-3900

Umatilla Co. Health Dept.
Vital Statistics Section
200 SE 3rd Street
Pendleton, OR 97801
(541) 278-5432

Union County Center for
Human Development
Public Health Services
1100 "K" Avenue
LaGrande, OR 97850
(541) 962-8823

Wallowa Co. Health Dept.
Vital Records Section
758 NW 1st Street
Enterprise, OR 97828
(541) 426-4848

Wasco-Sherman Co.
Health Dept.
Vital Records Section
419 E. 7th Street, Suite 100
The Dalles, OR 97058
(541) 296-2628

Washington Co. Health Dept.
Vital Records Section
155 N. 1st Avenue, Room 200
Hillsboro, OR 97124
(503) 846-8280
(503) 846-4490 (Fax)

Wheeler Co. Health Dept.
Vital Records Section
P.O. Box 327
Fossil, OR 97830
(541) 763-2400

Yamhill Co. Health Dept.
Vital Records Section
412 NE Ford Street
McMinnville, OR 97128
(503) 434-7477
(503) 472-9731 (Fax)

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CERTIFICATE OF DEATH

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	55. Date of Injury (MON DD YYYY)	56. Time of Injury	57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)			58. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	59. Location of Injury (Number & Street, City/Town, State, Zip + 4)						
	60. Describe how injury occurred.				61. If transportation injury, specify. <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		
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DATE OF DISPOSITION _____ SEXTON'S SIGNATURE _____

**THIS COPY IS TO BE RETAINED BY THE PERSON IN CHARGE OF THE PLACE OF FINAL DISPOSITION.
CEMETERY'S OR CREMATORY'S COPY**

