PROVISIONAL NOTIFICATION OF DEATH - BURIAL TRANSIT PERMIT

State Form 38220 (R2 / 9-06) / SDH 06-093-32

_____ COUNTY HEALTH DEPARTMENT

INSTRUCTION: Please type or print clearly.

A REPORT OF DEATH
(To be completed by facility where death occurred)

Name of deceased *(First, middle, last)*	Date of death *(month, day, year)*	Time of death (local) ☐ AM ☐ PM

County of death	City of death	Age	Race	Sex ☐ Male ☐ Female

Place of death *(If not facility such as hospital, nursing home, etc. give street address)*

Name of Medical Certifier *(official certifier of cause of death)*	Telephone number ( )

Address of Medical Certifier *(number and street, city, state, and ZIP code)*

B RELEASE
(To be completed by person having authority to release remains)

Authorization is hereby granted to release the remains of the above named to:

Name of funeral home	City	State

Signature of representative of facility releasing remains	Name of next of kin or legal representative authorizing release

C BURIAL - TRANSIT PERMIT
(To be completed by funeral director or representative)

I, representing _____ *name of funeral home* _____ *city* _____ *state* _____ *telephone number*

hereby accept the remains of the above named and agree to secure and file a complete certificate of death within the time limit established by law.

Signature of funeral director or representative	Printed name of Indiana Licensed Funeral Director	Indiana Funeral Director License number

A certificate of death having been filed or a provisional notification of death received as required by law, permission is hereby given for transportation and disposition of the remains - except for cremation which requires a completed certificate of death.

Signature of Health Officer	Local number	Date filed *(month, day, year)*

D RESIDENCE
(To be completed by funeral director)

Last known county of residence	Last known address of deceased *(number and street, city , state, and ZIP code)*

Address(es) two (2) years prior to death *(if different)*	*(number and street, city, state, and ZIP code)*
	(number and street, city, state, and ZIP code)

E DISPOSITION
(To be signed by sexton of cemetery or representative of crematory)

Name of cemetery / crematory	Date of disposition *(month, day, year)*	Date of cremation *(month, day, year)*

Place of disposition *(City, county, state, and ZIP code)*

Method of disposition *(check all that apply)* ☐ Burial ☐ Cremation ☐ Entombment ☐ Inurnment ☐ Removed from State ☐ Donation ☐ Scattering *(location)* _____

Cremains returned to :	Funeral Director	Family	Cemetery

Signature of sexton or crematory representative	Date *(month, day, year)*

DISTRIBUTION: White copy - Health Department copy to accompany the body to its disposition. Must be signed by the sexton of the cemetery or the representative of the crematory, and returned to health department in the county where the death occurred within two (2) days after burial or cremation. Copies may be made for faxing. Contact local health department for out-of-state shipment.

Canary copy - Cemetery/Crematory copy for their records.

Pink copy - To be mailed by the facility where the death occurred to the local health department within twenty four (24) hours following death. Copies of the white form may be made by the facility for its' records and for faxing in lieu of mailing.