INDIANA DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No.…… **State No.……**

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time of Death	4. Date of Death (Month/Day/Year)

5. Social Security Number	6a. Age – Yrs	6b. Under 1 Year (Months)	6c. Under 1 Month (Days)	6d. Under 1 Day (Hours)	6e. Under 1 Hour (Minutes)	7. Date of Birth (Month/Day/Year)	8. Birthplace (City and State or Foreign Country)

9. Ever in U.S. Armed Forces?	10. If Death Occurred in a Hospital:	10a. If Death Occurred Somewhere Other Than a Hospital:
☐ Yes ☐ No Unknown ☐	☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival	☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street and Number)

12. City or Town, State, and ZIP Code	13. County of Death	14. Marital Status at Time of Death
		☐ Married ☐ Married, but Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind of Business/Industry

18. Residence – State	18a. County	18b. City or Town

18c. Street and Number	18d. Apt. No.	18e. ZIP Code	18f. Inside City Limits?
			☐Yes ☐No

19. Decedent's Education	20. Decedent of Hispanic Origin	21. Decedent's Race

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name

24. Informant's Name	24a. Relationship to Decedent	24b. Mailing Address (Street and Number, City, State, ZIP Code)

25. Place of Disposition

25a. Method of Disposition:	25b. Place of Disposition (Name of Cemetery, Crematory, Other Place)	25c. Location – City, Town, and State
☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify):		

26. Was Coroner Contacted?	27. Name and Complete Address of Funeral Facility	27a. Funeral Home License Number
☐ Yes ☐ No		

27b. Signature of Indiana Funeral Service Licensee	27c. License Number (of Licensee)

Cause Of Death (See Instructions and Examples)

28. Part I. *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. Enter ONLY one Cause on a line. Add additional lines if necessary.*

Approximate Interval: Onset To Death

Immediate Cause (Final Disease or Condition Resulting in Death)

A. _____ Due To (Or as a Consequence Of):

Sequentially list conditions, if any, leading to the cause listed on line A. Enter the Underlying Cause (disease or injury that initiated the events resulting in death) last.

B. _____ Due To (Or as a Consequence Of):

C _____ Due To (Or as a Consequence Of):

D. _____

Part II. *Enter Other Significant Conditions Contributing to Death but Not Resulting in the Underlying Cause Given in Part I*

29. Was an Autopsy Performed? ☐ Yes ☐ No

30. Were Autopsy Findings Available to Complete the Cause of Death? ☐ Yes ☐ No

31. Did Tobacco Use Contribute to Death?	32 If Female:	33. Manner of Death:
☐ Yes ☐ Probably ☐ No ☐Unknown	☐ Not Pregnant Within Past Year ☐ Pregnant at Time of Death ☐ Not Pregnant, but Pregnant Within 42 Days of Death ☐ Not Pregnant, but Pregnant 43 Days to 1 Year Before Death ☐Unknown if Pregnant Within the Past Year	☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date of Injury (Month/Day/Year)	35. Time of Injury	36. Place of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury at Work?
			☐ Yes ☐ No

38. Location of Injury - State	38a. City or Town	38b. Street and Number	38c. Apt. No.	38d. ZIP Code

39. Describe How the Injury Occurred	40. If Transportation Injury, Specify:
	☐Driver/Operator ☐ Passenger ☐ Pedestrian ☐Other (Specify)

41. Signature, of Person Certifying Cause of Death	42. Certifier (Check Only One)
	☐ Certifying Physician ☐ Coroner ☐ Health Officer ☐ Physician's Assistant ☐ Advance Practice Registered Nurse

43. Name, Address and ZIP Code of Person Certifying Cause of Death:	44. License Number	45. Date Certified

46. Additional Funeral Service Provider	47. *AKAS:

48. Signature of Local Health Officer	49. **For Registrar Only –** Date Filed (Month/Day/Year)

State Form 10110 (R8 / 2-24) ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3 7-1-10