GEORGIA DEATH CERTIFICATE

A. BIRTH CERTIFICATE NUMBER **B. STATE FILE NUMBER**

DECEDENT'S INFORMATION

1. DECEDENT'S LEGAL FULL NAME (FIRST, MIDDLE, LAST)
1a. LAST NAME AT BIRTH (IF FEMALE)
2. SEX
2a. DATE OF DEATH (MO/DAY/YR)
3. SOCIAL SECURITY NUMBER
4a. AGE (YEARS)
4b. UNDER 1 YEAR — MONTHS / DAYS
4c. UNDER 1 DAY — HOURS / MINUTES
5. DATE OF BIRTH (MO/DAY/YR)
6. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY)
7a. STREET AND NUMBER OF RESIDENCE
7b. ZIP CODE
7c. CITY OR TOWN OF RESIDENCE
7d. COUNTY OF RESIDENCE
7e. STATE OF RESIDENCE
7f. COUNTRY
7g. INSIDE CITY LIMITS ☐Yes ☐No ☐Unknown
8. ARMED FORCES ☐Yes ☐No ☐Unknown
8a. OCCUPATION
8b. NATURE OF BUSINESS
8c. EMPLOYER
9. MARITAL STATUS
☐ Married ☐ Divorced
☐ Married, but separated ☐ Never Married
☐ Widowed ☐ Unknown
10. SPOUSE'S NAME (IF WIFE, GIVE NAME PRIOR TO FIRST MARRIAGE)
11. FATHER'S NAME (FIRST, MIDDLE, LAST)
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST)
13. DECEDENT'S EDUCATION (HIGHEST LEVEL)
☐ 8th grade or less
☐ 9th – 12th grade; no diploma
☐ High school graduate or GED completed
☐ Some college credit, but no degree
☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, Med, MSW)
☐ Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, LLB, JD)
☐ Unknown
14a. INFORMANT'S NAME (FIRST, MIDDLE, LAST)
14b. RELATIONSHIP TO DECEDENT
14c. MAILING ADDRESS (STREET AND NUMBER, CITY, COUNTY, STATE, ZIP CODE)
15. HISPANIC ORIGIN
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Puerto Rican
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino (specify) _____
☐ Unknown
16. DECEDENT'S RACE
☐ White ☐ Black/African American ☐ Samoan
☐ Japanese ☐ Korean ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Vietnamese ☐ Other Asian
☐ Chinese ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Filipino ☐ Guamanian/Chamorro ☐ Other
☐ Unknown
17a. IF DEATH OCCURRED IN HOSPITAL
☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
17b. IF DEATH OCCURRED OTHER THAN HOSPITAL
☐ Hospice Facility ☐ Nursing Home/Long Term Care Facility ☐ Decedent's Home ☐ Other ☐ Unknown
18. FACILITY NAME
19. FACILITY ADDRESS (STREET AND NUMBER, CITY, STATE, ZIP CODE)
20. COUNTY OF DEATH

DISPOSITION

21. METHOD OF DISPOSITION
☐ Burial ☐ Donation ☐ Removal from State
☐ Cremation ☐ Entombment ☐ Other
22. PLACE OF DISPOSITION (NAME AND COMPLETE ADDRESS)
23. DATE OF DISPOSITION (MO/DAY/YR)
24a. EMBALMER'S NAME & CERTIFIED INITIALS
24b. LICENSE NUMBER
25. FUNERAL HOME NAME
25a. FUNERAL HOME ADDRESS (STREET AND NUMBER, CITY, COUNTY, STATE, ZIP CODE)
26. FUNERAL DIRECTOR'S NAME (**PRINT**)
26a. SIGNATURE OF FUNERAL DIRECTOR
26b. LICENSE NUMBER

PRONOUNCER

27. DATE PRONOUNCED DEAD (MO/DAY/YR)
28. TIME PRONOUNCED DEATH
29a. PRONOUNCER'S NAME AND TITLE (**PRINT**)
29b. PRONOUNCER'S LICENSE NUMBER
30. ACTUAL OR PRESUMED TIME OF DEATH

CAUSE OF DEATH

31. 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.

Approximate interval between onset and 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

32. WAS AUTOPSY PERFORMED ☐ Yes ☐ No ☐ Unknown
33. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No ☐ Unknown
33a. WAS AN INJURY OF ANY KIND INDICATED IN THE CAUSE OF DEATH FOR PART I OR PART II WITH THE DECEDENT ☐ Yes ☐ No ☐ Unknown
34. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER ☐ Yes ☐ No ☐ Unknown
35. TOBACCO USE CONTRIBUTE TO DEATH
☐ Yes
☐ No
☐ Unknown
☐ Probably
36. IF FEMALE
☐ Not Applicable
☐ Not pregnant within the past year
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Pregnant at the time of death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH
☐ Accident ☐ Natural
☐ Could not be determined ☐ Pending Investigation
☐ Homicide ☐ Suicide
38. DATE OF INJURY (MO/DAY/YR)
39. TIME OF INJURY
40. PLACE OF INJURY (e.g., Decedent's home, construction site, restuarant wooded area)
41. INJURY AT WORK ☐ Yes ☐ No ☐ Unknown
42. LOCATION OF INJURY STREET AND NUMBER CITY STATE COUNTY ZIP CODE
43. DESCRIBE HOW INJURY OCCURRED
44. IF TRANSPORTATION INJURY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other

CERTIFICATION

45. To the best of my knowledge death occurred at the time, date, place, and due to the cause(s) stated. **Medical Certifier** (**Name, Title, License No.**) (**PRINT AND SIGN**)
46. On the basis of examination and/or investigation, in my opinion death occurred at the time date, place, and due to the cause(s) stated. **Medical Examiner/Coroner** (**Name, Title, License No.**) (**PRINT AND SIGN**)
45a. DATE SIGNED (MO/DAY/YR)
45b. HOUR OF DEATH
46a. DATE SIGNED (MO/DAY/YR)
46b. HOUR OF DEATH
47. PERSON COMPLETING CAUSE OF DEATH (NAME, ADDRESS, COUNTY, ZIP CODE)
48. REGISTRAR SIGNATURE(**PRINT AND SIGN**)
49. DATE FILED (REGISTRAR) (MO/DAY/YR)

Form 3903 (Rev. 09/2009)

This certificate does not constitute a certified copy without the appropriate certification on the back.