

MFS ILLINOIS DEATH CERTIFICATE WORKSHEET

**DECEDENT
INFO:**

FULL NAME: (FIRST MIDDLE LAST) _____

SOCIAL SECURITY NUMBER: _____

GENDER: _____

RESIDENCE ADDRESS: _____

RESIDENCE COUNTY: _____

CITY OF DEATH: _____ **COUNTY OF DEATH:** _____

DEATH INSIDE CITY LIMITS? YES _____ NO _____

DATE OF DEATH: _____ **TIME OF DEATH:** _____

DATE OF BIRTH: _____ **AGE LAST BIRTHDAY:** _____

WHERE DID DEATH OCCUR: (ANSWER BELOW)

IN HOSPITAL: (CIRCLE DEPT):	INPATIENT	EMERGENCY ROOM	DEAD ON ARRIVAL
If OTHER than hospital, where:	HOSPICE	NURSING HOME	RESIDENCE

HOSPITAL NAME: _____

ADDRESS: _____

PHONE: _____

BIRTHPLACE: _____

FATHER'S FULL NAME: _____

MOTHER'S FULL NAME: (INCLUDE MAIDEN NAME) _____

SURVIVING SPOUSE'S NAME: (INCLUDE MAIDEN NAME FOR WIFE) _____

MARITAL STATUS: (CIRCLE ONE):	MARRIED	DIVORCED	WIDOWED
	NEVER MARRIED	MARRIED BUT SEPARATED	UNKNOWN

EDUCATION: (CIRCLE ONE)	8TH GRADE OR LESS	9TH-12TH (NO DIPLOMA)	HIGH SCHOOL GRAD/GED
	SOME COLLEGE, NO DEGREE	ASSOCIATE'S	BACHELOR'S
	MASTER'S	DOCTORATE	UNKNOWN

RACE: (CIRCLE APPROPRIATE)	WHITE	BLACK/AFRICAN AMERICAN	ASIAN INDIAN
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OTHER: (FILL IN) _____

OF HISPANIC ORIGIN? YES _____ NO _____

EVER IN US ARMED FORCES: YES _____ NO _____

OCCUPATION (DO NOT WRITE "RETIRED"): _____

BUSINESS/INDUSTRY (DO NOT USE COMPANY NAME): _____

**PLEASE
PRINT**

**DOCTOR
SIGNING
CERTIFICATE:**

NAME: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

**INFORMANT
INFO:**

NAME: _____

RELATIONSHIP TO DECEASED: _____

ADDRESS: _____

EMAIL: _____

PHONE NUMBER: _____

**DELIVERY
INFO FOR
CERTIFICATES**

HOW WOULD YOU LIKE THE DEATH CERTIFICATES TO BE PROCESSED: (There will be a \$20 EXTRA charge for mailings)

_____ **PICK-UP MYSELF** **OR** **MAIL TO:** _____ **DECEDENT'S** _____ **INFORMANT'S**

NUMBER OF DEATH CERTIFICATES: _____