JANSEN PROFESSIONAL SERVICES

Jansen Family Funeral Home
4705 Pine Street / PO Box 77
Columbiaville, MI 48421
Daniel L. Jansen, Manager / Owner
www.jansenprofessionalservices.com
Phone 810-793-6234

Michigan Death Certificate

Please Use the attached PDF of a Michigan Death Certificate to obtain the needed vitals to complete a death certificate. Please return this with DC Information. Fax 810-793-4752

How Many Death Certificates are Needed ? _____
** Don't assume a FREE veterans copy will be provided by all clerks offices.

Cremation ☐ Yes ☐ No

Select One ☐ Standard Service ☐ Expedited Service

Standard - DC is completed 1-3 weeks. This service is provided in our standard cost already. Dc's mailed to your funeral home.

Expedited - An individual is placed on your DC till it is completed. 1 Week Max ($40 Extra) This Service is included in all Direct Cremations already. Dc's mailed to your funeral home.

Important Notes:

Item 8C - Please check on this item in order to insure accuracy. This is not always the city listed in the mailing address.

Our funeral home will obtain the place of death, date of death, and time of death.
Items - 4, 7A, 7B, 7C, 28A, 28B, 28C, 29, 30, 31, 39, 40A

Any item left blank will be listed on the certificate as "UNKNOWN"
A Proof will be faxed before Dc is filed at clerks office.
If you want Dc's mailed to another location - Please advise us of the change

TYPE/PRINT IN PERMANENT BLACK INK

LF _____

CF _____

STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBE _____

NAME OF DECEDENT
For use by physician or institution

DECEDENT

1. DECEDENT'S NAME *(First Middle Last)*

2. DATE OF BIRTH *(Month Day Year)*

3. SEX

4. DATE OF DEATH *(Month Day Year)*

5. NAME AT BIRTH OR OTHER NAME USED FOR PERSONAL BUSINESS *(include AKA's if any)*

6a. AGE - Last Birthday *(Years)*

6b. UNDER 1 YEAR

6c. UNDER 1 DAY

7a. LOCATION OF DEATH *(Enter place officially pronounced dead in 7a 7b 7c)*
HOSPITAL OR OTHER INSTITUTION - Name *(if not in either give street and number and zip code)*

7b. CITY, VILLAGE, OR TOWNSHIP OF DEATH

7c. COUNTY OF DEATH

8a. CURRENT RESIDENCE - STATE

8b. COUNTY

8c. LOCALITY - *(check the box that describes the location)*
☐ CITY OR VILLAGE *(inside limits of)* ☐ TOWNSHIP ☐ UNINCORPORATED PLACE

8d. STREET AND NUMBER *(Include Apt. No. if applicable)*

8w. ZIP CODE

9. BIRTHPLACE *(City and State or Country)*

10. SOCIAL SECURITY NUMBER

11. DECEDENT'S EDUCATION - What is the highest degree or level of school completed at the time of death?

12. RACE - American Indian, White, Black, etc. *if Asian give nationality ie. Chinese Filipino Asian Indian etc.) (Enter all that apply)*

13a. ANCESTRY - Mexican, Cuban, Arab, African, English, French, Dutch, etc. *(Enter all that apply)* If American Indian race, enter principal tribe

13b. HISPANIC ORIGIN *(Yes or No)*

14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES? *(yes or no)*

15. USUAL OCCUPATION *Give kind of work done during most of working life. Do not use retired.*

16. KIND OF BUSINESS OR INDUSTRY

17. MARITAL STATUS - Married, Never Married, Widowed, Divorced *(Specify)*

18. NAME OF SURVIVING SPOUSE *(if wife give name before first married)*

PARENTS

19. FATHER'S NAME *(First Middle Last)*

20. MOTHER'S NAME BEFORE FIRST MARRIED *(First Middle Last)*

INFORMANT

21a. INFORMANT'S NAME *(Type/Print)*

21b. RELATIONSHIP TO DECEDENT

21c. MAILING ADDRESS *(Street and Number or Rural Route Number City or Village State Zip Code)*

DISPOSITION

22. METHOD OF DISPOSITION
Burial Cremation Entombment
Donation Removal Storage (Specify)

23a. PLACE OF DISPOSITION *(Name of Cemetery Crematory or other location)*

23b. LOCATION - City or Village, State

24. SIGNATURE OF MORTUARY SCIENCE LICENSEE

25. LICENSE NUMBER *(of Licensee)*

26. NAME AND ADDRESS OF FUNERAL FACILITY

CERTIFICATION

27a. CERTIFIER *(Check only one)*

☐ Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated.

☐ 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.

Signature and Title _____

28a. ACTUAL OR PRESUMED TIME OF DEATH M

28b. PRONOUNCED DEAD ON *(Mo. Day Yr.)*

28c. TIME PRONOUNCED DEAD M

29. MEDICAL EXAMINER CONTACTED? *(Yes or No)*

30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) *(Specify)*

31. IF HOSPITAL, Inpatient, Outpatient, Emergency Room, DOA *(Specify)*

27b. DATE SIGNED *(Mo. Day Yr.)*

27c. LICENSE NUMBER

32. MEDICAL EXAMINER'S CASE NUMBER *(if applicable)*

33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER *(Type or Print)*

34. NAME AND ADDRESS OF CERTIFYING PHYSICIAN *(Type or Print)*

35a. REGISTRAR'S SIGNATURE

35b. DATE FILED *(Month Day Year)*

CAUSE OF DEATH

36. 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. Enter only one cause on a line.

Approximate Interval Between Onset and Death

If **diabetes** was an immediate, underlying or contributing cause of death be sure to record diabetes in either Part I or Part II of the cause of death section, as appropriate.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. _____

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. _____

c. _____

d. _____

PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I.

37. DID TOBACCO USE CONTRIBUTE TO DEATH?
☐ Yes ☐ Probably ☐ No ☐ Unknown

38. IF FEMALE
☐ 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

39. MANNER OF DEATH - Accident, Suicide, Homicide, Natural, Indeterminate or Pending *(Specify)*

40a. WAS AN AUTOPSY PERFORMED? *(Yes or No)*

40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? *(Yes or No)*

MEDICAL EXAMINER

41a. DATE OF INJURY *(Mo. Day Yr.)*

41b. TIME OF INJURY M

41c. DESCRIBE HOW INJURY OCCURRED

41d. INJURY AT WORK *(Yes or No)*

41e. PLACE OF INJURY - At home, farm, street, construction site, wooded area, etc. *(Specify)*

41f. IF TRANSPORTATION INJURY - Driver/Operator, Passenger, Pedestrian, etc. *(Specify)*

41g. LOCATION - Street or RFD No. City, Village or Twp. State