

State of Idaho
24-HOUR REPORT OF DEATH

Local Reg. No. _____

DECEDENT	* 1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last, Suffix)		2. SEX	3. SOCIAL SECURITY NUMBER
TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN FOR INSTRUCTIONS SEE HANDBOOKS	4a. AGE-Last Birthday	4b. UNDER 1 YEAR Months: _____ Days: _____	4c. UNDER 1 DAY Hours: _____ Minutes: _____	5. DATE OF BIRTH (Mo/Day/Yr)
	6. BIRTHPLACE (City and State, Territory, or Foreign Country)		7a. RESIDENCE - STATE OR FOREIGN COUNTRY	
	7b. COUNTY		7c. CITY OR TOWN	
	7d. STREET AND NUMBER		7e. APT. NO.	7f. ZIP CODE
PARENTS	8. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Unknown		9. SURVIVING SPOUSE'S NAME (If wife, give maiden name)	
	10. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No	11a. FATHER'S NAME (First, Middle, Last, Suffix)		11b. BIRTHPLACE (State, Territory, or Foreign Country)
		12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)		12b. BIRTHPLACE (State, Territory, or Foreign Country)
INFORMANT	13a. INFORMANT'S NAME (Type or print)		13b. RELATIONSHIP TO DECEDENT	13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)
DISPOSITION	* 14. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Donation <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Other (Specify) _____		* 15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)	
PLACE OF DEATH	* 16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY		* 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	
	* 17b. LICENSE NUMBER (Of licensee)		* 18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DATE OF DEATH	PLACE OF DEATH (19-22)			
CAUSE OF DEATH	* 19a. IF DEATH OCCURRED IN A HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Hospice facility 5 <input type="checkbox"/> Nursing home/Long term care facility 6 <input type="checkbox"/> Decedent's home 7 <input type="checkbox"/> Other (Specify) _____			
	* 19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: _____			
	* 20. FACILITY NAME (If not facility, give street and number)		* 21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE	
	* 22. COUNTY OF DEATH		* 23. DATE OF DEATH (Mo/Day/Yr) (Spell month)	
	* 24. TIME OF DEATH (24hr)		* 25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month)	
	* 26. TIME PRONOUNCED DEAD (24hr)		27. CAUSE OF DEATH 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: IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (or as a consequence of): _____ b. DUE TO (or as a consequence of): _____ c. DUE TO (or as a consequence of): _____ d. DUE TO (or as a consequence of): _____ PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I	
	28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
ITEMS 32-38 TO BE USED FOR EXTERNAL CAUSES ONLY (CORONER)	29. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		30. IF FEMALE (Aged 10-54): <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Unknown if pregnant within the past year	
	31. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		32. DATE OF INJURY (Mo/Day/Yr) (Spell month)	
	33. TIME OF INJURY (24hr)		34. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.)	
	35. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		36. LOCATION OF INJURY: State _____ City/Town or County _____ Zip Code _____ Street and Number or Location _____ Apartment Number _____	
	37. DESCRIBE HOW INJURY OCCURRED. IF TRANSPORTATION INJURY, STATE THE TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable			
CERTIFIER	TRANSPORTATION INJURY ONLY		38a. WAS DECEDENT: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____	
IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE	39a. CERTIFIER (Check only one, based on official capacity for this certificate) <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> ADVANCED PRACTICE PROFESSIONAL NURSE - To the best of my knowledge, death occurred at the time, date, and place, and due to the natural cause(s)/manner stated.		38b. WHAT SAFETY DEVICE(S) DID DECEDENT USE/EMPLOY? <input type="checkbox"/> Seat Belt <input type="checkbox"/> Child safety seat <input type="checkbox"/> Helmet <input type="checkbox"/> Air bag <input type="checkbox"/> None <input type="checkbox"/> Unknown	
	39b. LICENSE NUMBER		39c. DATE SIGNED MM / DD / YYYY	
	Signature and Title of Certifier _____ * 39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print)			
REGISTRAR	40a. REGISTRAR'S SIGNATURE		40b. DATE SIGNED MM / DD / YYYY	

STATISTICAL INFORMATION	
41. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life) Do not use retired 42. KIND OF BUSINESS/INDUSTRY 43. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death) 1 <input type="checkbox"/> 8th grade or less (includes none) 2 <input type="checkbox"/> 9th - 12th grade, but no diploma 3 <input type="checkbox"/> High school graduate or GED completed 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree (eg, AA, AS) 6 <input type="checkbox"/> Bachelor's degree (eg, AB, BA, BS) 7 <input type="checkbox"/> Master's degree (eg, MA, MBA, MEd, MEng, MS, MSW) 8 <input type="checkbox"/> Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)	44. DECEDENT OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino) 0 <input type="checkbox"/> No, not Spanish/Hispanic/Latino 1 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano 2 <input type="checkbox"/> Yes, Puerto Rican 3 <input type="checkbox"/> Yes, Cuban 4 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____ 45. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) 01 <input type="checkbox"/> White 02 <input type="checkbox"/> Black or African American 03 <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ 04 <input type="checkbox"/> Asian Indian 05 <input type="checkbox"/> Chinese 06 <input type="checkbox"/> Filipino 07 <input type="checkbox"/> Japanese 08 <input type="checkbox"/> Korean 09 <input type="checkbox"/> Vietnamese 10 <input type="checkbox"/> Other Asian (Specify) _____ 11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro 13 <input type="checkbox"/> Samoan 14 <input type="checkbox"/> Other Pacific Islander (Specify) _____ 15 <input type="checkbox"/> Other (Specify) _____

* At a minimum, complete items 1; 14; 16; 17a; 17b; 19a or 19b; 20; 21; 22; 23; and 39d for the 24-Hour Report and Authorization for Final Disposition