# Certificate of Death

Name of Deceased: _____

Date of Death: _____ Time of Death: _____

Description of the Deceased:

Sex: M F

Race: _____

Height: _____

Weight: _____

Hair: _____

Eyes: _____

Distinguishing Features or Marks:

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Cause of Death: _____

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Description of Death: _____

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Signature of Attending Physician Signature of Attending Physician

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Signature of Attending Physician