FAX COVER SHEET

CONFIDENTIAL AND TIME SENSITIVE INFORMATION ENCLOSED

RECIPIENT:	CERTIFIER'S NAME & TITLE AS APPEARS IN FIELD 115
FAX NUMBER:	CERTIFIER'S FAX XXX-XXX-XXXX
TOTAL NUMBER OF PAGES:	2
SENDER:	SENDER'S NAME
SENDER'S PHONE NUMBER:	SENDER'S PHONE XXX-XXX-XXXX

Please review the Physician Attestation Copy included in this fax. If the Medical Information is correct, use either the Fax Option or the Voice Option to electronically attest (sign) the information. By doing so, you certify that to the best of your knowledge, the death occurred at the hour, date, and place stated from the causes stated on the Death Certificate. Your electronic signature will be saved in the California Electronic Death Registration System (CA-EDRS).

- ***Do NOT make additions, changes, or modifications to the attestation copy.***
- ***Do NOT sign an incorrect attestation copy.***
- ***Do NOT sign if your name does not appear as the recipient identified on the cover sheet.***

IF CHANGES ARE REQUIRED: *Contact the sender immediately. The sender will make the requested changes, and the system will re-fax you the corrected copy with new attestation numbers. Then discard the attached incorrect copy.*

Fax Option

See instructions on the Physician Attestation Copy.

Voice Option

1. Call the toll-free CA-EDRS Interactive Voice Response System (IVRS) at **1-800-713-2908**.
2. Follow the instructions as prompted, entering the numbers below when prompted and confirming your authority to attest to the Medical Information.

   Death Certificate Record Number: XXXXXXXX

   Voice Attestation Number (VAN): XXXXXXXX
3. State the following phrase:

   "I [CERTIFIER'S NAME & TITLE] certify that the death certificate submitted to me for [DECEDENT NAME] is correct."

Per California Statute:

- Health and Safety Code 102800 gives the medical certifier 15 hours after the death to provide the medical and health data and attest to its validity on the Death Certificate.
- Health and Safety Code 102800 and 102825 identify the specific individuals who may certify a Death Certificate.

IF YOU RECEIVED THIS FAX IN ERROR, PLEASE NOTIFY THE SENDER.

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11(REV 1/06)

STATE FILE NUMBER | LOCAL REGISTRATION NUMBER

Physician Attestation Copy

If the form is correct, sign field 115 and fax this page to 1-800-913-6121.

DO NOT ALTER. NO COVERSHEET

Alterations invalidate the signature. If you require changes, additions, or corrections, contact the sender to re-fax a corrected form.

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT – FIRST (Given)	2. MIDDLE	3. LAST (Family)
FIRST NAME		LAST NAME

AKA. ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST) | 4. DATE OF BIRTH mm/dd/ccyy | 5. AGE Yrs. | IF UNDER ONE YEAR: Months, Days | IF UNDER 24 HOURS: Hours, Minutes | 6. SEX: M

9. BIRTH STATE/FOREIGN COUNTRY | 10. SOCIAL SECURITY NUMBER | 11. EVER IN U.S. ARMED FORCES? YES / NO / UNK | 12. MARITAL STATUS/SRDP* (at Time of Death) | 7. DATE OF DEATH mm/dd/ccyy: MM/DD/YYYY | 8. HOUR (24 Hours): HH:MM

13. EDUCATION – Highest Level/Degree | 14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back) YES / NO | 16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location)

21. CITY | 22. COUNTY/PROVINCE | 23. ZIP CODE | 24. YEARS IN COUNTY | 25. STATE/FOREIGN COUNTRY

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP | 27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)

SPOUSE/SRDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP* – FIRST | LAST (BIRTH NAME)

31. NAME OF FATHER/PARENT – FIRST | 32. MIDDLE | 33. LAST | 34. BIRTH STATE

35. NAME OF MOTHER/PARENT – FIRST | 36. MIDDLE | 37. LAST (BIRTH NAME) | 38. BIRTH STATE

FUNERAL DIRECTOR/LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy | 40. PLACE OF FINAL DISPOSITION

41. TYPE OF DISPOSITION(S) | 42. SIGNATURE OF EMBALMER | 43. LICENSE NUMBER

44. NAME OF FUNERAL ESTABLISHMENT | 45. LICENSE NUMBER | 46. SIGNATURE OF LOCAL REGISTRAR | 47. DATE mm/dd/ccyy

PLACE OF DEATH

101. PLACE OF DEATH: PLACE OF DEATH | 102. IF HOSPITAL, SPECIFY ONE: [X] IP, ER/OP, DOA | 103. IF OTHER THAN HOSPITAL, SPECIFY ONE: Hospice, Nursing Home/LTC, Decedent's Home, Other

104. COUNTY: COUNTY | 105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location): LOCATION OR FACILITY ADDRESS | 106. CITY: CITY

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

	Cause	Time Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) (A)	IMMEDIATE CAUSE	(AT) TIME
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST (B)	UNDERLYING CAUSE	(BT) TIME
(C)		(CT)
(D)		(DT)

108. DEATH REPORTED TO CORONER? YES / [X] NO — REFERRAL NUMBER
109. BIOPSY PERFORMED? YES / [X] NO
110. AUTOPSY PERFORMED? YES / [X] NO
111. USED IN DETERMINING CAUSE? YES / NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107: OTHER SIGNIFICANT CONDITIONS

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.): OPERATIONS PERFORMED | 113A. IF FEMALE, PREGNANT IN LAST YEAR? YES / NO / UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attended Since (A) mm/dd/ccyy: MM/DD/YYYY | Decedent Last Seen Alive (B) mm/dd/ccyy: MM/DD/YYYY

115. SIGNATURE AND TITLE OF CERTIFIER ▶ | 116. LICENSE NUMBER: XXXXXXX | 117. DATE mm/dd/ccyy

118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE: PHYSICIAN NAME, MAILING ADDRESS, CITY, STATE, ZIPCODE

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. MANNER OF DEATH: Natural, Accident, Homicide, Suicide, Pending Investigation, Could not be determined | 120. INJURED AT WORK? YES / NO / UNK | 121. INJURY DATE mm/dd/ccyy | 122. HOUR (24 Hours)

123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)

125. LOCATION OF INJURY (Street and number, or location, and city, and zip)

126. SIGNATURE OF CORONER / DEPUTY CORONER ▶ | 127. DATE mm/dd/ccyy | 128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER

STATE REGISTRAR	A	B	C	D	E		FAX/VOICE #	CENSUS TRACT
							XXXXXXX	