



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



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF DEATH

LF _____

CF _____

STATE FILE NUMBER _____

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) <input type="checkbox"/> CITY OR VILLAGE (inside limits of) <input type="checkbox"/> TOWNSHIP <input type="checkbox"/> 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)
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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)
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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
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CERTIFICATION

24. SIGNATURE OF MORTUARY SCIENCE LICENSEE	25. LICENSE NUMBER (of Licensee)	26. NAME AND ADDRESS OF FUNERAL FACILITY	
27a. CERTIFIER (Check only one) <input type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> 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.) M
27b. DATE SIGNED (Mo. Day Yr.)	27c. LICENSE NUMBER	29. MEDICAL EXAMINER CONTACTED? (Yes or No)	30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) (Specify)
34. NAME AND ADDRESS OF CERTIFYING PHYSICIAN (Type or Print)		31. IF HOSPITAL, Inpatient, Outpatient, Emergency Room, DOA (Specify)	32. MEDICAL EXAMINER'S CASE NUMBER (if applicable)
35a. REGISTRAR'S SIGNATURE		33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
35b. DATE FILED (Month Day Year)			

CAUSE OF DEATH

36. PART I. Enter the <u>chain of events</u> - 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) 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			
a. _____			
b. _____			
c. _____			
d. _____			
PART II. <u>OTHER SIGNIFICANT CONDITIONS</u> contributing to death but not resulting in the underlying cause given in Part I.		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	38. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year

MEDICAL EXAMINER

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)
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