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| **PERSONAL INFORMATION FOR BEQUEATHAL OF**  **ANATOMICAL GIFT TO THE DEPARTMENT OF FUNERAL SERVICE EDUCATION** | | |
| **Full Name (first, middle, last)** |  | |
| **Last name prior to first marriage** |  | |
| **Social Security Number** |  | |
| **Gender**  **Please circle:** | Male | Female |
| **Age as of last birthday** |  | |
| **Date of Birth**  **MM/DD/YYYY** |  | |
| **Birthplace**  **(County/State)** |  | |
| **Date of Death**  **MM/DD/YYYY** |  | |

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| **Place of death**  **Facility name**  **If death occurred outside of a facility, address where death occurred** | |  | |
|  | |  | |
| **Marital status:**  **Please circle:** | | **Decedent’s Usual Occupation:**  **Business or Industry** | |
| Married | Married, but separated |
| Divorced | Never married |
| Widowed | Unknown |
| **Decedent’s Resident address:** | | **County:** | **Is the residence inside city limits?**  **Please circle:** |
| Yes |
| No |
| **Was the Decedent ever in the Armed Forces?**  **Please circle:** | | **Surviving Spouse Name (if wife give maiden name):** | |
| Yes | No |

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| --- | --- | --- |
| **Race (please circle)** | | **Decedents Highest Level of Education:** |
| American Indian | Asian |
| Hispanic | White |
| Black | Other |
| **Decedent’s Father’s Name:** | | **Decedent’s Mother’s Name, include maiden name if known:** |
| **Name of Next of Kin and phone number:** | | **Next of Kin Address**: |
| **Name of Physician who will sign Death Certificate** | | **Address and Phone number of signing Physician:** |