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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**  |  |
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| **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:** |