



**SAN DIEGO FUNERAL SERVICE**

FD 1964

*In Celebration of Life*

**Jerry Balistreri, Funeral Director FDR 2911  
4891 Atlanta Drive San Diego, California 92115  
619 583-0400**

**Fax 619 583-0100**

**U R G E N T**

**Death Certificate Medical Information Request**

**TO: Doctor** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

**RE: Name of Decedent** \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_  
**Date of Death** \_\_\_\_\_ **Time of Death** \_\_\_\_\_

Please complete the "Causes of Death" section (below) regarding the decedent named above and **fax back this form to SDFS** as soon as possible so we may expedite the completion of the Death Certificate. *California law requires that the medical section of the Death Certificate be completed by the attending physician within 15 hours of death.*

You will be receiving "Physician Attestation" instructions (by fax) to confirm the causes of death as they appear on the Death Certificate **after SDFS's input of the causes to the death registration system (EDRS).**

**CAUSES OF DEATH**

101. Place of Death \_\_\_\_\_ 102. If Hospital Specify One \_\_\_\_\_ 103. Facility Other than Hospital: \_\_\_\_\_ 104. County \_\_\_\_\_  
IP ER/OP DOA Conv.Hosp. Res.Care Other  
105. Street Address (street & number or location) \_\_\_\_\_ 106. City \_\_\_\_\_

107. Death was caused by: (Enter only one cause per line for A.B.C.&D)	Interval Between Onset & Death	108. Death reported to Coroner Yes: No:
Immediate Cause A: _____		109. Biopsy Performed Yes: No:
Due to B: _____		110. Autopsy Performed Yes: No:
Due to C: _____		111. Used in determining Yes: No:
Due to D: _____		

112. Other significant conditions contributing to death but not related to cause given in 107. If female, pregnant in last year  
Yes \_\_\_ No \_\_\_ Unk \_\_\_

113. Was operation performed for any condition in item 107 or 112? If yes, list type of operation and date.

114. I certify that to the best of my knowledge death occurred at the hour, date and place from the causes stated.  
Attended since: \_\_\_\_\_ Last seen alive: \_\_\_\_\_

118. Type attending physician's name and address:

License# \_\_\_\_\_ Today's Date \_\_\_\_\_

THANK YOU. FAX 619 583-0100