

Mortuary Aid Co. 1050 Lakes Drive #252, West Covina, CA 91790

DECEDENT INFORMATION WORKSHEET

Loved one's first name?			Loved one's middle name?			Loved one's last name(s)?		
Other full names used?				Male or Female?		Date of birth?		If applicable, date of death?
If applicable, time of death?			Birth state or foreign country?			Social security number?		
Ever in U.S. armed forces? If yes, which branch?			Married, divorced, widowed, never married?			Education years or degree?		
Hispanic/Latino/Spanish?		If yes, country of origin?		Decedent's race, up to 3?				
Usual occupation in life? Do not use retired.				Usual type of business or industry in life?			Years in usual occupation?	
Loved one's last home street address?				Loved one's last home city, state and zip code?				Years in county?
Next of kin's / Informant's name?				Next of kin's / Informant's relationship?		Next of kin's / Informant's phone #?		
Next of kin's / Informant's phone #?			Next of kin's / Informant's email address?					Total siblings
Next of kin's / Informant's street address?					Next of kin's / Informant's city, state and zip code?			
First name of surviving spouse?		Middle name of surviving spouse?		Last name of surviving spouse?		If female, maiden last name?		
First name of loved one's father?			Middle name of loved one's father?		Last name of loved one's father?			
Loved one father's birth state or foreign country?							Is loved one's father alive?	
First name of loved one's mother?			Middle name of loved one's mother?		Last name of loved one's mother?			
Loved one mother's birth state or foreign country?				Maiden last name of loved one's mother?		Is loved one's mother alive?		
Cremation?	Goodbye viewing?	Insertion viewing?	Final resting place; name & address of cemetery, ocean, land, individual?				How did you hear about us? Google Yelp Bing AOL Yahoo Internet Family Friend Nurse Hospital Hospice Repeat Officer Counselor Other	
If applicable, approximate service/memorial date?								
Doctor's full name?					Hospice's name?			
Doctor's phone number?			Doctor's fax number?		Hospice's phone number?		Hospice's fax number?	
Doctor last seen?		Weight?	Implanted battery device?	If applicable, loved one's place of death?			If applicable, coroner case #?	

X _____

SIGNATURE

DATE

I certify that the above information is true and correct. I release Mortuary Aid Co. from all charges that may occur in the correction of the official record due to this information.