

Statement of death - Form 15

Note: Form 7 must be completed for stillbirths. This is a permanent record.
Please PRINT clearly in blue or black ink.

Hospital code number

INFORMATION ABOUT THE DECEASED

1. Last name		2. Social insurance number (optional)			
3. First and middle names			Sex (M or F)		
4. Date of death (d/m/y)	5. Date of birth (d/m/y)	6. City and province where born (if outside of Canada, state the country)			
7. Age at time of death (years)	If less than a year old (months and days)	If less than a day old (hours and minutes)			
8. Place of death (name of facility or location)		<input type="checkbox"/> hospital	<input type="checkbox"/> nursing home	<input type="checkbox"/> residence	<input type="checkbox"/> other (please specify)
City, town, village or township			regional municipality, county or district		
9. Name of physician/coroner/other who pronounced death		10. Marital or relationship status (check one)			
		<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> divorced <input type="checkbox"/> common-law <input type="checkbox"/> same-sex partner			
11. Last name of the deceased's spouse or partner (before this marriage or relationship)					
12. Type of work done most of working life		13. Type of business or industry that the deceased worked in most of working life			
14. Deceased's usual residence (street number and name, city, province, postal code (do not use post office box or rural route))					
15. City and province where father was born (if outside of Canada, state the country)		16. Father's name (last, first)			
17. City and province where mother was born (if outside Canada, state the country)		18. Mother's maiden name (last, first)			

TO BE COMPLETED ONLY BY THE PERSON PROVIDING THIS INFORMATION

19. Name (last, first, middle)	20. Relationship to deceased	21. Signature
		X
22. Address (street number and name, city, province, postal code)		Date (d/m/y)

TO BE COMPLETED ONLY BY THE FUNERAL DIRECTOR OR PERSON(S) IN CHARGE OF REMAINS

23. Type of disposition (burial, cremation or if other specify)		24. Proposed date of disposition (d/m/y)
25. Name and address of proposed cemetery, crematorium or place of disposition		
26. Name of funeral director (last, first, middle)		27. Name of funeral home
28. Address of the funeral home (street number and name, city, province, postal code)		
29. Signature of funeral director	30. Business code number	31. Date (d/m/y)
X		

TO BE COMPLETED ONLY BY THE DIVISION REGISTRAR

Name of person who issued burial permit		Place of issue	Date issued (d/m/y)
By signing below, I am satisfied that the information in the Medical certificate of death and this Statement of death is correct and sufficient and I agree to register the death.			
Signature	Date (d/m/y)	Registration number	Div. Reg. code number
X			

For the use of the Office of the Registrar General only

Personal information contained in this form is collected under the authority of the Vital Statistics Act, R.S.O. 1990, c.v.4 and will be used to register and record the births, still-births, deaths, marriages, additions or change of name, corrections or amendments, provide certified copies, extracts, certificates, search notices, photocopies and for statistical, research, medical, law enforcement, adoption and adoption disclosure purposes. Questions about this collection should be directed to the Deputy Registrar General at P.O. Box 4600, Thunder Bay, ON P7B 6L8. Telephone 1-800-461-2156 or 416-325-8305