

# Statement of death - Form 15

Hospital code number

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

## 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<br><b>X</b> |
| 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<br><b>X</b>   | 30. Business code number                 | 31. Date (d/m/y) |

## 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<br><b>X</b>  | Date (d/m/y)   | Registration number | Div. Reg. code number |

## For the use of the Office of the Registrar General only