



**VRS**  
 Vital Record Solutions  
 P.O. Box: 3445  
 Alpharetta, GA 30023

Please Fax All Documents to: 678-341-4685  
 Office No: 678-341-4680 email: Jim@vrsrecord.com

*Please Print or Type or use PDF Writer*  
**GEORGIA DEATH CERTIFICATE**

Full Legal Name of Deceased:				If Female Maiden Name:	
SEX:	Date of Death:	Social Security Number:	AGE :	Date of Birth:	
Place of Birth—City & State:		Residence Address of the Deceased:			
City:	State:	County:	Country :	Zip Code:	Inside City Limits: <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Unknown
Armed Forces: <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Unknown		Occupation:	Nature of Occupation:		Employer:
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed		<b>SPOUSE NAME:</b> <i>(If Widowed we require Spouse)</i> <i>If Female—Name/Maiden Prior to first marriage If Divorced NONE</i>		<i>Spouse Female -Maiden Name</i>	
Father's Name		Mother's Name (Maiden Name)		Highest Level of Education:	
Informant's Name		Relationship	Address: (City, State & Zip)		
<b>Hispanic Origin:</b> <input type="checkbox"/> No, not Spanish-Hispanic Latino <input type="checkbox"/> YES Origin		<b>Decedent's Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Other: _____		<b>For Office Use Only</b>	
<b>Method of Disposition:</b> <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State		<b>For Funeral Home Use Only</b> Date of Disposition:		<b>PLACE of DEATH:</b> <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing/Long Term <input type="checkbox"/> Scene/Other	
Place of Disposition: (Complete Address is Required)		County of Death		Coroner/ME Contacted	
Name:		License #		Time of Death:	
Address:		Signed By:			
City, State & Zip:					
No of Certified Copies	Mail to: <input type="checkbox"/> Informant <input type="checkbox"/> FH		Phone #		Fax #

**Out of State Funeral Home/Agency**  
 Name:  
 Address:  
 City, State, Zip:  
 Phone:

Fax:

**Other Information/Notes:**  
 Funeral Director & No#:  
 Embalmer & No#:

*At Present, Certified Death Certificates Are \$25 for the First Copy & \$5 for Each Additional Copy*