

--HEALTH DISTRICT LETTERHEAD--

(CURRENT DATE)

THE HEALTH AUTHORITIES
(NAME OF COUNTRY)

RE: *(NAME OF DECEDENT)*
DIED: *(DATE OF DEATH)*

FUNERAL FACILITY: *(NAME OF FACILITY)*
(STREET ADDRESS)
(CITY, STATE, ZIP)

THIS IS TO CERTIFY THAT DEATH WAS NOT CAUSED BY A
COMMUNICABLE DISEASE.

(NAME OF LOCAL DEPUTY STATE REGISTRAR)
LOCAL DEPUTY STATE REGISTRAR

SUBSCRIBED AND SWORN TO BEFORE ME THIS *(CURRENT DAY)* DAY OF
(CURRENT MONTH), *(CURRENT YEAR)*

NOTARY PUBLIC

RESIDING AT _____

MY COMMISSION EXPIRES _____