**

CHEVRA KADISHA MORTUARY

7832 SANTA MONICA BLVD. ⦁ LOS ANGELES, CA 90046

(323) 654-8415 ⦁ (800) 654-6772 ⦁ FAX (323) 654-3917

Please fill out, sign and return white copy.

**VITAL STATISTICS AND RELEASE FORM**

FD-1326

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PERSONALDATA | FIRST NAME | | | | 1. MIDDLE | | | | | | | | | | 3. LAST NAME | | | | | | | |
| (AKA) ALSO KNOWN AS | | | | | | | | | 4. DATE OF BIRTH | | | | | 5. AGE | | | 6. [] MALE [] FEMALE | | | | |
| PLACE OF BIRTH | SOCIAL SECURITY NO. | | | | | U.S. MILITARY SERVICE [ ] YES [ ] NO [ ] UNK. | | | | | 1. MARITAL STATUS   [ ] M [] W [ ] D [] NM | | | | 7. DATE OF DEATH | | | | | | 8. TIME |
| YEARS OF EDUCATION / HIGHEST DEGREE [ ] 0-11th GRADE (HIGHEST YEAR) \_\_\_\_\_\_ [ ] HIGH SCHOOL GRADUATE [ ] SOME COLLEGE  [ ] BACHELOR’S [ ] MASTER’S [ ] DOCTORATE (PHD, EDD) [ ]PROFESSIONAL (M.D., DDS) | | | | | | | | | | | 14/15. HISPANIC [ ]YES [ ] NO | | | | | 16. RACE [ ] CAUCASIAN | | | | | |
| USUAL OCCUPATION (DO NOT USE RETIRED) | | | | | 1. KIND OF BUSINESS (e.g. GROCERY STORE OR GENERAL MERCHANDISE) | | | | | | | | | | | | | 1. YEARS IN OCCUPATION | | | |
| USUAL RESIDENCE | RESIDENCE – (NUMBER AND STREET OF ADDRESS) | | | | | | | | | | | | | | | | | | | | | |
| CITY | | | 1. COUNTY | | | | | 1. ZIP CODE | | | | | 1. YRS IN COUNTY | | | | | | 1. STATE | | |
| INFORMANT | INFORMANT’S NAME – RELATIONSHIP | | | | | | | 1. INFORMANT’S MAILING ADDRESS | | | | | | | | | | | | | | |
| SPOUSE AND PARENT INFORMATION | NAME OF SURVIVING SPOUSE – FIRST | | | MIDDLE | | | | | | | | LAST (MAIDEN NAME) | | | | | | | | | | |
| NAME OF FATHER – FIRST | | | MIDDLE | | | | | | | | LAST [ ] SAME AS ABOVE | | | | | | | | | 34. BIRTH STATE | |
| NAME OF MOTHER – FIRST | | | MIDDLE | | | | | | | | LAST (MAIDEN NAME) | | | | | | | | | 38. BIRTH STATE | |
| HOSPITAL  INFORMATION | PLACE OF DEATH | | | IF HOSPITAL, SPECIFY ONE: [ ] IP [ ] ER/OP [ ] DOA | | | | | | | | HOSPITAL PHONE | | | | | | | | | | |
| STREET ADDRESS – STREET AND NUMBER OR LOCATION | | | | | | | | | | 1. CITY | | | | | | | | | | | |
| HEBREW NAME AND FATHER’S HEBREW NAME | | | RABBI’S NAME | | | | | | | | | | PHONE | | | | | | | | | |
| DOCTOR’S NAME | | | PHONE | | | | | | | | | | ADDRESS | | | | | | | | | |
| NEXT -OF-KIN | | | RELATION | | | | | | | | | | ADDRESS | | | | | | | | | |
| CITY, STATE, ZIP | | | HOME PHONE [ ] WORK | | | | | | | | | | CELLULAR PHONE  EMAIL ADDRESS: | | | | | | | | | |
| NEXT-OF-KIN | | | RELATION | | | | | | | | | | ADDRESS | | | | | | | | | |
| CITY, STATE, ZIP | | | HOME PHONE [ ] WORK | | | | | | | | | | CELLULAR PHONE EMAIL ADDRESS: | | | | | | | | | |
| NAME OF CEMETERY | | | LOCATION OF GRAVE | | | | | | | | | | TIME OF SERVICE [ ] CHAPEL  [ ] GS | | | | TOTAL # OF DCS CASKET # | | | | | |

AUTHORITY FOR RELEASE OF REMAINS

I hereby acknowledge that the above vital statistics are true and correct. I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize the release of the remains of decedent indicated above to Chevra Kadisha Mortuary and its assignees, and to do everything according to Jewish law. I agree there will be no embalming, no autopsy, no public viewing, and no cremation, as all are forbidden by Jewish law. Family agrees by this authorization to be financially responsible for funeral of deceased.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witnessed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_