THE FOLLOWING STATISTICAL INFORMATION CONCERNING DONOR (YOURSELF) IS <u>REQUIRED</u> FOR THE PROPER COMPLETION OF THE CERTIFICATE OF DEATH. <u>PLEASE PRINT OR TYPE.</u>

One Original copy of this form properly completed and signed should be sent to the University of Rochester Medical School, Anatomical Gift Program, 601 Elmwood Ave, Box 603, Rochester, NY 14642. Also to this address, you must send in writing any necessary changes in the information supplied on this form. Please advise any institution, hospital, or nursing home, etc. of your donation. TYPE OR PRINT CLEARLY ALL INFORMATION.

1. Name: (first)		(middle)	(last)	2. Sex: [] Male [] Female
3. Age: 4. Birth Date: 5. Soc. Sec. #: 6. Race (check all that apply): [] White [] Black or African American [] Amer. Indian or Alaska Native (specify) [] Native Hawaiian [] Other (specify) []			16. Education: (check highest level or degree completed) [] 0-8	
7. Of Spanish / Hispanic / Latino Origin: [] Yes [] No (If yes, check below appropriately) [] Mexican [] Mexican American [] Chicano [] Cuban [] Central or South America [] Other (specify) 8. Veteran of U.S. Armed Forces: If yes, below, specify war or dates of service: [] Yes [] No				
9. City and State of Birth: (If not born in the U.S.A, give town and country.)				
10. Citizen of what Country:				
Marital Status: [] Never Married [] Married [] Separated [] Widowed [] Divorced			19. Name of Father: (First, Middle, Last name)	
12. Spouse's Name: (If wife, please give her maiden name)			20. Name of Mother: (First, Middle, Maiden Last name)	
13. Your main occupation currently or when you were working: (do not enter retired)			21. Name of immediate next of kin:	
14. Type of business or industry:			Address:City/State/Zip:	
15. Name and locality (town/state) of company/firm identified in Item #13.			Phone #: () Relation	onship:
We may obtain any additional information needed concerning yourself from: (fill in each section with all requested information – if you have no attorney, just place "N/A" in that area) Attorney:				
-	Name		Complete Address	Phone
Physician:	Name		Complete Address	Phone
Additional Relative: (other than # 21)	Name	Relationship	Complete Address	Phone
3 rd Relative / or Close Family Friend	Name	Relationship	Complete Address	Phone