Clergy's Record

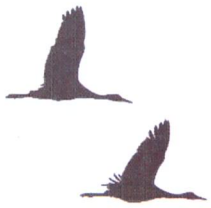
Cali Home Funeral Services

4683 Mercury Street, Suite A

San Diego, CA 92111

Tel. 619-708-9716

Fax. 888-245-5399



Name : _____

Residence: _____

_____

Family Telephone: _____

Place of Birth:_____

Date of Birth:_____

Place of Death: _____

Date of Death: _____

Age-Years: _____

Date of Service : _____

_____

Place of Service:_____

_____

Final Resting Place: _____

RELATIVES:

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

4) _____ Relationship: _____

5) _____ Relationship: _____

6) _____ Relationship: _____

7) _____ Relationship: _____

8) _____ Relationship: _____

9) _____ Relationship: _____

10_____ Relationship: _____

RELEASE AUTHORIZATION

TO:_____

THE UNDERSIGNED HEREBY AUTHORIZES AND REQUESTS RELEASE OF THE

REMAINS OF: Mr./Ms._____

TO: Cali Home Funeral Services, 4683 Mercury Street, Suite A, CA 92111.
FD #2057 Telephone: (858)722-2185. (619) 708-9716 Fax (888) 245-5399
INCLUDING ITS AGENTS:

_____

_____

The above named funeral home, including its agents, is hereby authorized to sign on the undersigned's behalf, any and all other authorizations that may be required to secure release of the above named decedent. The undersigned further represent that they have the legal right to make this authorization.

_____ _____ _____
(signature) **(relationship to decedent)** **(date)**
Full name:_____

_____ _____ _____
(signature) **(relationship to decedent)** **(date)**
Full name:_____

AUTHORIZATION TO ACCEPT OR DECLINE EMBALMING

TO: CALI HOME FUNERAL SERVICES
(Funeral Establishment Name)

RE: _____
(Decedent)

Embalming is the addition to, or the replacement of, body fluids by chemical preservatives or the application of chemical preservatives for the temporary preservation of the body. **I understand that embalming is not required by law.**

I, _____, do ☐ do not ☐ (check one) request embalming.
I understand that for storage or embalming purposes the decedent may be transported to the following location:

_____
(Location Name and Address)

The undersigned hereby represents that he/she has the legal right to control disposition of the remains of the decedent.

Signed: _____, Relationship to Decedent: _____

Executed this ____ day of _____ (Month), _____ (Year), at _____ (City and State).

This section is to be completed by the funeral establishment if authorization to accept or decline embalming is obtained orally.

The above statement regarding embalming and storage was read and/or provided to _____, Relationship to Decedent: _____, who did ☐ did not ☐ (check one) authorize embalming at the above named funeral establishment. Telephone Number: _____
Date and time authorization granted: _____

This section is to be completed by the funeral establishment representative who is executing this authorization to accept or decline embalming.

I declare under penalty of perjury that the foregoing is true and correct.
Executed this ____ day of _____ (Month), _____ (Year), at _____ (City and State).

_____ _____
Funeral Establishment Representative (Print Name) Funeral Establishment Representative (Signature)

INFORMATION FOR DEATH CERTIFICATE and DISPOSITION PERMIT

(Please check for accuracy to avoid delaying permit approval)

1. Name First	2.Middle	3. Last (Family)		
Also Known As: (include Full name First, Middle, Last)	4. Date of Birth (MM/DD/YYYY)	5. Age	If under One Year Month - (Day - Hours) If under 24 hrs (hours-Minutes') __M, __D or __Hr, __Min	6. Sex

9. Birth State/Foreign Country	10. Social Security Number	11. Ever In U.S. Armed Forces?	12. Marial Status Married, Single, Divorced, Never Married, Widows	7.Date of Death	8. HOUR (24 hours) ____: __

13. Education -- Highest level/Degree	14/15. Was Decedent Spanish/Hispanic/Latino?	Decedent's Race --- Up to 3 races may be listed

17. Usual Occupation (type of work for most of life. Do not use Retired)	18. Kind of Business or Industry	19. Years in Occupation

20. Decedent's Residence (street and number)		21. City	22. County	23. Zip Code	24. Years in county

26. Informant Name (First Last) / Relationship	27. Informant's Mailing Address and Telephone N

28. Name of Surviving Spouse/SRDP FIRST	29.MIDDLE	30. LAST (Birth Name)

31. Name of Father FIRST	32. MIDDLE	33. LAST	34. BIRTH STATE
35. Name of Mother FIRST	36. MIDDLE	37. LAST(Birth Name)	38. BIRTH STATE

101.Place of death: Address:_____
Hospital (ER,IP,DOA) or Hospice

118. Attending Physician Name, Mailing Address, Tel, Fax number	Last day seen by Dr.

Last Location of disposition: Cemetery or address keeping cremains

Prepared by: Name:_____Tel:_____Email:_____

Request Picture of deceased to email to calihomefs@hotmail.com

Disclosure of Preneed Funeral Agreement

The funeral establishment, CALI HOME FUNERAL SERVICES _____,
(funeral establishment name)
license number FD_____, **DOES** ____, **DOES NOT** ____ (check one) have a preneed arrangement, as defined below, made by or on behalf of _____.
(name of decedent)

If the funeral establishment ***does have*** a preneed agreement, complete the following:

In compliance with Business and Professions Code Section 7745, the funeral establishment has presented to the person named below a copy of any preneed agreement which has been signed and paid for in full, or in part by, or on behalf of the deceased and is in the possession of the funeral establishment.

_____ _____
Signature of funeral establishment representative Date

"Preneed arrangement," "preneed agreement" or "preneed" is written instruction regarding goods or services or both goods and services for final disposition of human remains when the goods or services are not provided until the time of death, and may be either unfunded or paid for in advance of need.

Funeral Establishment's Responsibility – Business and Professions Code Section 7745 requires a funeral establishment to present to the survivor of the decedent or the responsible party a copy of any preneed agreement in its possession which has been signed and paid for in full, or in part by, or on behalf of the deceased. Business and Professions Code Section 7685.6 requires a copy of any preneed arrangements to be disclosed prior to drafting any contract for funeral goods or services. The funeral establishment may present the copy in person, by certified mail, or by facsimile transmission, as agreed upon by the person with the right to control disposition. A funeral establishment that knowingly fails to present a preneed agreement as required is liable for a civil fine equal to three times the cost of the preneed agreement, or one thousand dollars ($1,000), whichever is greater.

You may contact the Cemetery and Funeral Bureau for more information on funeral, cemetery or cremation matters or to file a complaint against a licensee:

Cemetery and Funeral Bureau
1625 North Market Blvd., Suite S-208
Sacramento, CA 95834
916-574-7870

_____ _____
Signature of the survivor or responsible party Date

_____
Print name of the survivor or responsible party

_____ _____
Signature of funeral establishment representative Date

_____ _____
Print name of funeral establishment representative Title

The funeral establishment must:

- Give a copy of the completed statement to the survivor or responsible party.
- Retain the original or a copy of the completed disclosure statement on file for not less than one (1) year after the preneed account has been audited by the Bureau or seven (7) years from the date the disclosure statement was made, whichever comes first.

CALI HOME FUNERAL SERVICES FD#2057

4683 Mercury St., Suite A, San Diego, CA 92111

From _____ - PHONE # _____ FAX # **(888)-245-5399**

URGENT- CAUSE OF DEATH WORKSHEET

ONCE COMPLETED, FAX BACK IMMEDIATELY TO MORTUARY

DOCTOR _____ LIC # _____

PHONE # FAX#

_____ _____

ADDRESS STE# CITY ZIP

Doctor, please complete this worksheet and fax back to our office ASAP. Once the causes are cleared with the local health dept., you will receive the "Physician Attestation" copy for your signature or voice attestation.

DECEDENT: _____ **M/F**

DATE OF BIRTH _____ **SS#** _____

DATE OF DEATH: _____ **TIME OF DEATH:** _____

PLACE OF DEATH

101 PLACE OF DEATH

102. IF HOSPITAL, SPECIFY ONE ☐ IP ☐ ER/OP ☐ DOA

103. IF OTHER THAN HOSPITAL. SPECIFY ONE ☐ Hospice ☐ Nursing ☐ Decedent's ☐ Other

104. COUNTY

105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location)

106. CITY

CAUSE OF DEATH

107. CAUSE OF DEATH Enter the chain of events --- diseases, injuries, or complications -- that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

Time interval between Onset and Death

IMMEDIATE CAUSE (Final Disease or condition resulting in death) (A) _____ (AT)

(B) _____ (BT)

Sequentially, list condition, if any, leading to cause on line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST (C) _____ (CT)

(D) _____ (DT)

108. DEATH REPORTED TO CORONER ☐ YES ☐ NO REFERRAL NUMBER

109. BIOPSY PERFORMED? ☐ YES ☐ NO

110. AUTOPSY PERFORMED? ☐ YES ☐ NO

111. USED IN DETERMININGCAUSE? ☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)

113A. IF FEMALE. PREGNANT IN LAST YEAR? ☐ NO ☐ UNK

PHYSICIAN'S CERTIFICATION,

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR. DATE AND PLACE STATED FROM THE CAUSES STATED.

Decedent Attended Since: (A) mm/dd/ccyy

Decedent Last Seen Alive: (B) mm/dd/ccyy

115. SIGNATURE AND TITLE OF CERTIFIER

116. LICENSE NUMBER

117. DATE mm/dd/ccyy

118. TYPE ATTENDING PHYSICIAN'S NAME. MAILING ADDRESS, ZIP CODE

FAXED:

TIMEFRAME FOR WORKSHEET COMPLETION: In accordance with the Health & Safety code, Section 102800, the physician must complete the medical and health section within **15 hours** after the patient dies. The responsibility extends to a physician's designee, as applicable.