



JANSEN PROFESSIONAL SERVICES

Jansen Family Funeral Home
4705 Pine Street / PO Box 77
Columbiaville, MI 48421
Daniel L. Jansen, Manager / Owner
www.jansenprofessionalservices.com
Phone 810-793-6234

Selection of Services

- ☐ Removal / Embalming & Vitals
- ☐ Removal / Embalming W/ Transport & Vitals
- ☐ Expedite Death Certificate
- ☐ Ship Out & Vitals - Embalmed
- ☐ Ship Out & Vitals - Un-Embalmed
- ☐ Direct Cremation Service & Vitals
- ☐ Airport Transport
- ☐ Disinterment
- ☐ Autopsy Services
- ☐ Other: _____

◆ Please complete this information about your firm and fax over immediately. Fax 810-793-4752

Name of funeral home

Contact person at funeral home

Funeral home address (Be sure to include PO Box if needed)

City

State

Zip code

Phone Number

Fax Number

Email Address



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AUTHORIZATION FOR RELEASE OF REMAINS

The undersigned hereby authorizes: _____
Name of Hospital or Medical Examiners Office

to release the said remains of: _____ to:
Name of Deceased

**Jansen Family Funeral Home (Agent Funeral Home)
4705 Pine St. - PO Box 77
Columbiaville, Michigan 48421
(810) 793-6234**

Jansen Family Funeral Home is acting as a legal agent on behalf of:

Name of Funeral Home

City & State

Phone

This order is above all previous orders written or verbal and takes immediate effect. I represent that I'm of the same and nearest degree of relationship to the said deceased and/or legally authorized or charged with the responsibility for handling such final disposition.

Printed Name of Next of Kin

Phone Number

Signature of Next of Kin

Relation

Printed Name of Witness

Signature of Witness

Date



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Michigan Death Certificate

Please Use the attached PDF of a Michigan Death Certificate to obtain the needed vitals to complete a death certificate. Please return this with DC Information. Fax 810-793-4752

How Many Death Certificates are Needed ? _____

** Don't assume a FREE veterans copy will be provided by all clerks offices.

Cremation ☐ Yes ☐ No

Select One ☐ Standard Service ☐ Expedited Service

Standard - DC is completed 1-3 weeks. This service is provided in our standard cost already. Dc's mailed to your funeral home.

Expedited - An individual is placed on your DC till it is completed.
1 Week Max (\$40 Extra) This Service is included in all
Direct Cremations already. Dc's mailed to your funeral home.

Important Notes:

Item 8C - Please check on this item in order to insure accuracy.
This is not always the city listed in the mailing address.

Our funeral home will obtain the place of death, date of death, and time of death.
Items - 4, 7A, 7B, 7C, 28A, 28B, 28C, 29, 30, 31, 39, 40A

Any item left blank will be listed on the certificate as "UNKNOWN"
A Proof will be faxed before Dc is filed at clerks office.
If you want Dc's mailed to another location - Please advise us of the change



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

NAME OF DECEDENT
For use by physician or institution

LF _____
CF _____

1. DECEDENT'S NAME (First Middle Last)		2. DATE OF BIRTH (Month Day Year)		3. SEX		4. DATE OF DEATH (Month Day Year)					
5. NAME AT BIRTH OR OTHER NAME USED FOR PERSONAL BUSINESS (include AKA's if any)				6a. AGE - Last Birthday (Years)		6b. UNDER 1 YEAR		6c. UNDER 1 DAY			
7a. LOCATION OF DEATH (Enter place officially pronounced dead in 7a 7b 7c) HOSPITAL OR OTHER INSTITUTION - Name (if not in either give street and number and zip code)				7b. CITY, VILLAGE, OR TOWNSHIP OF DEATH				7c. COUNTY OF DEATH			
8a. CURRENT RESIDENCE - STATE		8b. COUNTY		8c. LOCALITY - (check the box that describes the location) <input type="checkbox"/> CITY OR VILLAGE (inside limits of) <input type="checkbox"/> TOWNSHIP <input type="checkbox"/> UNINCORPORATED PLACE		8d. STREET AND NUMBER (Include Apt. No. if applicable)					
8w. ZIP CODE		9. BIRTHPLACE (City and State or Country)		10. SOCIAL SECURITY NUMBER		11. DECEDENT'S EDUCATION - What is the highest degree or level of school completed at the time of death?					
12. RACE - American Indian, White, Black, etc. (if Asian give nationality ie. Chinese Filipino Asian Indian etc.) (Enter all that apply)				13a. ANCESTRY - Mexican, Cuban, Arab, African, English, French, Dutch, etc. (Enter all that apply) If American Indian race, enter principal tribe				13b. HISPANIC ORIGIN (Yes or No)		14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES? (yes or no)	
15. USUAL OCCUPATION Give kind of work done during most of working life. Do not use retired.			16. KIND OF BUSINESS OR INDUSTRY		17. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)		18. NAME OF SURVIVING SPOUSE (if wife give name before first married)				

19. FATHER'S NAME (First Middle Last)				20. MOTHER'S NAME BEFORE FIRST MARRIED (First Middle Last)			
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21a. INFORMANT'S NAME (Type/Print)		21b. RELATIONSHIP TO DECEDENT		21c. MAILING ADDRESS (Street and Number or Rural Route Number City or Village State Zip Code)			
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22. METHOD OF DISPOSITION Burial Cremation Entombment Donation Removal Storage (Specify)		23a. PLACE OF DISPOSITION (Name of Cemetery Crematory or other location)				23b. LOCATION - City or Village, State	
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24. SIGNATURE OF MORTUARY SCIENCE LICENSEE		25. LICENSE NUMBER (of Licensee)		26. NAME AND ADDRESS OF FUNERAL FACILITY			
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27a. CERTIFIER (Check only one) <input type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. Signature and Title _____				28a. ACTUAL OR PRESUMED TIME OF DEATH M		28b. PRONOUNCED DEAD ON (Mo. Day Yr.)		28c. TIME PRONOUNCED DEAD M	
				29. MEDICAL EXAMINER CONTACTED? (Yes or No)		30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) (Specify)		31. IF HOSPITAL, Inpatient, Outpatient, Emergency Room, DOA (Specify)	

27b. DATE SIGNED (Mo. Day Yr.)		27c. LICENSE NUMBER		32. MEDICAL EXAMINER'S CASE NUMBER (if applicable)		33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
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34. NAME AND ADDRESS OF CERTIFYING PHYSICIAN (Type or Print)							
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35a. REGISTRAR'S SIGNATURE				35b. DATE FILED (Month Day Year)			
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36. PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. If diabetes was an immediate, underlying or contributing cause of death be sure to record diabetes in either Part I or Part II of the cause of death section, as appropriate. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, IF ANY, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I. a. _____ b. _____ c. _____ d. _____ 37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown 38. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year								Approximate Interval Between Onset and Death	
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39. MANNER OF DEATH - Accident, Suicide, Homicide, Natural, Indeterminate or Pending (Specify)		40a. WAS AN AUTOPSY PERFORMED? (Yes or No)		40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)			
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41a. DATE OF INJURY (Mo. Day Yr.)		41b. TIME OF INJURY M		41c. DESCRIBE HOW INJURY OCCURRED			
41d. INJURY AT WORK (Yes or No)		41e. PLACE OF INJURY - At home, farm, street, construction site, wooded area, etc. (Specify)		41f. IF TRANSPORTATION INJURY - Driver/Operator, Passenger, Pedestrian, etc. (Specify)		41g. LOCATION - Street or RFD No. City, Village or Twp. State	

Number _____

Sunset Hills Association

G-4413 Flushing Road
Flint, Michigan 48504
(810)732-0260

AUTHORIZATION FOR CREMATION AND DISPOSITION OF CREMATED REMAINS

I hereby authorize and request Sunset Hills Association, in accordance with and subject to its rules and regulations, to cremate the human remains of: _____
who died on _____.

I certify and represent that I have the right to authorize cremation and that the consent of no other person is necessary for this order, and I agree to hold said association harmless for any liability on account of said authorization and cremation.

I further state that the deceased has not had a **heart pacemaker, radiation producing device** nor any other life sustaining device implanted that could be explosive. If such device exists, I have instructed the funeral director or others to remove it before cremation. I also agree that in the event of my failure to notify the funeral director or any others responsible for the removal of such device, I will be liable for any damages to the crematorium or injury to its personnel.

I hereby instruct Sunset Hills Association to dispose of the cremated remains of the above deceased as follows:

- ☐ Return to the funeral director at the office of Sunset Hills Association.
- ☐ Return to the family at the office of Sunset Hills Association

Signature _____ Date _____

Relationship to deceased _____ Phone _____

Address _____

Funeral Home Name
Address
City, State, Zip
Phone #

THIS AUTHORIZATION, FULLY SIGNED AND COMPLETED MUST ACCOMPANY THE BODY OF THE DECEASED AND BE DELIVERED TO SUNSET HILLS ASSOCIATION TOGETHER WITH A BOARD OF HEALTH PERMIT, SIGNED BY THE MEDICAL EXAMINER OF THE COUNTY IN WHICH THE THE DEATH OCCURRED, APPROVING THE BODY OF SAID DECEASED TO BE CREMATED.



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Release of Cremains

We have developed 4 different options for the release of cremated remains back to your family. Cremains may be received at the funeral home or crematory office at NO COST or mailed to you're the address you specify for a minimal charge. Also, cremated remains can be delivered in person to local family member by our staff if so desired. Please select an option below.

- ☐ Release at the Funeral Home_____No Cost
- ☐ Release at the Crematory Office_____No Cost
- ☐ Mail Cremains Via Standard
Registered Mail (Insured \$500)_____ \$45.00
- ☐ Overnight Cremains_____ \$55.00
- ☐ Deliver Cremains in Person_____ \$115.00

◆ If cremains are being picked up at funeral home or crematory - Please list name on line below

Name of person receiving cremains (Please make sure they bring a valid ID)

◆ If cremains are being mailed or delivered - Please give name of person or funeral home

Name of person or funeral home name receiving cremains

Address of person or funeral home receiving cremains (Be sure to include PO Box if needed)

City

State

Zip code

Phone Number



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CREMATION AUTHORIZATION REQUIREMENTS

In order to adhere to the laws of the State of Michigan, We have listed the order for next of kin when signing a cremation authorization. Whoever is living, and closest to the top of the list is required by law to sign the cremation authorization before cremation can take place. In the event that there is more than 1 child, Sibling, Etc... - then a majority would be required to consent. **If you have questions, please contact our office.**

Legal Next Of Kin Order

Legal Spouse / Legal Guardian / Court Appointed Guardian

Children - Majority must consent

Parents - Both should consent if living

Siblings - Majority must consent

Grandchildren - Majority must consent

Nieces & Nephews - Majority must consent

This form must be signed by contracting funeral home and returned VIA fax to our funeral home, before cremation will take place. (Fax: 810-793-4752)

By signing below you acknowledge receiving this information to the legal next of kin when authorizing cremation. Further, you assume all liability of collecting the proper signatures of next of kin and representations of those individuals and there capacity.

SIGNATURE OF FUNERAL DIRECTOR

DATE

PRINTED NAME