



PEOPLE'S  
MEMORIAL  
ASSOCIATION

## PUTTING MY HOUSE IN ORDER

- PLANNING FORM: SECTION 1 -

### INFORMATION FOR FUNERAL HOME AT THE TIME OF YOUR DEATH KEEP ORIGINAL WITH YOUR IMPORTANT PAPERS

*(Please Print)*

Full Legal Name: \_\_\_\_\_ PMA Number: \_\_\_\_\_

#### Disposition:

It is my wish that my remains be: \_\_\_\_\_ Cremated \_\_\_\_\_ Interred/Buried

It is my wish that that ashes (if cremated) be: \_\_\_\_\_ Scattered \_\_\_\_\_ Buried \_\_\_\_\_ Released to:

If burial is preferred, cemetery arrangements: \_\_\_\_\_ Should be made \_\_\_\_\_ Have been made

If already arranged, name and location of Cemetery/Mausoleum/Columbarium: \_\_\_\_\_

Section and plot: \_\_\_\_\_

#### Ceremony:

I \_\_\_\_\_ do \_\_\_\_\_ do not want a service.

If a service is held, I prefer: \_\_\_\_\_ Memorial (body not present)

\_\_\_\_\_ Funeral (body present)

If a service is held, I would like it held at: \_\_\_\_\_ Church \_\_\_\_\_ Mortuary chapel \_\_\_\_\_ Other:

#### Notices:

I \_\_\_\_\_ do \_\_\_\_\_ do not want newspaper notices published.

#### Memorial Gifts:

I \_\_\_\_\_ do \_\_\_\_\_ do not prefer memorial gifts in lieu of flowers.

If memorials requested, I ask that donations be sent to the following organization(s):

#### Organ And Tissue Donation:

I \_\_\_\_\_ do \_\_\_\_\_ do not wish to donate my eyes at the time of my death to the eye bank.

I \_\_\_\_\_ do \_\_\_\_\_ do not wish to donate such other organs, bone or tissue, at the time of death as may be considered medically useful. This also authorizes donation of pacemaker, if applicable.

- PLANNING FORM: SECTION 2 -

**VITAL STATISTICS**

Information on this page is required by the Department of Vital Statistics *(Please Print)*

**Full Legal Name** \_\_\_\_\_

**Street Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_ **County** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_ Never Married \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced

If married, widowed, or divorced, list all given names of spouse, including maiden name of wife:

\_\_\_\_\_  
\_\_\_\_\_

**Occupation:**

(a) Kind of business or industry (if retired, give former): \_\_\_\_\_

(b) Kind of work done during most of working life: \_\_\_\_\_

\_\_\_\_\_

**Birth Date:**

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Age on your last birthday: \_\_\_\_\_

Your Birthplace (city and state) \_\_\_\_\_

**Your Father's Name:**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

**Your Mother's Name:**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

**Your Sex:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Hispanic (yes or no):** \_\_\_\_\_

**Tribal Reservation Name:** \_\_\_\_\_

**Your Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Doctor's Address:** \_\_\_\_\_

\_\_\_\_\_

**VITAL STATISTICS (Continued)**

Information on this page is required by the Department of Vital Statistics *(Please Print)*

**Next of Kin:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Military Service** (rank, branch, serial number): \_\_\_\_\_

**Date & Place of entry:** \_\_\_\_\_

**Date & Place of Discharge:** \_\_\_\_\_

**VA Claim Number** (if applicable): \_\_\_\_\_

**High School Graduate:** \_\_\_\_ Yes \_\_\_\_ No **Education completed:** \_\_\_\_\_

**Resided in County since:** \_\_\_\_\_ **Smoked in Past 15 Years:** \_\_\_\_ Yes \_\_\_\_ No

**Current Residence Inside City Limits:** \_\_\_\_ Yes \_\_\_\_ No

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**KEEP WITH YOUR IMPORTANT PAPERS**

**DISCUSS WITH YOUR NEXT OF KIN**