

GENESIS FUNERAL HOME
5749 PEMBROKE RD. HOLLYWOOD, FL. 33023
OFFICE: (954) 962-3017 FAX: (954) 962-3019
Email: genesisfuneralhome@gmail.com

ARRANGEMENT WORKSHEET

Name: _____ **Age:** _____
 First Middle Last

Date of Death: _____ **Hour:** _____

Decedents Address: _____
 Street Address Apt #

 City/Town State/Zip County

Place of Death: _____
 Hospital/Hospice Name Street Address Apt #

 City/Town State/Zip County

Sex: MALE FEMALE **Race/Ethnicity:** _____ **If Hispanic Provide Origin** _____

Date of Birth: _____ **Place of Birth:** _____
 MM / DD / YYYY (Provide City and State)

Fathers Full Name: _____ **Mothers Full Name** _____
 (If Married Provide Maiden Name)

Marital Status: S M D W SEP **Surviving Spouse Full Name** _____
 (If Female provide Maiden Name)

Occupation: _____ **Type of Business:** _____
 (If Retired Provide Last or Usual Occupation)

Social Security Number _____ **Education:** 8 GRADE OR LESS GRADES 9-12 NO DIPLOMA GED OR H.S. DIPLOMA SOME COLLEGE NO DEGREE

Veteran: YES NO AS BA MA DOC UNKNOWN

Legal Next of kin/ Informant Name/Address: _____
 Name Street Address Apt #

 City/Town State/Zip County

Phone: _____ **Relationship:** _____

Please review this form carefully, the information provided will be used for the completion of the death certificate and you will be responsible for any amendment, court or attorney fees necessary due to any incorrect/illegible information provided.

Name _____ **Signature** _____ **Date** _____

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Release of Remains Authorization

To Whom It May Concern At: _____
(Name of the Hospital or Residence Address)

This Is Your Authority To Release The Remains of:

(Deceased Name)

To Genesis Funeral Home & \$495 Cremation Center Inc. To Care For and Prepare For Burial and/or Other Disposition.

X _____
Printed Name of Person Granting Authorization

Relationship

X _____
Signature of Person Granting Authorization

Date

Witness Signature

Date

Type of Service Selected: _____

Information For Medical Examiner Department Record

Race: _____

Sex: _____

Date Of Birth: _____

Age: _____

Office us only:

Fax To: Medical Examiner

Hospital

Hospice

Other

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Authorization for Embalming

The undersigned represents to Genesis Funeral Home & \$495 Cremations Center Inc. That the undersigned is the surviving next of kin to: _____

(Name of Deceased)

or is the legal representative of such person and has paramount right to direct the disposition of the body of the decedent. The undersigned authorizes and directs the Genesis Funeral Home funeral home, its employees, independent contractors and agents to embalm, care for and prepare the body for disposition. The undersigned acknowledges and agrees that this authorization permits the funeral home to use the services of independent embalmers, apprentices or student interns in connection with such embalming, care and preparation for disposition, provided that any person rendering such services is allowed to perform such work under applicable law. The undersigned further acknowledges and agrees that the embalming, care and preparation for disposition authorized hereby may be performed at the funeral home's facility or at another facility equipped to provide such services. I the undersigned represent that I have the legal authority to give this authorization. I agree to indemnify and hold harmless the Genesis Funeral Home, its affiliates and their agents and employees from any and all liability or claims which may arise as a result of this *Authorization to Embalm and Prepare* or any action taken in accordance herewith.

Printed Name of Person Granting Authorization

Relationship

Signature of Person Granting Authorization

Date

Witness Signature

Date

Type of Service Selected: _____