

U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

TYPE/PRINT
IN
PERMANENT
BLACK INK
FOR
INSTRUCTIONS
SEE OTHER SIDE
AND HANDBOOK

1. DECEDENT'S NAME (First, Middle, Last)							2. SEX	3. DATE OF DEATH (Month, Day, Year)		
4. SOCIAL SECURITY NUMBER		5a. AGE—Last Birthday (Years)		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Month, Day, Year)		7. BIRTHPLACE (City and State or Foreign Country)
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or no)			9a. PLACE OF DEATH (Check only one: see instructions on other side)							
			HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
9b. FACILITY NAME (If not institution, give street and number)					9c. CITY, TOWN, OR LOCATION OF DEATH			9d. COUNTY OF DEATH		
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)			11. SURVIVING SPOUSE (If wife, give maiden name)			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)			12b. KIND OF BUSINESS/INDUSTRY	
13a. RESIDENCE—STATE		13b. COUNTY		13c. CITY, TOWN, OR LOCATION			13d. STREET AND NUMBER			
13e. INSIDE CITY LIMITS? (Yes or no)		13f. ZIP CODE		14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:			15. RACE—American Indian, Black, White, etc. (Specify)		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)				
19a. INFORMANT'S NAME (Type/Print)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)			20c. LOCATION—City or Town, State			
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH				21b. LICENSE NUMBER (of Licensee)		22. NAME AND ADDRESS OF FACILITY				
Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.			23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title			23b. LICENSE NUMBER		23c. DATE SIGNED (Month, Day, Year)		
24. TIME OF DEATH M			25. DATE PRONOUNCED DEAD (Month, Day, Year)			26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)				
27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
a. _____ DUE TO (OR AS A CONSEQUENCE OF):										
b. _____ DUE TO (OR AS A CONSEQUENCE OF):										
c. _____ DUE TO (OR AS A CONSEQUENCE OF):										
d. _____ DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							28a. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
29. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		30a. DATE OF INJURY (Month, Day, Year)		30b. TIME OF INJURY M	30c. INJURY AT WORK? (Yes or no)		30d. DESCRIBE HOW INJURY OCCURRED			
30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)					30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
31a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER/CORONER 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 as stated.										
31b. SIGNATURE AND TITLE OF CERTIFIER						31c. LICENSE NUMBER		31d. DATE SIGNED (Month, Day, Year)		
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)										
33. REGISTRAR'S SIGNATURE								34. DATE FILED (Month, Day, Year)		

DECEDENT

SEE INSTRUCTIONS ON OTHER SIDE

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

CAUSE OF DEATH

CERTIFIER

REGISTRAR

DEPARTMENT OF HEALTH AND HUMAN SERVICES — PUBLIC HEALTH SERVICE — NATIONAL CENTER FOR HEALTH STATISTICS — 1989 REVISION

INSTRUCTIONS FOR SELECTED ITEMS

Item 9. — Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Items 13-a-f. — Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home State," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence.

If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13f.

If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Items 23 and 31 — Medical Certification

The PRONOUNCING PHYSICIAN is the person who determines that the decedent is legally dead but who was not in charge of the patient's care for the illness or condition which resulted in death. Items 23a through 23c are to be completed only when the physician responsible for completing the medical certification of cause of death (Item 27) is not available at time of death to certify cause of death. The pronouncing physician is responsible for completing only items 23 through 26.

The CERTIFYING PHYSICIAN is the person who determines the cause of death (Item 27). This box should be checked only in those cases when the person who is completing the medical certification of cause of death is not the person who pronounced death (Item 23). The certifying physician is responsible for completing items 27 through 32.

The PRONOUNCING AND CERTIFYING PHYSICIAN box should be checked when the same person is responsible for completing items 24 through 32, that is, when the same physician has both pronounced death and certified the cause of death. If this box is checked, items 23a through 23c should be left blank.

The MEDICAL EXAMINER/CORONER box should be checked when investigation is required by the Post Mortem Examination Act and the cause of death is completed by a medical examiner or coroner. The Medical Examiner/Coroner is responsible for completing items 24 through 32.

Item 27. — Cause of Death

The cause of death means the disease, abnormality, injury, or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

In Part I, the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause, should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. **ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE.** Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify.

In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

See examples below.

SEE INSTRUCTIONS ON OTHER SIDE	27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death								
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 2px;"> IMMEDIATE CAUSE (Final disease or condition resulting in death) → </td> <td style="width: 55%; padding: 2px;"> a. <u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="width: 20%; text-align: center; padding: 2px;">Mins.</td> </tr> <tr> <td style="padding: 2px;"> b. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="padding: 2px;"> c. <u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="text-align: center; padding: 2px;">6 days</td> </tr> <tr> <td style="padding: 2px;"> d. _____ DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="padding: 2px;"> _____ DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="text-align: center; padding: 2px;">5 years</td> </tr> </table>	IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. <u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):	Mins.	b. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):	c. <u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):	6 days	d. _____ DUE TO (OR AS A CONSEQUENCE OF):	_____ DUE TO (OR AS A CONSEQUENCE OF):	5 years
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CAUSE OF DEATH	PART II. <u>Other significant conditions</u> contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes, Chronic obstructive pulmonary disease, smoking</u>	28a. WAS AN AUTOPSY PERFORMED? <i>(Yes or no)</i> Yes	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>(Yes or no)</i> Yes							
29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	30a. DATE OF INJURY <i>(Month, Day, Year)</i> _____	30b. TIME OF INJURY _____ M	30c. INJURY AT WORK? <i>(Yes or no)</i> _____	30d. DESCRIBE HOW INJURY OCCURRED _____						
	30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. <i>(Specify)</i> _____	30f. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____								

SEE INSTRUCTIONS ON OTHER SIDE	27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death								
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 2px;"> IMMEDIATE CAUSE (Final disease or condition resulting in death) → </td> <td style="width: 55%; padding: 2px;"> a. <u>Cerebral laceration</u> DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="width: 20%; text-align: center; padding: 2px;">10 mins.</td> </tr> <tr> <td style="padding: 2px;"> b. <u>Open skull fracture</u> DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="padding: 2px;"> c. <u>Automobile accident</u> DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="text-align: center; padding: 2px;">10 mins.</td> </tr> <tr> <td style="padding: 2px;"> d. _____ DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="padding: 2px;"> _____ DUE TO (OR AS A CONSEQUENCE OF): </td> <td style="text-align: center; padding: 2px;">10 mins.</td> </tr> </table>	IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. <u>Cerebral laceration</u> DUE TO (OR AS A CONSEQUENCE OF):	10 mins.	b. <u>Open skull fracture</u> DUE TO (OR AS A CONSEQUENCE OF):	c. <u>Automobile accident</u> DUE TO (OR AS A CONSEQUENCE OF):	10 mins.	d. _____ DUE TO (OR AS A CONSEQUENCE OF):	_____ DUE TO (OR AS A CONSEQUENCE OF):	10 mins.
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CAUSE OF DEATH	PART II. <u>Other significant conditions</u> contributing to death but not resulting in the underlying cause given in Part I. _____	28a. WAS AN AUTOPSY PERFORMED? <i>(Yes or no)</i> No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>(Yes or no)</i> No							
29. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	30a. DATE OF INJURY <i>(Month, Day, Year)</i> <u>11/15/85</u>	30b. TIME OF INJURY <u>1 p.</u> M	30c. INJURY AT WORK? <i>(Yes or no)</i> No	30d. DESCRIBE HOW INJURY OCCURRED <u>2-car collision—driver</u>						
	30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. <i>(Specify)</i> <u>Street</u>	30f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>Route 4, Raleigh, North Carolina</u>								