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

LOCAL FILE NUMBER

U.S. STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT

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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Residence ☐ 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.) ☐ No ☐ 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+)

SEE INSTRUCTIONS ON OTHER SIDE

NAME OF DECEDENT: For use by physician or institution

PARENTS

17. FATHER'S NAME *(First, Middle, Last)*
18. MOTHER'S NAME *(First, Middle, Maiden Surname)*

INFORMANT

19a. INFORMANT'S NAME *(Type/Print)*
19b. MAILING ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DISPOSITION

20a. METHOD OF DISPOSITION
☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ 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

SEE DEFINITION ON OTHER SIDE

PRONOUNCING PHYSICIAN ONLY

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)*

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH M
25. DATE PRONOUNCED DEAD *(Month, Day, Year)*
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? *(Yes or no)*

SEE INSTRUCTIONS ON OTHER SIDE

CAUSE OF DEATH

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

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**

b. _____

DUE TO (OR AS A CONSEQUENCE OF):

c. _____

DUE TO (OR AS A CONSEQUENCE OF):

d.

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
☐ Natural ☐ Pending Investigation
☐ Accident
☐ Suicide ☐ Could not be Determined
☐ 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)

SEE DEFINITION ON OTHER SIDE

CERTIFIER

31a. CERTIFIER *(Check only one)*

☐ 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.

☐ 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.

☐ 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)*

REGISTRAR

33. REGISTRAR'S SIGNATURE ▶
34. DATE FILED *(Month, Day, Year)*

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

CAUSE OF DEATH

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
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Rupture of myocardium	Mins.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute myocardial infarction	6 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic ischemic heart disease	5 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes, Chronic obstructive pulmonary disease, smoking

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

29. MANNER OF DEATH: [X] Natural; [ ] Accident; [ ] Suicide; [ ] Homicide; [ ] Pending Investigation; [ ] Could not be Determined

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)

SEE INSTRUCTIONS ON OTHER SIDE

CAUSE OF DEATH

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
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebral laceration	10 mins.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Open skull fracture	10 mins.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Automobile accident	10 mins.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

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): No

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

29. MANNER OF DEATH: [ ] Natural; [X] Accident; [ ] Suicide; [ ] Homicide; [ ] Pending Investigation; [ ] Could not be Determined

30a. DATE OF INJURY (Month, Day, Year): 11/15/85

30b. TIME OF INJURY: 1 p. M

30c. INJURY AT WORK? (Yes or no): No

30d. DESCRIBE HOW INJURY OCCURRED: 2-car collision—driver

30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): Street

30f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Route 4, Raleigh, North Carolina