TYPE/PRINT IN PERMANENT BLACK INK

LF _____

CF _____

STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER _____

NAME OF DECEDENT
For use by physician or institution

DECEDENT

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 — MONTHS | DAYS
6c. UNDER 1 DAY — HOURS | MINUTES
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)* ☐ CITY OR VILLAGE *(inside limits of)* ☐ TOWNSHIP ☐ UNINCORPORATED PLACE
8d. STREET AND NUMBER *(Include Apt. No. if applicable)*
8e. 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)*

PARENTS

19. FATHER'S NAME *(First, Middle, Last)*
20. MOTHER'S NAME BEFORE FIRST MARRIED *(First, Middle, Last)*

INFORMANT

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)*

DISPOSITION

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
24. SIGNATURE OF MORTUARY SCIENCE LICENSEE
25. LICENSE NUMBER *(of Licensee)*
26. NAME AND ADDRESS OF FUNERAL FACILITY

CERTIFICATION

27a. CERTIFIER *(Check only one)*

☐ Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated.

☐ Medical Examiner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, data, 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)*
34. NAME AND ADDRESS OF CERTIFYING PHYSICIAN *(Type or Print)*
35a. REGISTRAR'S SIGNATURE
35b. DATE FILED *(Month, Day, Year)*

CAUSE OF DEATH

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.

Approximate Interval Between Onset and Death

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)

a. _____ DUE TO (OR AS A CONSEQUENCE OF)

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**

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.

37. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

38. IF FEMALE:
☐ Not pregnant within past year
☐ Pregnant at time of death
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Unknown if pregnant within the past year

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)*

MEDICAL EXAMINER

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