

**INSTRUCTIONS FOR PHYSICIANS
COMPLETING THE MEDICAL PORTION OF THE
CERTIFICATE OF DEATH**

**The 2004 version of the death certificate
Last Revised March 1, 2004**

These instructions are intended to inform physicians on the proper completion of the certificate of death that has been adopted for use in recording deaths which occur in 2004. The 2004 version of the certificate should be used for deaths that occur on and after January 1, 2004.

Those deaths that occurred during 2003, which remain to be reported in 2004 should be reported on the previous version of the death certificate. All pre-2004 forms will become obsolete and should be destroyed on December 31, 2004, which is the last day that a 2003 death could be routinely recorded.

The 2004 version of the death certificate is identified by the form number of DCH-0483 and a revision date of 10/03 or later indicated in the lower left margin of the form. These forms are 8 1/2 inches by 11 inches with a 3-inch tear-off instructional stub.

General Information

The proper preparation of a death certificate is an important function of the attending physician. The certification of the death should be provided within the 48 hours immediately following pronounced death. This responsibility is placed upon the attending physician by law (MCL 333.2843) and has been part of the role of the physician historically. As the determination that death has occurred rests with the physician and as the attending physician is informed on the conditions that led to the death, the attendant is the single best source of information on the medical facts related to the death. The personal physician of the decedent is most knowledgeable of the health and the history of the decedent and is the certifier of choice. When not available, however, any physician who attended to the patient around the time of death may certify as the attendant.

Not infrequently, when a death occurs, the personal physician of the decedent is unavailable or unable to certify to the death in the very short period of time after the death wherein certification is necessary. It is possible under the law to insure prompt and accurate certification of these cases by authorizing a physician to act in place of the attendant. By assuring that such arrangements are in place, especially in instances where patients are seriously ill, the proper reporting of such deaths can proceed rapidly. Delay and inconvenience to family members can be avoided and the potential for unnecessarily involving the medical examiner can be eliminated through appropriate planning.

If the attendant is unavailable and a representative for the attendant can not be found, the law delineates the transfer of the duty to certify to a death. If the death occurred within a hospital or was pronounced therein, certification of the death becomes the responsibility of the chief medical officer or a pathologist of that hospital. This certification must be based upon a review of pertinent medical records and such investigation as is considered necessary. Deaths outside of hospitals become the duty of the medical examiner and then, in turn, the health officer to certify when no attending physician is available. In this latter

circumstance, the process for determining the causes of death is at the discretion of the medical examiner.

The statutes provide for and permit this process for assuring the rapid certification of a death to facilitate the prompt removal and disposition of bodies and to speed the ability of family members to begin to address the many legal issues that must be handled. As important as these objectives are, the process most generally does not result in the best recording of medical facts concerning the decedent. The attendant is clearly the best source of this information. Every effort should be made to minimize the need for the certification of a death by a physician or medical examiner who is unfamiliar with the patient.

Medical Examiner Referrals

An attending physician has the primary responsibility to identify deaths that should be investigated by the medical examiner. Generally, the medical examiner should be contacted whenever a death is encountered where the cause of death is due to a violent or external cause, the death was unexpected or when the cause of the death is unknown to the attendant. The specific statutes that define medical examiners cases are MCL 52.202 and 333.2844. Many county medical examiners have prepared instructions to aid identifying when a referral is indicated. It is important to be familiar with the guidelines in effect within the county where your practice is located.

The medical examiners of many counties rely upon death certificate information to identify cases that may require investigation. This screening process is done with the cooperation of the local and state vital records offices. It is important to keep this in mind as you complete the cause of death section of the death certificate. When an injury, including an historic injury, is listed on the certificate, a referral to the medical examiner may become necessary. As a result, historic injuries should be listed in Item 36 **only if** the injury is believed to have contributed to the eventual death of the decedent in order to avoid unnecessary referrals. Consult with the medical examiner in your county should you wish clarification in this area generally or in relation to a specific case.

Completion of the Certificate of Death

The certificate of death that is completed and filed is retained in the state vital records repository as a permanent legal record of the event. The document will be available for the issuance of certified copies to permit establishing the facts of death in settling the affairs of the decedent and will serve as an historical record of interest to descendants into the future. Great care should be taken in the preparation of these documents to insure each is complete, accurate and legible.

By exercising care in completing the death certificate, intended purposes of supplying data on the mortality of people in Michigan and serving as a permanent legal record of the event can be accomplished. The most direct value of a death certificate is derived by the immediate family of the deceased. Certified copies of the filed document will be an important part of handling pension and insurance claims, probating an estate, obtaining social security benefits and other purposes in the weeks and months following the death. The document will become of historical and genealogical interest with time, as well. At the same time, the information on certificates of death will collectively be used in the study of

mortality within the state in both very general and very specific ways. The mortality data is an integral part of evaluating many public health and medical problems, program planning and evaluation and other valuable uses.

In order to properly complete the Michigan Certificate of Death it is important to follow these simple rules:

1. COMPLETE ALL ITEMS THAT ARE THE RESPONSIBILITY OF THE CERTIFYING PHYSICIAN. UNLESS SPECIFIED BELOW, DO NOT LEAVE ANY ITEMS BLANK THAT ARE WITHIN THE MEDICAL PORTION OF THE DOCUMENT (ITEMS 27-31,33-34,36-40). SPECIFIC INSTRUCTIONS FOR EACH REQUIRED ITEM ARE GIVEN BELOW.
2. TYPE OR LEGIBLY PRINT IN BLACK INK THE ENTRIES FOR EACH ITEM. ONE OF THE USES OF THE CERTIFICATE IS TO PROVIDE COPIES FOR A VARIETY OF LEGAL, STATISTICAL AND EPIDEMIOLOGIC PURPOSES. ILLEGIBLE CERTIFICATES WILL NOT BE CONDUCTIVE TO SUCH USES. BLUE INK MUST NOT BE USED ON THESE DOCUMENTS.
3. SIGN THE CERTIFICATE IN ITEM 27a WITHIN 48 HOURS OF DEATH. THIS MUST BE AN ORIGINAL SIGNATURE. RUBBER STAMPS OR OTHER FACSIMILES ARE NOT ACCEPTABLE.
4. WHEN ENTERING A DATE IN ITEM 4 AND ITEM 27b, SPELL OUT OR ABBREVIATE THE MONTH, DO NOT USE A NUMBER.
5. The document must not be corrected or altered in any way so as to damage the document or make the document appear altered. Minor changes or alterations must be made carefully so that the alteration can not be detected on a copy of the document. The use of correcting fluid, image overlay or correcting tapes are not acceptable. Use of a correcting typewriter with a lift off process for correction is permitted, if the correction is not detectable upon copying.
6. Do not make extraneous marks on the document. Additionally, do not fold, bend, mutilate, staple or alter the form.
7. Avoid abbreviations except as recommended for specific items.

Specific Instructions on the Completion of Individual Items

The funeral director is generally responsible for completing the upper portion of the certificate of death. It is best to permit the funeral director to complete items 1 through 26, except as provided for below.

Item 1 Name of Decedent

It is recommended that the completion of this item be left to the funeral director. This will significantly reduce the likelihood of an error in the entry of the decedent's full legal name. The medical record on the decedent often contains a name that is not complete or is somehow different from the correct legal name. The funeral

director, by consulting with family, is generally able to obtain the accurate name.

Entry of the decedent's name on the line in the margin of the certificate provided for this purpose is encouraged, when certifying to an incomplete or partially completed certificate.

Item 4 Date of Death

This item is usually completed by the funeral director. However, the certifying physician is responsible for the accuracy of the item. If this item has been completed, review the entry for accuracy. If it is incorrect, notify the funeral director so that he/she may correct the error. If the item has not been completed enter the exact date of death (month, day, year). The month portion of the date must be spelled out (do not use numbers). You may abbreviate.

Item 7 County and Location Pronounced Dead

The completion of these items are usually handled by the funeral director. As the information recorded reflects the place where the decedent was first pronounced dead, the funeral director should be notified if there is an error in these entries.

Should these items be blank when certifying to the death, entering the appropriate information is permissible.

Item 7a must contain the name of the hospital or institution or the address for the location where pronounced dead.

Enter the name of the city, village or township in item 7b where the death occurred.

The county where the body was located when first pronounced dead is entered in item 7c.

Item 27a Certifier

The first box should be checked if the case is determined not to be a medical examiner's case and the physician is certifying to the death facts. The certifying physician must sign and enter his/her degree, title or position in this space.

The second box should be checked if this is determined to be a medical examiner's case and the medical examiner or his/her authorized representative certifies to the medical information on the death certificate. The medical examiner or his/her authorized representative must sign and enter his/her degree, title or position in this space.

If the second box is checked the authorized representative must be a physician deputized as a medical examiner.

Item 27b Date Signed

The month, day and year the certifier signed the certificate must appear here. The

month the certifier signed the certificate should appear in full or in standard

abbreviation (Jan., Feb., March, etc). The year should also be complete such as 2004 instead of '04.

Item 27c License Number

Enter the state license number of the physician or medical examiner who signs the certificate as the certifier of the medical facts (item 27a).

Item 28a Actual or Presumed Time of Death

The actual or presumed time of death (hours and minutes) should appear in this item. If the exact time of death is unknown, enter the approximate time. If the time of death cannot be approximated, this item may be indicated as 'unknown'.

Item 28b Pronounced Dead On

The month, day and year the decedent was pronounced dead should appear here.

Item 28c Time Pronounced Dead

The time the decedent was pronounced dead (hours and minutes) should appear in this item.

Item 29 Was Medical Examiner Contacted?

"Yes" should be entered if the medical examiner was contacted in regard to the case, otherwise "no" should be entered. The medical examiner should be contacted when a death: involves violence, is accidental, is unexpected, is due to abortion, is to a prisoner, has no known cause of death, is unattended or is to someone who has not seen a doctor in more than ten days.

It is possible that the medical examiner might be contacted regarding a case but he/she may determine that medical examiner involvement is not necessary. In that situation, the medical examiner has no further responsibility in the completion of the death certificate. If the death is determined to be a medical examiner's case, refer to Instructions for Medical Examiners.

This item should not be left blank.

Item 30 Place of Death

A categorical description of the place where death was **pronounced**, as listed in item 7, should appear in this item.

This item should not be left blank.

Note: The actual place of death, which was collected prior to 2004 is no longer recorded.

Item 31 If Hospital

If the description of the place pronounced dead in item 30 is a hospital, an entry specifying inpatient, outpatient, emergency room patient or dead on arrival, must appear here.

If the decedent was pronounced dead in a nursing home or in any place other than a hospital, this item may be left blank.

Item 33 Name of Attending Physician if Other than Certifier

The name of the attending physician if other than the certifier should appear here. If the certifier is the attending physician no entry is required.

Item 34 Certifying Physician

This section allows for the entry of the physician's certification.

Item 36 Cause of Death

A cause of death is a disease, abnormality, injury or poisoning that contributed directly or indirectly to death. A death often results from the combined effect of two or more conditions. These conditions may be completely unrelated, arising independently of each other; or they may be causally related to each other, that is, one condition may lead to another which in turn leads to a third condition, etc. The cause of death section of the Michigan Certificate of Death is designed to elicit the opinion of the medical certifier as to the immediate cause of death and the antecedent causes, as well as the contributing causes of death.

Note, that it is not permissible to report the cause of death as "unknown" in any circumstance nor can the cause be reported as "pending" by the attending physician. A pending cause of death is acceptable only if the death is certified by the medical examiner.

Part I Cause of Death

Conditions which caused the death of the individual are to be entered in this section.

The entries in the section must be ordered etiologically so as to imply the underlying cause of the death. The underlying cause of death is the disease or injury responsible for initiating the lethal sequence of events. This underlying cause of death is the condition that started the sequence of events between normal health and the immediate cause of death.

The mode of dying (e.g., cardiac arrhythmia, cardiac or respiratory arrest, renal failure, heart failure, asphyxia) should not be stated at all since it is no more than a symptom of the fact that death occurred and provides no useful information. These mechanisms of death lack any etiologic specificity and are reflections of the effects of the conditions which led to the death but do not serve to identify the causes of the death.

The cause of death section cannot be left blank. In addition, reporting “Unknown” or “Natural Causes” are not acceptable entries. A death certificate can be accepted for registration when the cause of death is reported using terms for the mode of dying as the cause of death. Note, however, that the physician will be contacted by state vital records registry staff for clarification in such cases.

Only one cause is to be entered on each line of Part I. The underlying cause of death should be entered on the lowest line used in Part I.

Line a Immediate Cause

The direct or immediate cause of death is reported on line a. This is the disease, injury or complication that directly preceded death. It can be the sole entry in the cause of death statement if only one condition was present at death. There must always be an entry on line a.

Line b Due to or as a Consequence of

The disease, injury or complication, if any, which gave rise to the direct or immediate cause of death is reported on line b. This condition must be considered to have been antecedent to the immediate cause, both with respect to time and etiological or pathological relationship. If it is believed to have prepared the way for the immediate cause, a condition can be considered as antecedent to the immediate cause even though a long interval of time has elapsed since its onset.

Line c Due to, or as a Consequence of

The condition, if any, which gave rise to the antecedent condition on line b is reported on line c. This condition must be considered to have been antecedent to the cause entered on line b, both with respect to time and etiology or pathological relationship. This condition can be antecedent to the cause entered on line b even though a long interval of time has elapsed since its onset.

Line d Due to, or as a Consequence of

The condition, if any, which gave rise to the antecedent condition on line c is reported on line d. This condition must be considered to have been antecedent to the cause entered on line c and to otherwise relate to cause listed in line c as case outlined above for the cause in line c as related to line b.

If the decedent had more than four causally related conditions leading to death, lines e, f, etc. should be added by the certifier so all conditions related to the immediate cause of death are entered in Part I with only one condition to a line.

Interval Between Onset and Death

Space is provided at the end of lines a, b, c and d for recording the interval between onset and death for the immediate cause, antecedent condition, if any, and underlying cause. These intervals usually are established by the physician on the

basis of information available. The time of onset may be obscure or entirely unknown, in which case the physician can state that the interval is "unknown." A certificate can be registered if the interval between onset and death was omitted, but the physician may be contacted by state vital records registry staff for clarification in such cases.

DO NOT LEAVE THE INTERVAL BLANK.

Part II Other Significant Conditions

Any other important disease or condition that was present at the time of death which may have contributed to death but which was not related to the immediate cause of death listed on line a should be recorded on this line. For example, a patient who died of metastasis from carcinoma of the breast may also have had a hypertensive heart disease that contributed to the death. In this case, the hypertensive heart disease would be entered in Part II as a contributory cause of death.

This item may be blank, when so indicated.

Items 37-40 must reflect the individual who has taken responsibility for certifying to the cause(s) of the decedent's death. If the medical examiner has taken charge of the case and has checked the box so indicating, these items must pertain to the medical examiner.

Item 37 Did Tobacco Use Contribute to Death?

Choose 'yes' if, in your opinion, any use of tobacco or tobacco exposure contributed to the death of the decedent. For example, tobacco use may contribute to deaths due to emphysema or lung cancer. Tobacco use also may contribute to some heart disease and cancers of the head or neck. Tobacco use should also be reported in deaths due to fires due to smoking.

Check 'yes' if in the physician's clinical judgment, tobacco use contributed to this particular death.

Check 'probably' if tobacco use may have contributed to the death.

Check 'no' if, in the physician's opinion, the use of tobacco did not contribute to death.

Unknown may be selected if the physician has no knowledge of tobacco exposure or use by the decedent.

Item 38 If Female

If the decedent is a female, check the appropriate box. If the decedent is a male, leave the item blank. If the female is either too old or too young to be fecund, check the not pregnant within the last year box.

Item 39 Manner of Death

Complete this item for all deaths. Deaths not due to external causes should be identified as 'natural'.

If the manner of death is natural, no entry is required in items 41a through 41g.

Note that beginning in 2004, **the manner of death item should be completed for all deaths including those not certified by a medical examiner.**

Note also that an entry of other than natural implies a medical examiner should be contacted on the death.

Item 40a Was an Autopsy Performed?

Enter "yes" if a partial or complete autopsy was performed. Autopsy should involve both external and internal (organ dissection) examination of the body. If no autopsy was performed, enter "no."

Item 40b Were Autopsy Findings Available Prior to Completion Of Cause Of Death?

Enter "yes" if the autopsy findings were available and used to determine the cause of death. Otherwise, enter "no." If no autopsy was performed, leave this item blank.