DH-PHS-DC-CORR-MED-04/2011

STATE OF VERMONT
DEPARTMENT OF HEALTH
REQUEST TO CORRECT A DEATH CERTIFICATE

Changes to medical information may only be requested by the Certifying Physician or Medical Examiner

It is requested that the death certificate for _____ (First Name) _____ (Last Name) who died on _____ (mm/dd/yyyy)

In the town/city of _____ be corrected or completed with the following information.

MEDICAL CERTIFICATION

27. Manner of Death

☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could Not Be Determined

28. CAUSE **PART I.**

The following information should ___ **Replace** *or* ___ **Add to** *the cause part I as it appears on certificate.*

APPROXIMATE INTERVAL: ONSET TO DEATH

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):

29. CAUSE **PART II.** *Enter other significant conditions contributing to death but not resulting in the underlying cause given in* ***PART I.***

The following information should ___ **Replace** *or* ___ **Add to** *the cause part I as it appears on certificate.*

_____

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

31. 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.

32a. WAS MEDICAL EXAMINER CONTACTED?
☐ Yes ☐ No

32b. M.E. CASE NUMBER _____

33. WAS AN AUTOPSY PERFORMED?
☐ Yes ☐ No

34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH?
☐ Yes ☐ No

35. DATE OF INJURY *(Month, Day, Year)* _____

36. TIME OF INJURY _____
☐ AM ☐ PM

37. PLACE OF INJURY *(e.g. Decedent's home, construction site, restaurant, wooded area)* _____

38. INJURY AT WORK?
☐ Yes ☐ No

39. LOCATION OF INJURY *(Street and Number, City or Town, State)* _____

40. DESCRIBE HOW INJURY OCCURRED _____

41. IF TRANSPORTATION INJURY, SPECIFY:
☐ Driver/Operator ☐ Pedestrian
☐ Passenger ☐ Other (specify) _____

OTHER CORRECTIONS:

_____

Print Name of Person Requesting Change _____

Authority to Request Change
☐ Medical Examiner
☐ Medical Certifier

Phone Number: _____

Vermont Department of Health – Vital Records
108 Cherry Street – P.O. Box 70
Burlington, VT 05402-0070
802-863-7275

Date of Request: