

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 _____ who died on _____
First Name Last Name mm/dd/yyyy

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

MEDICAL CERTIFICATION

27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could Not Be Determined			
28. CAUSE PART I. <i>The following information should ___ Replace or ___ Add to the cause part I as it appears on certificate.</i>			APPROXIMATE INTERVAL: ONSET TO DEATH
a. _____ <small>Due to (or as a consequence of):</small>			_____
b. _____ <small>Due to (or as a consequence of):</small>			_____
c. _____ <small>Due to (or as a consequence of):</small>			_____
d. _____			_____
29. CAUSE PART II. <i>Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I</i> <i>The following information should ___ Replace or ___ Add to the cause part I as it appears on certificate.</i>			
30. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> NO <input type="checkbox"/> Unknown		31. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not Pregnant but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the past year. <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death	
32a. WAS MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No	32b. M.E. CASE NUMBER _____	33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No
35. DATE OF INJURY <small>(Month, Day, Year)</small> _____	36. TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM	37. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) _____	38. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
39. LOCATION OF INJURY (Street and Number, City or Town, State) _____			
40. DESCRIBE HOW INJURY OCCURRED _____		41. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (specify) _____	
OTHER CORRECTIONS: _____			
Name of Person Requesting Change _____ Date of Request: _____		Authority to Request Change <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Funeral Director/ <input type="checkbox"/> Certifying Physician <input type="checkbox"/> Authorized Person	
		Phone Number: _____	

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

To submit your request:

- 1) E-mail the completed form to EDRS@vermont.gov
- OR
- 2) Fax the completed form to 802-651-1787