Department of Health
Center for Health Statistics

DRAFT Guidelines

Title:	Completion of Death Certificates	*Number: XXXX*
References:	RCW 70.58.170	
Effective Date:	TBD	

The Department of Health provides this guideline for medical and osteopathic physicians, physician assistants, advanced registered nurse practitioners, coroners and medical examiners to follow when completing death certificates.

The Department receives complaints that medical providers fail to complete death certificates in a timely manner or fail to accurately list the cause of death on the death certificate. The death certificate provides important information about the decedent and the cause of death. Death certification errors are common and range from minor to severe.

Under RCW 70.58.170, a funeral director or person having the right to control the disposition of human remains must present the death certificate to the physician, physician assistant or nurse practitioner last in attendance upon the deceased. The certifying clinician then has two business days to certify the cause of death according to his or her best knowledge and sign or electronically approve the certificate, unless there is good cause for not doing so. The certifying clinician should register cause and manner of death information through the Washington State Electronic Death Reporting System (EDRS). The EDRS facilitates timely registration of the death and rapid collection of cause and manner of death information. The EDRS can be found at https://fortress.wa.gov/doh/edrs/EDRS/.

The death certificate is a public legal document that deserves the certifying physician's best effort to ensure that it contains precise and accurate information. The death certificate serves different medical, statistical, and legal functions. The death certificate has the vital function of providing the synopsis of the cause and manner of death. It is in this scientific role that the certifying clinician has a responsibility to the general public's health and advancement of medical science.
The cause and manner of death documented on a death certificates is coded to national and World Health Organization standards using the International Classification of Diseases, 10th Revision by the National Center for Health Statistics, a division of the Centers for Disease Control and Prevention (CDC). These coded data, collected by all states, are used by CDC, states, local health jurisdictions, and researchers to calculate life expectancy and mortality rates by race, age, sex, educational attainment, veteran status, and geographic area. These data are also used to determine which medical conditions receive research and development

funding, to set public health goals, monitor disease outbreaks, and to measure health status at local, state, national, and international levels.

The completion of the death certificate also serves several different functions for the patient's family, loved ones, and estate. The death certificate is crucial as legal proof of death. From a genealogical viewpoint, the death certificate serves as a historical reference to an individual, recounting name, dates and places of birth and death, parent's names, as well as other useful demographic information. Providing accurate and timely cause and manner of death information is a final act of care for the decedent, their family, and their loved ones.

Recommendation

Certifying clinicians who complete death certificates should meet the standard of care in completing all the information to the best of their ability. This must be done in a timely manner. The physician or physician assistant must certify the cause and manner of death if he or she pronounced the death, were the first medical certifier to observe the decedent (e.g. died in transport to the emergency department), were the primary care provider for the decedent and recently treated the decedent, or is covering for another physician who is unavailable. If a medical certifier pronounces the death but does not have enough information to accurately and precisely fill out the cause and manner of death, the medical certifier may consult with another clinician or clinician's records.

Deaths known or suspected of having been caused by injury or poisoning must be reported to the medical examiner or coroner, and the medical examiner or coroner will make the decision as to who completes the cause and manner of death.

Guideline

The Department provides this guideline for practitioners completing death certificates.

Cause of Death

There are four lines or spaces provided to report the etiology of the cause of death. A complete logical sequence should be reported that explains why the patient died. The sequence may be an etiological or pathological sequence as well as a sequence in which an earlier condition is believed to have prepared the way for a subsequent condition by damage to tissues or impairment. The immediate cause of death should be on the top line and should be the condition that occurred closest to the time of death. Do not list a mechanism of death, such as cardio-pulmonary arrest, respiratory arrest, electromechanical dissociation, or asystole. No other entry is needed if the immediate cause of death explains completely the chain of events resulting in death. What is of most scientific interest is not the immediate cause of death, but the specific disease condition or injury that set in motion the events leading to death (i.e., the underlying cause of death). On the remaining three lines, sequentially list antecedent causes, if any, that lead to the immediate cause of death. Terminate the sequence with the underlying cause of death and leave unused lines or spaces blank.

If the attending physician or physician assistant has not seen the patient for a period of time he or she should apply medical training, knowledge of medicine, available medical history,

symptoms, diagnostic test and autopsy results to render a medical opinion on the cause of death, and qualify the etiology by use of words such as 'probable' or 'presumed' or, as a last resort, state the cause of death as 'unknown'.

Provide the best estimate of the interval between the presumed onset of each condition (not the date of diagnosis) and death. The terms approximately or unknown may be used. Indicate if the time interval is unknown.

Conditions that were present at the time of death and may have contributed to death but did not result in the immediate cause of death should be listed in the box listed "Significant Conditions Contributing to Death". If two or more possible sequences resulted in death, report the one that in your opinion most directly caused death in the cause of death section. Report the other conditions in the "Significant Conditions Contributing to Death" box.

- Cause of death information should be your best medical opinion
- List only one condition per line or space in the cause of death section. If you need more lines or spaces to describe the train of events leading to death, you may write more than one condition per line if the conditions are separated by the words "due to"
- Avoid abbreviations
- A condition can be listed as probable, possible or presumed even if it has not been diagnosed
- Elderly terms such as senescence, old age, and advanced age have little value for public health or medical research. The decedent's age is already listed on the death certificate.
- Infant prematurity should not be entered without explaining the etiology of the prematurity
- Surgery, Procedure, or Medication--report the condition that necessitated the treatment
- Always report an etiology for organ system failure such as congestive heart failure, renal failure, or respiratory failure in the lines below it
- Always report an etiology for cardiac arrest, cirrhosis, dementia, hemorrhage, malnutrition, aspiration, inhalation, asphyxia, dehydration, hepatitis, pneumonia, or sepsis
- Report a primary site and/or histological type for neoplasms
- If information with regard to specificity, etiology, pathology, or cause of death is unknown, indicate explicitly that this is the case

If additional medical information or autopsy findings become available that would change the cause of death originally reported, the original death certificate should be amended by the certifying physician or physician assistant by filing an affidavit of correction with the Department of Health.

Examples:

Part I. Diseases, injuries, or complications that caused the death.

		Approximate interval between onset and death
Immediate cause a.	Acute renal failure	5 days
	Due to (or as a consequence of)	
Sequentially list antecedent causes, if any, leading to the immediate cause with underlying cause last — b.	Hyperosmolar nonketotic coma	8 days
	Due to (or as a consequence of)	
c.	Diabetes mellitus, non-insulin dependent	15 years
	Due to (or as a consequence of)	
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause

Hypertension

Part I. Diseases, injuries, or complications that caused the death.

		Approximate interval between onset and death
Immediate cause a.	Pulmonary embolism	30 min
	Due to (or as a consequence of)	
Sequentially list antecedent causes, if any, leading to the immediate cause with underlying cause last — b.	Acute iliofemoral deep venous thrombosis	5 days
	Due to (or as a consequence of)	
c.	Congestive heart failure	4 years
	Due to (or as a consequence of)	
d.	Hypertension	years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause

Poorly differentiated adenocarcinoma of the prostate, old myocardial infarction

Manner of Death

Choose from natural, homicide, suicide, accident, undetermined or pending. Refer all deaths due to injury or poisoning to the medical examiner or coroner. Complete the cause and manner of death if the medical examiner or coroner does not accept the case. Pending is used if you are waiting on toxicology or other test results. The record should be amended by the

certifying physician filing an Affidavit of Correction with the Department of Health once the results are received.

Time of death (Hour of death)

The exact time should be entered, if known, using the 24 hour clock.

Checkboxes

1. *Autopsy*

   Yes or no

2. Autopsy results available to complete the cause of death

   Yes or no

3. *Pregnancy*

   This must be answered if the decedent was female and ages 10 to 55. The check boxes include responses for women who are pregnant at the time of death as well as options for women who were pregnant up to one year before their death. Pregnancy includes live births, fetal deaths, and abortions.

4. *Tobacco*

   Yes, probably, no or unknown if to the best of your knowledge use of tobacco or exposure to tobacco contributed to death.

Injury Information

Most injury deaths are accepted for cause of death certification by the medical examiner or coroner. Occasionally, especially for deaths where a fall in someone elderly is on the causal pathway, a physician or physician assistant will fill out the cause and manner of death. In the instance where this occurs, the injury information must be filled out.

1. *Date of injury*
   Enter the act the actual date, if known.

2. *Time of injury (hour of injury)*
   Enter the exact time, if known, using the 24 hour clock.

3. *Place of injury.*
   Enter the general type of place where the injury occurred. Do not enter firm or organization names.

4. *Injury at work?*

   Enter yes if injury occurred at work.

5. *Location of Injury*

   Enter the complete address including ZIP Code. Fill in as many of the items as known.

6. *Describe how the injury occurred*

   Enter in narrative form, a brief description of how the injury occurred. Explain the circumstances or cause of the injury. If the injury is a fall, describe how the fall occurred, if the fall involved an object (ladder, stairs, wheelchair, furniture, bed), other person (supported or carried by another person), or if the fall occurred from tripping or falling from the same level (standing or sitting to the floor or from the toilet to the floor) or from another level (hole or well).

Name and Title of the Attending Physician (if other than Certifier)

This is optional and would be the attending physician of record that is different than the medical certifier filling out the death certificate. It is helpful to have this name if the certifier is a medical resident and may not be available to answer questions about the cause of death information.

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References:

Medical Quality Assurance Commission. (2011, September). Death Certificate Rules Revisited. Update!. Volume 1, Fall. p. 10. Retrieved from www.doh.wa.gov/Portals/1/Documents/Pubs/658004.pdf.

"Physicians Handbook on Medical Certification of Death." U.S. Department of Human and health Services, Centers for Disease Control and Prevention, National Center for Health Statistics, 2003 Revision, page 1