Ministry of Consumer and Business Services
Office of the Registrar General

Ontario

Medical Certificate of Death - Form 16

Hospital code number

You must use the Stillbirth Registration Form 8 when registering stillbirths. This form must be complete by the attending physician, coroner, or designated person before a burial permit can be issued. Please PRINT clearly in blue or black ink as it is a permanent legal record.

INFORMATION ABOUT THE DECEASED

1. Name of deceased (last, first, middle)
patSurname, patFirstName patMiddleName

2. Date of death [month - *by name*, day, year *(in full)*]

3. Sex (M or F)
patSex

4. Age
patAge

5. If under 1yr. Months / Days

6. If under 1 day Hours / Minutes

7. Gestation age

8. Birth weight

9. Place of death (name of facility or location)
☐ hospital ☐ nursing home ☐ residence ☐ other (specify):

10. City, town village or township

Regional municipality, county or district

CAUSE OF DEATH

CAUSE OF DEATH

11. **Part I** — **Approximate interval between onset & death**

Immediate cause of death **(a)**

due to, or as a consequence of

(b)

Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last

due to, or as a consequence of

(c)

due to, or as a consequence of

(d)

Part II
Other significant conditions contributing to the death but not causally related to the immediate cause (a) above

12. If deceased was a female, did the death occur: ☐ during pregnancy (including abortion and ectopic pregnancy) ☐ within 42 daysvc thereafter ☐ between 43 days and 1 year thereafter

13. Was the deceased dead on arrival at the hospital? ☐ Yes ☐ No

14. Was there a surgical procedure within 28 days of death? ☐ Yes ☐ No

15. Date of surgery (m/d/y)

16. Reason for surgery and operative findings

Autopsy particulars

17. Autopsy being held? ☐ Yes ☐ No

18. Does the cause of death states above take account of autopsy findings ☐ Yes ☐ No

19. May further information relating to the cause of death be available later? ☐ Yes ☐ No

Accidental or violent death (if applicable)

20. If accident, suicide, homicide or undetermined (specify)
---

21. Place of injury (e.g. home, farm, highway, etc.)

22. Date of injury (m/d/y)

23. How did injury occur? (describe circumstances)

CERTIFICATION

By signing below, you certify that the information on this form is correct to the best of your knowledge.

24. Your signature (physician, coroner, RN(EC), other)
X

25. Date (m/d/y)

26. Your name (last, first, middle)

27. Your title: ☐ Physician ☐ Coroner ☐ RN(EC) ☐ other (specify)

28. Your address (street number and name, city, province, postal code)

TO BE COMPLETED BY THE DIVISION REGISTRAR

By signing below, I am satisfied that the information in this Medical certificate of death and the Statement of death is correct and sufficient and I agree to register the death.

Signature
X

Date (m/d/y)

Registration number

Div. reg. code no.

For the use of the Office of the Registrar General only

Personal information contained in this form is collected under the authority of the Vital Statistics ACt, R.S.O. 1990, c.v.4 and will be used to register and record the births, still-births, deaths, marriages, additions or change of name, corrections or amendments, provide certified opies, extracts, certificates, search notices, photocopies and for statistial, research, medical, law enforcement, adoption and adoption disclosure purposes. Questions about this collection should be directed to the Deputy Registrar General at P.O. Box 4600, Thunder Bay, ON P7B 6L8. Telephone 1-800-461-2156 or 416-325-8305

11291(07/01)