

LF _____
CF _____STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER _____

NAME OF DECEDENT
For use by physician or institution

PARENTS

INFORMANT

DISPOSITION

CERTIFICATION

CAUSE OF
DEATHMEDICAL
EXAMINER

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF BIRTH (Month, Day, Year)		3. SEX		4. DATE OF DEATH (Month, Day, Year)			
5. NAME AT BIRTH OR OTHER NAME USED FOR PERSONAL BUSINESS (include AKA's if any)				6a. AGE - Last Birthday (Years)		6b. UNDER 1 YEAR MONTHS DAYS		6c. UNDER 1 DAY HOURS MINUTES	
7a. LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c) HOSPITAL OR OTHER INSTITUTION - Name (if not in either, give street and number and zip code)				7b. CITY, VILLAGE, OR TOWNSHIP OF DEATH			7c. COUNTY OF DEATH		
8a. CURRENT RESIDENCE - STATE		8b. COUNTY		8c. LOCALITY (check the box that describes the location) <input type="checkbox"/> CITY OR VILLAGE (inside limits of) <input type="checkbox"/> TOWNSHIP <input type="checkbox"/> UNINCORPORATED PLACE			8d. STREET AND NUMBER (Include Apt. No. if applicable)		
8e. ZIP CODE		9. BIRTHPLACE (City and State or Country)			10. SOCIAL SECURITY NUMBER		11. DECEDENT'S EDUCATION - What is the highest degree or level of school completed at the time of death?		
12. RACE - American Indian, White, Black, etc. (if Asian, give nationality, ie. Chinese, Filipino, Asian Indian, etc.) (Enter all that apply)			13a. ANCESTRY - Mexican, Cuban, Arab, African, English, French, Dutch, etc. (Enter all that apply) If American Indian race, enter principal tribe			13b. HISPANIC ORIGIN (Yes or No)		14. WAS DECEDENT EVER IN THE U.S. ARMED FORCES? (yes or no)	
15. USUAL OCCUPATION Give kind of work done during most of working life. Do not use retired.			16. KIND OF BUSINESS OR INDUSTRY		17. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)		18. NAME OF SURVIVING SPOUSE (if wife, give name before first married)		
19. FATHER'S NAME (First, Middle, Last)				20. MOTHER'S NAME BEFORE FIRST MARRIED (First, Middle, Last)					
21a. INFORMANT'S NAME (Type/Print)			21b. RELATIONSHIP TO DECEDENT		21c. MAILING ADDRESS (Street and Number or Rural Route, City or Village, State, Zip Code)				
22. METHOD OF DISPOSITION Burial, Cremation, Entombment, Donation, Removal, Storage (Specify)		23a. PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other location)				23b. LOCATION - City or Village, State			
24. SIGNATURE OF MORTUARY SCIENCE LICENSEE			25. LICENSE NUMBER (of Licensee)		26. NAME AND ADDRESS OF FUNERAL FACILITY				
27a. CERTIFIER (Check only one) <input type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred at the time, place, and manner stated. <input type="checkbox"/> Medical Examiner - On the basis of examination, and/or investigation, and/or opinion, death occurred at the time, date, and place, and due to the cause(s) stated.				27b. DATE SIGNED (Mo. Day, Yr.)		27c. LICENSE NUMBER		27d. SIGNATURE	
29. MEDICAL EXAMINER CONTACTED? (Yes or No)				30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) (Specify)		31. IF HOSPITAL, Inpatient, Outpatient, Emergency Room, DOA (Specify)			
32. MEDICAL EXAMINER'S CASE NUMBER (if applicable)				33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)					
34. NAME AND ADDRESS OF ATTENDING PHYSICIAN (Type or Print)									
35a. REGISTRAR'S SIGNATURE						35b. DATE FILED (Month, Day, Year)			
36. PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. If diabetes was an immediate, underlying or contributing cause of death be sure to record diabetes in either Part I or Part II of the cause of death section, as appropriate. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, IF ANY, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I.									
39. MANNER OF DEATH - Accident, Suicide, Homicide, Natural, Indeterminate or Pending (Specify)				40a. WAS AN AUTOPSY PERFORMED? (Yes or No)		40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	
41a. DATE OF INJURY (Mo., Day, Yr.)		41b. TIME OF INJURY M		41c. DESCRIBE HOW INJURY OCCURRED					
41d. INJURY AT WORK (Yes or No)		41e. PLACE OF INJURY - At home, farm, street, construction site, wooded area, etc. (Specify)		41f. IF TRANSPORTATION INJURY - Driver/Operator, Passenger, Pedestrian, etc. (Specify)		41g. LOCATION - Street or RFD No. City, Village or Twp. State			