LF _____

CF _____

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

FOR USE BY PHYSICIAN OR INSTITUTION

DECEDENT

1 DECEDENT'S NAME *(First, Middle, Last)* | 2 SEX | 3 DATE OF DEATH *(Month, Day, Year)*

4a AGE - Last Birthday *(Years)* | 4b UNDER 1 YEAR: MONTHS / DAYS | 4c UNDER 1 DAY: HOURS / MINUTES | 5 DATE OF BIRTH *(Month, Day, Year)* | 6 COUNTY OF DEATH

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)* | 7b IF HOSP OR INST Inpatient, Op /Emer Room, DOA *(Specify)* | 7c. CITY, VILLAGE, OR TOWNSHIP OF DEATH

8 SOCIAL SECURITY NUMBER | 9a. USUAL OCCUPATION *(Give kind of work done during most of working life. Do not use retired)* | 9b KIND OF BUSINESS OR INDUSTRY

10a CURRENT RESIDENCE - STATE | 10b COUNTY | 10c. LOCALITY *(Check one box and specify)* ☐ INSIDE CITY OR VILLAGE OF ☐ TWP. OF | 10d STREET AND NUMBER

10e ZIP CODE | 11 BIRTHPLACE *(City and State or Foreign Country)* | 12 MARITAL STATUS - Married, Never Married, Widowed, Divorced *(Specify)* | 13 SURVIVING SPOUSE *(If wife, give name before first married)* | 14 WAS DECEDENT EVER IN U S ARMED FORCES? *(Specify Yes or No)*

15. ANCESTRY - Mexican, Puerto Rican, Cuban, Central or South American, Chicano, other Hispanic, Afro-American, Arab, English, French, Finnish, etc. *(Specify below)* | 16. RACE - American Indian, Black, White, etc. If Asian, give nationality i.e., Chinese, Filipino, Asian Indian, etc *(Specify below)* | 17. DECEDENT'S EDUCATION *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4 or 5 +)

PARENTS

18. FATHER'S NAME *(First, Middle, Last)* | 19 MOTHER'S NAME *(First, Middle, Surname before first married)*

INFORMANT

20a INFORMANT'S NAME *(Type/Print)* | 20b. MAILING ADDRESS *(Street and Number or Rural Route Number, City or Village, State, ZIP Code)*

DISPOSITION

21. METHOD OF DISPOSITION - Burial, Cremation, Removal, Donation, Other *(specify)* | 22a. PLACE OF DISPOSITION *(Name of Cemetery, Crematory, or other place)* | 22b. LOCATION - City or Village, State

23. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 24. LICENSE NUMBER *(of Licensee)* | 25. NAME AND ADDRESS OF FACILITY

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do **NOT** enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition → resulting in death)
a. _____ DUE TO (OR AS A CONSEQUENCE OF)

Sequentially list conditions, IF ANY, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____ DUE TO (OR AS A CONSEQUENCE OF)
c. _____ DUE TO (OR AS A CONSEQUENCE OF)
d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I | 27a. WAS AN AUTOPSY PERFORMED? *(Yes or No)* | 27b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? *(Yes or No)*

CERTIFIER

28. ACTUAL PLACE OF DEATH (Home, Nursing Home, Hospital, Ambulance) *(Specify)* | 29. WAS CASE REFERRED TO MEDICAL EXAMINER? *(Specify Yes or No)*

CERTIFYING PHYSICIAN

30a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated
(Signature and Title) ▶
30b. DATE SIGNED *(Mo., Day, Yr.)* | 30c. TIME OF DEATH M
30d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER *(Type or Print)*

MEDICAL EXAMINER

31a. *(Check one only)* ☐ The case reviewed and determined not to be a medical examiner's case. ☐ On the basis of examination and of investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner stated.
(Signature and Title) ▶
31b. DATE SIGNED *(Mo., Day, Yr.)* | 31c CASE NUMBER
31d PRONOUNCED DEAD *(Mo., Day, Yr.)* ON | 31e TIME OF DEATH M

32a NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) *(Type or Print)* | 32b LICENSE NUMBER

MEDICAL EXAMINER

33a ACC SUICIDE, HOM., NATURAL OR PENDING INVEST *(Specify)* | 33b DATE OF INJURY *(Mo., Day, Yr.)* | 33c. TIME OF INJURY M | 33d DESCRIBE HOW INJURY OCCURRED

33e INJURY AT WORK *(Specify Yes or No)* | 33f PLACE OF INJURY - At home, farm, street, factory, office building, etc *(Specify)* | 33g LOCATION - Street or R F D No | City, Village or Twp | State

34a REGISTRAR'S SIGNATURE ▶ | 34b. DATE FILED *(Month, Day, Year)*