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COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

CERTIFICATE OF DEATH

State File Number:

To Be Completed/Verified By: FUNERAL DIRECTOR

1. Decedent's Legal Name (First, Middle, Last, Suffix) | 2. Sex | 3. Social Security Number | 4. Date of Death (Mo/Day/Yr) (Spell Mo)

5a. Age-Last Birthday (Yrs) | 5b. Under 1 Year: Months, Days | 5c. Under 1 Day: Hours, Minutes | 6. Date of Birth (Mo/Day/Year) (Spell Month) | 7a. Birthplace (City and State or Foreign Country) | 7b. Birthplace (County)

8a. Residence (State or Foreign Country) | 8b. Residence (Street and Number - Include Apt No.) | 8c. Did Decedent Live in a Township? ☐ Yes, decedent lived in _____ twp. ☐ No, decedent lived within limits of _____ city/boro.

8d. Residence (County) | 8e. Residence (Zip Code)

9. Ever in US Armed Forces? ☐ Yes ☐ No ☐ Unknown

10. Marital Status at Time of Death ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown

11. Surviving Spouse's Name (If wife, give name prior to first marriage)

12. Father's Name (First, Middle, Last, Suffix)

13. Mother's Name Prior to First Marriage (First, Middle, Last)

14a. Informant's Name | 14b. Relationship to Decedent | 14c. Informant's Mailing Address (Street and Number, City, State, Zip Code)

15a. Place of Death (Check only one)

If Death Occurred in a Hospital: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

If Death Occurred Somewhere Other Than a Hospital: ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify) _____

15b. Facility Name (If not institution, give street and number) | 15c. City or Town, State, and Zip Code | 15d. County of Death

16a. Method of Disposition ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)_____

16b. Date of Disposition | 16c. Place of Disposition (Name of cemetery, crematory, or other place)

16d. Location of Disposition (City or Town, State, and Zip) | 17a. Signature of Funeral Service Licensee or Person in Charge of Interment | 17b. License Number

17c. Name and Complete Address of Funeral Facility

18. Decedent's Education - Check the box that best describes the highest degree or level of school completed at the time of death.
- ☐ 8th grade or less
- ☐ No diploma, 9th - 12th grade
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

19. Decedent of Hispanic Origin - Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.
- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify) _____

20. Decedent's Race - Check ONE OR MORE races to indicate what the decedent considered himself or herself to be.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Other (Specify) _____

ALIAS USED

21. Decedent's Single Race Self-Designation - Check **ONLY ONE** to indicate what the decedent considered himself or herself to be.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Don't Know/Not Sure
- ☐ Refused
- ☐ Other (Specify) _____

22a. Decedent's Usual Occupation - Indicate type of work done during most of working life. DO NOT USE RETIRED.

22b. Kind of Business/Industry

To Be Completed By: MEDICAL CERTIFIER

ITEMS 23a - 23d MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

23a. Date Pronounced Dead (Mo/Day/Yr) | 23b. Signature of Person Pronouncing Death (Only when applicable) | 23c. License Number

23d. Date Signed (Mo/Day/Yr) | 24. Time of Death

25. Was Medical Examiner or Coroner Contacted? ☐ Yes ☐ No

CAUSE OF DEATH

26. **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. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary

Approximate Interval: Onset to Death

IMMEDIATE CAUSE ----------> a. _____ Due to (or as a consequence of):

(Final disease or condition resulting in death)

b. _____ Due to (or as a consequence of):

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**.

c. _____ Due to (or as a consequence of):

d. _____ Due to (or as a consequence of):

26. **Part II.** Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I

27. Was an autopsy performed? ☐ Yes ☐ No

28. Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No

29. If Female:
- ☐ Not pregnant within past year
- ☐ Pregnant at time of death
- ☐ Not pregnant, but pregnant within 42 days of death
- ☐ Not pregnant, but pregnant 43 days to 1 year before death
- ☐ Unknown if pregnant within the past year

30. Did Tobacco Use Contribute to Death? ☐ Yes ☐ Probably ☐ No ☐ Unknown

32. Date of Injury (Mo/Day/Yr) (Spell Month)

31. Manner of Death ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

33. Time of Injury

34. Place of Injury (e.g. home; construction site; farm; school)

35. Location of Injury (Street and Number, City, State, Zip Code)

36. Injury at Work ☐ Yes ☐ No

37. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify) _____

38. Describe How Injury Occurred:

39a. Certifier (Check only one):
- ☐ Certifying physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated
- ☐ Pronouncing & Certifying physician - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated
- ☐ Medical Examiner/Coroner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated

Signature of certifier:_____ Title of certifier:_____ License Number:_____

39b. Name, Address and Zip Code of Person Completing Cause of Death (Item 26) | 39c. Date Signed (Mo/Day/Yr)

NAME OF DECEDENT

40. Registrar's District Number | 41. Registrar's Signature | 42. Registrar File Date (Mo/Day/Yr)

43. Amendments

State Use Only

Disposition Permit No._____

H105-143
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