

TYPE/PRINT
IN
PERMANENT
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STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATE OF DEATH

STATE FILE NUMBER
4027533

DECEDENT
NAME OF DECEDENT
For use by physician or institution
PARENTS
INFORMANT
DISPOSITION
CERTIFICATION
CAUSE OF DEATH
MEDICAL 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	
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 Number, 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 due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner - 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 and Title _____		28a. ACTUAL OR PRESUMED TIME OF DEATH M		28b. PRONOUNCED DEAD ON (Month, Day, Year)		28c. TIME PRONOUNCED DEAD M	
27b. DATE SIGNED (Month, Day, Year)		27c. LICENSE NUMBER		29. MEDICAL EXAMINER CONTACTED? (Yes or No)		30. PLACE OF DEATH (Home, Hospice, Nursing Home, Hospital, Ambulance) (Specify) HOSPITAL	
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 CERTIFYING 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, HEAVY, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST. a. _____ DUE TO (OR AS A CONSEQUENCE OF) _____ 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. 37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown 38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant but pregnant within 42 days of death <input type="checkbox"/> Not pregnant but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year							Approximate Interval Between Onset and Death
39. MANNER OF DEATH - Accident, Suicide, Homicide, Natural, Indeterminate, or Pending (Specify) Natural		40a. WAS AN AUTOPSY PERFORMED? (Yes or No) NO/yes		40b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) NO			
41a. DATE OF INJURY (Month, Day, Year)		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	