

Reg. Dist. No.: _____

COMMONWEALTH OF MASSACHUSETTS

State File No.: _____

Primary Reg. Dist. No.: _____

DEPARTMENT OF HEALTH

Registrar's No.: _____

VITAL STATISTICS

CERTIFICATE OF DEATH

Decedent's Name:		Sex:	Marital Status:	Surviving Spouse:	
Race:	Education:	Place of Death: <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other (specify) _____		Facility Name (address if residence):	
Decedent's Residence:					
Age (from last birthday):	Date of Birth:	Date of Death:	Decedent's Usual Occupation:		
Under 1 year (months/days):	Birthplace:	Kind of Business/Industry:			
Under 1 day (hours/minutes):					
Father's Name:		Mailing Address:			
Mother's Name:					
Informant's Name:					
Registrar's Signature:			Date Filed:		
Signature of Person Issuing Permit for Disposition:			Date Permit issued:		
Method of Disposition: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (specify) _____				Place of Disposition (cemetery, etc.):	
Name of Embalmer:		License #:			
Signature of Funeral Director or other person:		License #:		Date of Disposition:	
Certifier (Check only one):					
<input type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, place, and date and due to the cause(s) and manner as specified.					
<input type="checkbox"/> 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 as stated.					
Certifier's Signature and Title:		License #:	Date signed:	Time of Death:	
Name and Address of Person who Completed Cause of Death:			Was Case Referred to Coroner? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Pronounced Dead:
Immediate Cause (final disease or condition resulting in death):			Approximate interval between onset and death:		
Sequentially list conditions, if any leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST .					
a _____					
b _____					
c _____					
d _____					
Other significant conditions (contributed to death, but not resulting in Underlying Cause):			Was Autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were Autopsy findings available prior to completion of Cause of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Manner of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		Date of Injury:	Time of Injury:	Describe how Injury occurred:	
		Place of Injury:	Injury at Work?	Location:	