



# PHYSICIANS' BULLETIN

Donald G. Ramras, M.D.  
Health Officer, 236-2237

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## DEATH CERTIFICATE REVISED

The State's Certificate of Death has been revised significantly. Old copies of the certificate, dated 1/85, should be destroyed and only the new, dated 1/89, should be used. The following is an explanation of those changes along with a copy of the new certificate. Instructions cover only items in the shaded area, that portion of the certificate physicians are responsible for certifying.

Item 2A     **Date of Death.** While this section has not changed, it is important to note that the month must be spelled out or the standard abbreviation used. Do not use a number. This entry should be typewritten.

Item 2B     **Hour of Death.** This section has not changed but physicians are requested to use the 24-hour clock with no punctuation, i.e., for 8:00 p.m. use 2000 hours. This information should be typewritten.

Item 19     **Place of Death.** All sections of this item should be typewritten.

- A - Enter location where death occurred (e.g., residence, name of hospital, name of convalescent home, name of retirement home, etc.).
- B - If death occurred in an acute care hospital, enter "IP" for In-Patient, "ER/OP" for Emergency Room or Out-Patient, or "DOA" for Dead on Arrival. If death did not occur in an acute care hospital, enter a dash or "n/a."
- C - Enter the county of death.
- D - Enter the street address where the death occurred. P.O. boxes are not acceptable. Please enter the physical location.
- E - Enter the city of death.

Item 21     **Cause of Death.** For statistical and research purposes, the causes of death must be reported as specifically and precisely as possible. Enter one condition per line with the most recently developed condition at the top and the underlying cause on the lowest line used. It is not necessary to use all three lines; use as many as are appropriate, as many as will give a clear picture of the cause of death.

(MORE)

- A - Enter the immediate cause of death and the time interval between onset and death. This is the final disease or complication directly causing death. This does not mean the mode of dying. The mode of dying (for example, cardiac or respiratory arrest) is not specifically related to the disease process, but merely attests to the fact of death and provides no additional information on the cause of death.
- B - Enter the disease or complication, if any, that gave rise to the immediate cause of death and the interval between onset and death.
- C - Enter the underlying cause of death and the interval between onset and death. This is the disease that initiated the sequence of events leading directly to death.

**NOTE:** If death was caused by a complication of, or from an accident in surgery or other medical procedure, it is important to report what the complication or accident was, what medical procedure was performed, and what condition was being treated.

Item 22      **Report to Coroner.** Mark the appropriate box, "Yes" or "No." Enter the Coroner's waive (referral) number if "Yes" is marked. If you call the Coroner's office to report the case and they **do not** give you a waive number, you must mark "No." There are times when you may want to discuss a case with the Coroner's office, but they do not consider the case reportable. They will not issue a waive number because they do not want to inflate their statistics on reportable cases. Mark the "Yes" box only when you are given the waive number by the Coroner's staff.

Item 23      **Biopsy.** Mark "Yes" or "No" as appropriate.

Item 24A     **Autopsy.** Mark "Yes" or "No" as appropriate.

Item 24B     **Autopsy.** If autopsy findings were used in determining the cause of death, mark "Yes." If no autopsy was performed, this item may be left blank.

Item 25      **Other Conditions.** List other important diseases or conditions that were present at the time of death but did not lead to the underlying cause listed in Item 21. You **must** include the existence of any cancer (if not already listed in Item 21) per Health and Safety Code 10225.

Any disease, abnormality or injury you believe to have adversely affected the decedent should be reported. If the use of alcohol and/or other substances or a smoking history or a recent pregnancy was believed to have contributed to death, this condition should be reported. The conditions present at the time of death may be completely unrelated, arising independently of each other, or they may be causally related to each other.

Item 26      **Operations.** Enter the dates and types of any operations relating to a condition listed in Items 21 and 25.

Item 27A **Attendance Dates.** Enter the date the deceased was first attended and the date he or she was last attended alive. Report the death to the Coroner (694-2895) if the deceased had not been attended by a physician in the 20 days before death (Govt. Code Sec. 27491).

Items 27B-D **Signature.** The licensed physician last in attendance or his/her designated physician must sign the completed statement, including degree, license number, and date of certification. Rubber stamps or other facsimile signatures are not acceptable.

If the designated physician is signing in place of the attending physician, he/she must enter his/her own license number, but the dates of attendance must be those of the attending physician.

Item 27E **Typed Name.** Type in the name, degree and address of the attending physician. If the certificate is being signed by the designated physician, type in the name of the signing physician, the word "for" and the name and address of the attending physician (both names must appear).

If there are any questions on these instructions, please contact Vicki Call or Twila Scribner of County Health Services' Vital Records office, 236-2297.

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# CERTIFICATE OF DEATH

STATE OF CALIFORNIA

USE BLACK INK ONLY

STATE FILE NUMBER			LOCAL REGISTRATION DISTRICT AND CERTIFICATE NUMBER				
1A. NAME OF DECEDENT—FIRST (GIVEN)		1B. MIDDLE	1C. LAST (FAMILY)		2A. DATE OF DEATH— MONTH, DAY, YEAR	2B. HOUR	3. SEX
4. RACE		5. SPANISH/HISPANIC <input type="checkbox"/> YES _____ <input type="checkbox"/> NO <small>SPECIFY</small>		6. DATE OF BIRTH— MONTH, DAY, YEAR	7. AGE IN YEARS	IF UNDER 1 YEAR MONTHS    DAYS	IF UNDER 24 HOURS HOURS    MINUTES
DECEDENT PERSONAL DATA	8. STATE OF BIRTH	9. CITIZEN OF WHAT COUNTRY	10A. FULL NAME OF FATHER		10B. STATE OF BIRTH	11A. FULL MAIDEN NAME OF MOTHER	
	12. MILITARY SERVICE? 19__ To 19__ <input type="checkbox"/> NONE		13. SOCIAL SECURITY NUMBER	14. MARITAL STATUS	15. NAME OF SURVIVING SPOUSE (IF WIFE, ENTER MAIDEN NAME)		
	16A. USUAL OCCUPATION		16B. USUAL KIND OF BUSINESS OR INDUSTRY	16C. USUAL EMPLOYER	16D. YEARS IN USUAL OCCUPATION	17. NUMBER OF HIGHEST GRADE COMPLETED (1-12 OR COLLEGE 13-17+)	
	18A. RESIDENCE—STREET AND NUMBER OR LOCATION				18B. CITY	18C. ZIP CODE	
USUAL RESIDENCE	18D. COUNTY		18E. NUMBER OF YEARS IN THIS COUNTY	18F. STATE OR FOREIGN COUNTRY	20. NAME, RELATIONSHIP, MAILING ADDRESS AND ZIP CODE OF INFORMANT		
	19A. PLACE OF DEATH		19B. IF HOSPITAL, SPECIFY ONE: IP, ER/OP, DOA	19C. COUNTY			
PLACE OF DEATH	19D. STREET ADDRESS—STREET AND NUMBER OR LOCATION			19E. CITY		TIME INTERVAL BETWEEN ONSET AND DEATH	22. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> YES _____ <input type="checkbox"/> NO <small>REFERRAL NUMBER</small>
	21. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR A, B, AND C)—TYPE OR PRINT						23. WAS BLOODY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CAUSE OF DEATH	IMMEDIATE CAUSE { (A) _____ ▶						24A. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
	DUE TO { (B) _____ ▶						24B. IF YES, WAS IT USED IN DETERMINING CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
	DUE TO { (C) _____ ▶						
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN 21				26. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 21 OR 25? MONTH, DAY, YEAR			
PHYSICIAN'S CERTIFICATION	I CERTIFY THAT DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED FROM THE CAUSES STATED.			27B. SIGNATURE AND DEGREE OR TITLE OF PHYSICIAN		27C. PHYSICIAN'S LICENSE NUMBER	27D. DATE SIGNED
	27A. DECEDENT ATTENDED SINCE: MONTH, DAY, YEAR	DECEDENT LAST SEEN ALIVE: MONTH, DAY, YEAR		27E. TYPE ATTENDING PHYSICIAN'S NAME AND ADDRESS			
CORONER'S USE ONLY	I CERTIFY THAT DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED FROM THE CAUSES STATED.			28A. SIGNATURE OF CORONER OR DEPUTY CORONER			28B. DATE SIGNED
	29. MANNER OF DEATH—specify one: natural, accident, suicide, homicide, pending investigation or could not be determined		30A. PLACE OF INJURY	30B. INJURY AT WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	30C. DATE OF INJURY MONTH, DAY, YEAR	31. HOUR	
	32. LOCATION (STREET AND NUMBER OR LOCATION AND CITY)			33. DESCRIBE HOW INJURY OCCURRED (EVENTS WHICH RESULTED IN INJURY)			
FUNERAL DIRECTOR AND LOCAL REGISTRAR	34A. DISPOSITION		34B. PLACE OF FINAL DISPOSITION		34C. DATE OF DISPOSITION MONTH, DAY, YEAR		35A. SIGNATURE OF EMBALMER
	35A. NAME OF FUNERAL DIRECTOR (OR PERSON ACTING AS SUCH)		35B. LICENSE NO.	37. SIGNATURE OF LOCAL REGISTRAR		38. REGISTRATION DATE	
STATE REGISTRAR	A.	B.	C.	D.	E.	F.	CENSUS TRACT