



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:

**PLEASE PRINT OR TYPE ALL INFORMATION LEGIBLY AND CORRECTLY BELOW.**

**Section 1: DECEDENT'S INFORMATION**

STATE FILE NUMBER		DATE (MONTH, DAY, YEAR)	
DECEDENT'S FIRST NAME	MIDDLE NAME	LAST NAME	GENERATION (JR., II, III, ETC.)
DATE OF DEATH (MONTH, DAY, YEAR)		COUNTY OF DEATH	

**Section 2: CAUSE OF DEATH PART 1**

A. IMMEDIATE CAUSE (FINAL DISEASE OR CONDITION RESULTING IN DEATH)	APPROXIMATE INTERVAL: ONSET TO DEATH
B. DUE TO (OR AS A CONSEQUENCE OF)	APPROXIMATE INTERVAL: ONSET TO DEATH
C. DUE TO (OR AS A CONSEQUENCE OF)	APPROXIMATE INTERVAL: ONSET TO DEATH
D. DUE TO (OR AS A CONSEQUENCE OF)	APPROXIMATE INTERVAL: ONSET TO DEATH

**Section 3: CAUSE OF DEATH PART 2**

Alzheimer's Disease  
 Asthma  
 Blood Alcohol Content (BAC Value)  


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 Dementia  
 Diabetes  
 Hypertension  
 Obesity  
 Prescription Drug (Opioid) Overdose  
 Other \_\_\_\_\_  


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ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART1:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section 4: MANNER OF DEATH/AUTOPSY INFORMATION**

MANNER OF DEATH		AUTOPSY INFORMATION	
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide	CORONER CONTACTED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably	Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Were autopsy findings available to complete cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

DID TOBACCO USE CONTRIBUTE TO DEATH?	IF FEMALE AGED (10-54) PREGNANT	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	<input type="checkbox"/> Not pregnant within the 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 within 43 days to one year <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown if pregnant within the past year



**Section 5: INJURY INFORMATION**

DATE AND TIME OF INJURY		
ANY INJURY INFORMATION TO REPORT <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
DATE OF INJURY (MONTH, DAY, YEAR)	TIME OF INJURY	AM/PM
DESCRIBE HOW INJURY OCCURRED. IF TRANSPORTATION INJURY, STATE THE TYPE(S) OF VEHICLES INVOLVED. <hr/> <hr/>		
WAS INJURY RELATED TO A TRANSPORTATION INJURY ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	DECEDENT'S ROLE IN TRANSPORTATION INJURY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify): _____	
PLACE OF INJURY		
PLACE WHERE INJURY OCCURRED		
INJURY AT WORK <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
ADDRESS (STREET NAME & NUMBER, CITY, STATE, ZIP CODE, & COUNTY)		

**Section 6: SAFETY DEVICE(S)**

WHAT SAFETY DEVICE(S) DID DECEDENT USE/EMPLOY? <input type="checkbox"/> Seatbelt <input type="checkbox"/> Child Safety Seat <input type="checkbox"/> Helmet <input type="checkbox"/> Airbag <input type="checkbox"/> None <input type="checkbox"/> Unknown
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**Section 7: CERTIFIER**

CERTIFIER'S TYPE (E.G. PHYSICIAN, CORONER, ETC.)	CERTIFIER'S NAME	CERTIFIER'S OFFICE NAME
ADDRESS (STREET NAME & NUMBER, CITY, STATE, ZIP CODE, & COUNTY)		
CERTIFIER'S SIGNATURE		
DATE CERTIFIER SIGNED	WHO WILL BE HANDLING DISPOSITION?	