Attachment 32:
DOH-1961 Certificate of Death.pdf

New York State, Department of Health
Electronic Death Registration System
FAU 1002191052

NEW YORK STATE DEPARTMENT OF HEALTH
INSTRUCTIONS FOR COMPLETING THE DEATH CERTIFICATE PURSUANT TO SECTIONS 4102, 4140 AND 4165 OF THE PUBLIC HEALTH LAW.

1. REMOVE ONLY THIS INSTRUCTION SHEET BEFORE COMPLETING THIS CERTIFICATE.
2. TYPE ALL ENTRIES OR PRINT IN PERMANENT BLACK INK. This certificate has been designed for typewriter use.
3. COMPLETE ALL ITEMS. INCOMPLETE CERTIFICATES WILL BE RETURNED.
4. **ALL DATES MUST BE ENTERED IN NUMERICAL FORM - USE - MM DD YYYY**

Funeral Director is responsible for completing Items 1-24.
Either the Attending Physician, the Coroner and Coroner's Physician, or the Medical Examiner is responsible for completing Items 25-33.

INSTRUCTIONS FOR SELECTED ITEMS

ITEM NUMBER	CERTIFICATE ITEM
4A.	**PLACE OF DEATH.** If death occurred in a hospital, check one of the following: DOA for dead on arrival, ER for died in emergency room prior to admission, OUTPATIENT for died during outpatient visit, INPATIENT for died after admission to the institution. Check NURSING HOME if skilled nursing or long term care facility. If death occurred in PRIVATE RESIDENCE, check that. If death occurred in a HOSPICE FACILITY, check that. Under OTHER, include such places as: health related facility, psychiatric institution, group residence, school, etc.
4B.	**IF FACILITY, DATE ADMITTED.** Enter the date decedent was admitted to the institution where the death occurred.
4F.	**MEDICAL RECORD NUMBER.** If the death occurred in a hospital, nursing home, or mental health facility, enter the patient's medical record number. For Emergency Room deaths, where a medical record number was not assigned, enter the number that your hospital assigns to identify Emergency Room cases.
4G.	**WAS DECEDENT TRANSFERRED?** Check yes if decedent had been an inpatient in a hospital, nursing home or mental health facility and was directly transferred to the facility where the death occurred. This applies to all transfers regardless of the length of stay in the facility where the death occurred. Enter name of institution, city or town, county and state.
6A.B &C	**AGE** in years at last birthday, enter in 6A. If decedent is less than 1 year enter months/days in 6B. If decedent is less than 1 day enter hours/minutes in 6C.
8.	**SERVED IN U.S. ARMED FORCES?** Enter years of service, e.g. 1941-1944. If years of service are unknown, enter the war in which decedent served: WWI, WWII, etc.
9.	**DECEDENT OF HISPANIC ORIGIN?** Check the box that best describes whether the decedent was Spanish/Hispanic/Latino and specify origin where required. More than one box may be checked.
10.	**DECEDENT'S RACE:** Check the box or boxes that indicate what the decedent considered himself / herself to be and specify race where required. DO NOT enter HISPANIC in Item 10.
11.	**DECEDENT'S EDUCATION:** Check the box that best describes the highest degree or level of school completed at the time of death. (If highest degree is: AA, AS, etc. then check Associate's degree. If BA, AB, BS, etc. check Bachelor's degree. If MA, MS, MEng, MEd, MSW, MBA, etc. check Master's degree. If PhD, EdD, MD, DDS, DVM, LLB, JD, etc. check Doctorate/Professional degree.)
13.	**MARITAL STATUS** of the decedent at the time of death.
15A.	**USUAL OCCUPATION.** Enter the kind of work done most of decedent's working life. Do not enter retired.

ITEM NUMBER	CERTIFICATE ITEM
16.	**RESIDENCE.** Residence of the decedent is the place where he or she actually resided. This may not necessarily be the same as the mailing address. Do not give post office box or RD numbers; provide the highway or street name instead. The address of the decedent during military tour or attendance at college is the place of residence. If the decedent had been living in a nursing home or hospital for more than a full year, enter the institution as the place of residence. Do not enter a temporary residence such as one used during a vacation or business trip.
20A.	**DISPOSITION.** If disposition is anatomical gift, check DONATION. If the remains are being shipped out-of-state **and** the type of disposition is unknown, check REMOVAL. Otherwise, check the specific type of out-of-state disposition, i.e., BURIAL, CREMATION, etc.
25.	**CORONER OR MEDICAL EXAMINER.** If the coroner is not a New York State licensed physician, then the coroner must appoint a coroner's physician. The non-physician coroner must certify the death certificate by signing Item 25A. The coroner's physician must jointly certify the death certificate by signing Item 25B. Both signatures are required. **CERTIFYING OR ATTENDING PHYSICIAN.** If the Certifying Physician in 25A. is not the Attending Physician enter Attending Physician's information in 25C.
30.	**CAUSE OF DEATH. Part I.** Enter the diseases, injuries, or complications that caused death. Do not enter the mode of dying such as respiratory arrest or shock. List only one cause on each line. Line (A) contains the immediate cause or final disease or condition resulting in death. Sequentially list conditions, if any, leading to the immediate cause. Enter the underlying cause, that is, the disease or injury (trauma), that initiated the events resulting in death last. Enter tobacco, alcohol, illegal or prescribed drugs in Part I, if any of these substances or combination thereof contributed to the underlying cause of death. **Part II.** Indicate other significant conditions contributing to death but not resulting in the underlying cause in Part I. Enter tobacco, alcohol, illegal or prescribed drugs in Part II if any of these substances or combination thereof contributed to the death, but were not related to the cause given in Part I. Do not use abbreviations. Name of the decedent may be entered in the lower left margin at the time of certification. See below for examples. **DID TOBACCO USE CONTRIBUTE TO DEATH?** Indicate if tobacco use contributed to death.
31.	**IF INJURY.** Complete this item for all deaths that have not resulted from natural causes. In Item 31B, LOCALITY, enter city or town, county and state. In Item 31 D, PLACE, enter farm, office, beach, etc.
32.	**HOSPITALIZATION.** Do not include current hospitalization.

27. MANNER OF DEATH: NATURAL CAUSE ☒ 1 | ACCIDENT ☐ 2 | HOMICIDE ☐ 3 | SUICIDE ☐ 4 | UNDETERMINED CIRCUMSTANCES ☐ 5 | PENDING INVESTIGATION ☐ 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☒ NO 1 ☐ YES
29A. AUTOPSY? NO YES REFUSED: ☐ 0 ☒ 1 ☐ 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO 1 ☒ YES

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

CAUSE OF DEATH
PART I. IMMEDIATE CAUSE: (A) Rupture of myocardium — mins.
DUE TO OR AS A CONSEQUENCE OF: (B) Acute myocardial infarction — 6 days
DUE TO OR AS A CONSEQUENCE OF: (C) Chronic ischemic disease — 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☒ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN

DATE OF DEATH: MONTH DAY YEAR — AM/PM — TIME OF DEATH: HOUR: m
NAME OF DECEDENT: (For use by physician or institution)
31A. IF INJURY, DATE: MONTH DAY YEAR — HOUR: m
31B. INJURY LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO ☒ 0 YES ☐ 1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐ 0 YES ☒ 1
33A. IF FEMALE: 0 ☒ Not pregnant within last year 1 ☐ Pregnant at time of death 2 ☐ Not pregnant, but pregnant within 42 days of death 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death 4 ☐ Unknown if pregnant within past year
33B. DATE OF DELIVERY: MONTH DAY YEAR

Example of a death from a natural cause.

NOTE: If death was caused by drug overdose, include specific information regarding the drug or drugs involved. For example: Heroin overdose.

27. MANNER OF DEATH: NATURAL CAUSE ☐ 1 | ACCIDENT ☒ 2 | HOMICIDE ☐ 3 | SUICIDE ☐ 4 | UNDETERMINED CIRCUMSTANCES ☐ 5 | PENDING INVESTIGATION ☐ 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☐ NO 1 ☒ YES
29A. AUTOPSY? NO YES REFUSED: ☐ 0 ☒ 1 ☐ 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO 1 ☒ YES

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

CAUSE OF DEATH
PART I. IMMEDIATE CAUSE: (A) Cerebral laceration — 10 mins.
DUE TO OR AS A CONSEQUENCE OF: (B) Open skull fracture — 10 mins.
DUE TO OR AS A CONSEQUENCE OF: (C) Automobile accident — 10 mins.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☒ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN

DATE OF DEATH: MONTH DAY YEAR 11 15 2000 — AM/PM — TIME OF DEATH: HOUR: 2:06 p m
NAME OF DECEDENT: (For use by physician or institution)
31A. IF INJURY, DATE: MONTH DAY YEAR 11 15 2000 — HOUR: 2:06 p m
31B. INJURY LOCALITY: (City or town and county and state) Route 5 Colonie Albany NY
31C. DESCRIBE HOW INJURY OCCURRED: Car hit telephone pole
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO ☒ 0 YES ☐ 1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☒ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☒ 0 YES ☐ 1
33A. IF FEMALE: 0 ☒ Not pregnant within last year 1 ☐ Pregnant at time of death 2 ☐ Not pregnant, but pregnant within 42 days of death 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death 4 ☐ Unknown if pregnant within past year
33B. DATE OF DELIVERY: MONTH DAY YEAR

Example of a death from an injury.

DOH-1961 (10/2005)

RECORDED DISTRICT

REGISTER NUMBER

RESIDENCE

NCHS

4C

4G

7A

7B

SI

25

30

31

31B

QR

QS

QCOD

CANCER

NEW YORK STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT

1. NAME: FIRST MIDDLE LAST

2. SEX: MALE ☐ 1 FEMALE ☐ 2

3A. DATE OF DEATH: MONTH DAY YEAR

3B. HOUR: m

4A. PLACE OF DEATH: (Check one) HOSPITAL DOA ☐ ER ☐ HOSPITAL OUTPATIENT ☐ HOSPITAL INPATIENT ☐ NURSING HOME ☐ PRIVATE RESIDENCE ☐ HOSPICE FACILITY ☐ OTHER (Specify): ☐

4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR

4C. NAME OF FACILITY: (If not facility, give address)

4D. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐

4E. COUNTY OF DEATH:

4F. MEDICAL RECORD NO.

4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☐ YES ☐

5. DATE OF BIRTH: MONTH DAY YEAR

6A. AGE IN YEARS: yrs.

6B. IF UNDER 1 YEAR ENTER: months days

6C. IF UNDER 1 DAY ENTER: hours minutes

7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province)

7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☐ 0 YES ☐ 1

9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.
A ☐ No, not Spanish/Hispanic/Latino B ☐ Yes, Mexican, Mexican American, Chicano
C ☐ Yes, Puerto Rican D ☐ Yes, Cuban
E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)

10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be:
A ☐ White/Caucasian B ☐ Black or African American C ☐ Asian Indian D ☐ Chinese
E ☐ Filipino F ☐ Japanese G ☐ Korean H ☐ Vietnamese
J ☐ Native Hawaiian K ☐ Guamanian or Chamorro M ☐ Samoan
N ☐ American Indian or Alaska Native (specify)
P ☐ Other Asian (specify) R ☐ Other Pacific Islander (specify)
S ☐ Other (specify)

11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death.
1 ☐ ≤ 8th grade 2 ☐ 9th-12th grade, no diploma 3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree 5 ☐ Associate's degree 6 ☐ Bachelor's degree
7 ☐ Master's degree 8 ☐ Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER:

13. MARITAL STATUS: NEVER MARRIED ☐ 1 MARRIED ☐ 2 WIDOWED ☐ 3 DIVORCED ☐ 4 SEPARATED ☐ 5

14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name.

15A. USUAL OCCUPATION: (Do not enter retired)

15B. KIND OF BUSINESS OR INDUSTRY:

15C. NAME AND LOCALITY OF COMPANY OR FIRM:

16A. RESIDENCE: (State or Country if not USA)

16B. County or Region/Province if not USA:

16C. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐

16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☐YES ☐NO IF NO, SPECIFY TOWN:

16D. STREET AND NUMBER OF RESIDENCE:

16E. ZIP CODE:

PARENTS

17. NAME OF FATHER: FIRST MI LAST

18. MAIDEN NAME OF MOTHER: FIRST MI LAST

19A. NAME OF INFORMANT:

19B. MAILING ADDRESS: (include zip code)

DISPOSITION

20A. 1 ☐ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT MONTH DAY YEAR

20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION.

20C. LOCATION: (City or town and state)

21A. NAME AND ADDRESS OF FUNERAL HOME:

21B. REGISTRATION NUMBER:

22A. NAME OF FUNERAL DIRECTOR:

22B. SIGNATURE OF FUNERAL DIRECTOR:

22C. REGISTRATION NUMBER:

23A. SIGNATURE OF REGISTRAR:

23B. DATE FILED: MONTH DAY YEAR

24A. BURIAL OR REMOVAL PERMIT ISSUED BY:

24B. DATE ISSUED: MONTH DAY YEAR

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: License No.: Signature: Month Day Year

Certifier's Title: 0 ☐ Attending Physician 0 ☐ Physician acting on behalf of Attending Physician 1 ☐ Coroner 2 ☐ Medical Examiner / Deputy Medical Examiner Address:

25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: Month Day Year

25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address:

26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year

26B. Deceased last seen alive by attending physician: Month Day Year

26C. Pronounced Dead ON Month Day Year AT Time m

27. MANNER OF DEATH: NATURAL CAUSE ☐ 1 ACCIDENT ☐ 2 HOMICIDE ☐ 3 SUICIDE ☐ 4 UNDETERMINED CIRCUMSTANCES ☐ 5 PENDING INVESTIGATION ☐ 6

28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☐ NO 1 ☐ YES

29A. AUTOPSY? NO ☐ 0 YES ☐ 1 REFUSED ☐ 2

29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO 1 ☐ YES

CONFIDENTIAL **SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH** **CONFIDENTIAL**

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. IMMEDIATE CAUSE:
(A)
DUE TO OR AS A CONSEQUENCE OF:
(B)
DUE TO OR AS A CONSEQUENCE OF:
(C)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):

DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☐ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN

31A. IF INJURY, DATE: MONTH DAY YEAR HOUR: m

31B. INJURY LOCALITY: (City or town and county and state)

31C. DESCRIBE HOW INJURY OCCURRED:

31D. PLACE OF INJURY:

31E. INJURY AT WORK? NO ☐ 0 YES ☐ 1

31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)

32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐ 0 YES ☐ 1

33A. IF FEMALE
0 ☐ Not pregnant within last year 1 ☐ Pregnant at time of death 2 ☐ Not pregnant, but pregnant within 42 days of death
3 ☐ Not pregnant but pregnant 43 days to 1 year before death 4 ☐ Unknown if pregnant within past year

33B. DATE OF DELIVERY: MONTH DAY YEAR

For use by physician or institution:
NAME OF DECEDENT: _____
DATE OF DEATH: _____
AM/PM
TIME OF DEATH: _____

DOH-1961 (10/2005)

RECORDED DISTRICT

REGISTER NUMBER

RESIDENCE

NCHS

4C

4G

7A

7B

SI

25

30

31

31B

OR

QS

QCOD

CANCER

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL REGISTRAR COPY

DECEDENT

1. NAME: FIRST MIDDLE LAST

2. SEX: MALE ☐ 1 FEMALE ☐ 2

3A. DATE OF DEATH: MONTH DAY YEAR

3B. HOUR: m

4A. PLACE OF DEATH: (Check one) HOSPITAL DOA ☐ ER ☐ HOSPITAL OUTPATIENT ☐ HOSPITAL INPATIENT ☐ NURSING HOME ☐ PRIVATE RESIDENCE ☐ HOSPICE FACILITY ☐ OTHER (Specify): ☐

4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR

4C. NAME OF FACILITY: (If not facility, give address)

4D. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐

4E. COUNTY OF DEATH:

4F. MEDICAL RECORD NO.

4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☐ YES ☐

5. DATE OF BIRTH: MONTH DAY YEAR

6A. AGE IN YEARS: yrs.

6B. IF UNDER 1 YEAR ENTER: months days

6C. IF UNDER 1 DAY ENTER: hours minutes

7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province)

7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☐ 0 YES ☐ 1

9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.
A ☐ No, not Spanish/Hispanic/Latino
B ☐ Yes, Mexican, Mexican American, Chicano
C ☐ Yes, Puerto Rican
D ☐ Yes, Cuban
E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)

10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be
A ☐ White/Caucasian
B ☐ Black or African American
C ☐ Asian Indian
D ☐ Chinese
E ☐ Filipino
F ☐ Japanese
G ☐ Korean
H ☐ Vietnamese
J ☐ Native Hawaiian
K ☐ Guamanian or Chamorro
M ☐ Samoan
N ☐ American Indian or Alaska Native (specify)
P ☐ Other Asian (specify)
R ☐ Other Pacific Islander (specify)
S ☐ Other (specify)

11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death.
1 ☐ ≤ 8th grade
2 ☐ 9th-12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate's degree
6 ☐ Bachelor's degree
7 ☐ Master's degree
8 ☐ Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER:

13. MARITAL STATUS: NEVER MARRIED ☐ 1 MARRIED ☐ 2 WIDOWED ☐ 3 DIVORCED ☐ 4 SEPARATED ☐ 5

14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name.

15A. USUAL OCCUPATION: (Do not enter retired)

15B. KIND OF BUSINESS OR INDUSTRY:

15C. NAME AND LOCALITY OF COMPANY OR FIRM:

16A. RESIDENCE: (State or Country if not USA)

16B. County or Region/Province if not USA:

16C. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐

16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☐YES ☐NO IF NO, SPECIFY TOWN:

16D. STREET AND NUMBER OF RESIDENCE:

16E. ZIP CODE:

PARENTS

17. NAME OF FATHER: FIRST MI LAST

18. MAIDEN NAME OF MOTHER: FIRST MI LAST

DISPOSITION

19A. NAME OF INFORMANT:

19B. MAILING ADDRESS: (include zip code)

20A. 1 ☐ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT MONTH DAY YEAR

20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION.

20C. LOCATION: (City or town and state)

21A. NAME AND ADDRESS OF FUNERAL HOME:

21B. REGISTRATION NUMBER:

22A. NAME OF FUNERAL DIRECTOR:

22B. SIGNATURE OF FUNERAL DIRECTOR:

22C. REGISTRATION NUMBER:

23A. SIGNATURE OF REGISTRAR:

23B. DATE FILED: MONTH DAY YEAR

24A. BURIAL OR REMOVAL PERMIT ISSUED BY:

24B. DATE ISSUED: MONTH DAY YEAR

CERTIFIER

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: License No.: Signature: Month Day Year

Certifier's Title: 0 ☐ Attending Physician 0 ☐ Physician acting on behalf of Attending Physician 1 ☐ Coroner 2 ☐ Medical Examiner / Deputy Medical Examiner
Address:

25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: Month Day Year

25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address:

26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year

26B. Deceased last seen alive by attending physician: Month Day Year

26C. Pronounced Dead DN Month Day Year AT Time M

27. MANNER OF DEATH: NATURAL CAUSE ☐ 1 ACCIDENT ☐ 2 HOMICIDE ☐ 3 SUICIDE ☐ 4 UNDETERMINED CIRCUMSTANCES ☐ 5 PENDING INVESTIGATION ☐ 6

28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☐ NO 1 ☐ YES

29A. AUTOPSY? NO ☐ 0 YES ☐ 1 REFUSED ☐ 2

29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ ND 1 ☐ YES

CONFIDENTIAL **SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH** **CONFIDENTIAL**

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. IMMEDIATE CAUSE:
(A)
DUE TO OR AS A CONSEQUENCE OF:
(B)
DUE TO OR AS A CONSEQUENCE OF:
(C)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):

DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☐ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN

31A. IF INJURY, DATE: MONTH DAY YEAR HOUR: m

31B. INJURY LOCALITY: (City or town and county and state)

31C. DESCRIBE HOW INJURY OCCURRED:

31D. PLACE OF INJURY:

31E. INJURY AT WORK? NO ☐ 0 YES ☐ 1

31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)

32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐ 0 YES ☐ 1

33A. IF FEMALE: 0 ☐ Not pregnant within last year 1 ☐ Pregnant at time of death 2 ☐ Not pregnant, but pregnant within 42 days of death 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death 4 ☐ Unknown if pregnant within past year

33B. DATE OF DELIVERY: MONTH DAY YEAR

For use by physician or institution:
NAME OF DECEDENT:
DATE OF DEATH:
AM/PM
TIME OF DEATH:

DOH-1961 (10/2005)

RECORDED DISTRICT

REGISTER NUMBER

RESIDENCE

NCHS

4C

4G

7A

7B

SI

25

30

31

31B

QR

QS

QCOD

CANCER

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL HEALTH UNIT COPY

DECEDENT

1. NAME FIRST MIDDLE LAST | 2. SEX MALE ☐1 FEMALE ☐2 | 3A. DATE OF DEATH MONTH DAY YEAR | 3B. HOUR: m

4A. PLACE OF DEATH. (Check one) HOSPITAL DOA ☐ ER ☐ | HOSPITAL OUTPATIENT ☐ | HOSPITAL INPATIENT ☐ | NURSING HOME ☐ | PRIVATE RESIDENCE ☐ | HOSPICE FACILITY ☐ | OTHER (Specify) ☐ | 4B. IF FACILITY, DATE ADMITTED MONTH DAY YEAR

4C. NAME OF FACILITY (If not facility give address) | 4D. LOCALITY (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐ | 4E. COUNTY OF DEATH

4F. MEDICAL RECORD NO | 4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name city or town, county and state) NO ☐ YES ☐

5. DATE OF BIRTH: MONTH DAY YEAR | 6A. AGE IN YEARS yrs. | 6B. IF UNDER 1 YEAR ENTER months days | 6C. IF UNDER 1 DAY ENTER: hours minutes | 7A. CITY AND STATE OF BIRTH (If not USA, Country and Region/Province) | 7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☐0 YES ☐1

9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino
A ☐ No, not Spanish/Hispanic/Latino | B ☐ Yes, Mexican, Mexican American, Chicano
C ☐ Yes, Puerto Rican | D ☐ Yes, Cuban
E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)

10. DECEDENT'S RACE. Check one or more races to indicate what the decedent considered himself or herself to be
A ☐ White/Caucasian | B ☐ Black or African American | C ☐ Asian Indian | D ☐ Chinese
E ☐ Filipino | F ☐ Japanese | G ☐ Korean | H ☐ Vietnamese
J ☐ Native Hawaiian | K ☐ Guamanian or Chamorro | M ☐ Samoan
N ☐ American Indian or Alaska Native (specify)
P ☐ Other Asian (specify) | R ☐ Other Pacific Islander (specify)
S ☐ Other (specify)

11. DECEDENT'S EDUCATION Check the box that best describes the highest degree or level of school completed at the time of death
1 ☐ ≤ 8th grade | 2 ☐ 9th-12th grade, no diploma | 3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree | 5 ☐ Associate's degree | 6 ☐ Bachelor's degree
7 ☐ Master's degree | 8 ☐ Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER: | 13. MARITAL STATUS NEVER MARRIED ☐1 MARRIED ☐2 WIDOWED ☐3 DIVORCED ☐4 SEPARATED ☐5 | 14. SURVIVING SPOUSE. Enter name if married or separated. If surviving spouse is wife, enter maiden name

15A. USUAL OCCUPATION (Do not enter retired) | 15B. KIND OF BUSINESS OR INDUSTRY | 15C. NAME AND LOCALITY OF COMPANY OR FIRM

16A. RESIDENCE (State or Country if not USA) | 16B. County or Region/Province if not USA: | 16C. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐ | 16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☐YES ☐NO IF NO, SPECIFY TOWN:

16D. STREET AND NUMBER OF RESIDENCE | 16E. ZIP CODE:

PARENTS

17. NAME OF FATHER: FIRST MI LAST | 18. MAIDEN NAME OF MOTHER: FIRST MI LAST

DISPOSITION

19A. NAME OF INFORMANT | 19B. MAILING ADDRESS: (Include zip code)

20A. 1 ☐ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT MONTH DAY YEAR | 20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION. | 20C. LOCATION: (City or town and state)

21A. NAME AND ADDRESS OF FUNERAL HOME: | 21B. REGISTRATION NUMBER:

22A. NAME OF FUNERAL DIRECTOR | 22B. SIGNATURE OF FUNERAL DIRECTOR: ▶ | 22C. REGISTRATION NUMBER:

23A. SIGNATURE OF REGISTRAR. ▶ | 23B. DATE FILED: MONTH DAY YEAR | 24A. BURIAL OR REMOVAL PERMIT ISSUED BY: | 24B. DATE ISSUED MONTH DAY YEAR

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CDRONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: | License No.: | Signature: ▶ | Month Day Year

Certifier's Title: 0 ☐ Attending Physician | 0 ☐ Physician acting on behalf of Attending Physician | 1 ☐ Coroner | 2 ☐ Medical Examiner / Deputy Medical Examiner | Address

25B. If coroner is not a physician, enter Coroner's Physician's name & title: | License No.: | Signature ▶ | Month Day Year

25C. If certifier is not attending physician, enter Attending Physician's name & title | License No. | Address

26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year | 26B. Deceased last seen alive by attending physician: Month Day Year | 26C. Pronounced Dead ON Month Day Year AT Time M

27. MANNER OF DEATH NATURAL CAUSE ☐1 | ACCIDENT ☐2 | HOMICIDE ☐3 | SUICIDE ☐4 | UNDETERMINED CIRCUMSTANCES ☐5 | PENDING INVESTIGATION ☐6

28. WAS CASE REFERRED TO COFONER OR MEDICAL EXAMINER? 0 ☐ NO 1 ☐ YES

29A. AUTOPSY? NO ☐0 YES ☐1 REFUSED ☐2

29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO 1 ☐ YES

CONFIDENTIAL **SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH** **CONFIDENTIAL**

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. IMMEDIATE CAUSE:
(A)
DUE TO OR AS A CONSEQUENCE OF:
(B)
DUE TO OR AS A CONSEQUENCE OF
(C)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): | DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☐ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN

31A. IF INJURY, DATE MONTH DAY YEAR | HOUR. m | 31B. INJURY LOCALITY: (City or town and county and state) | 31C. DESCRIBE HOW INJURY OCCURRED: | 31D. PLACE OF INJURY. | 31E. INJURY AT WORK? NO ☐0 YES ☐1

31F. IF TRANSPORTATION INJURY, SPECIFY 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)

32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐0 YES ☐1

33A. IF FEMALE: 0 ☐ Not pregnant within last year | 1 ☐ Pregnant at time of death | 2 ☐ Not pregnant but pregnant within 42 days of death | 3 ☐ Not pregnant but pregnant 43 days to 1 year before death | 4 ☐ Unknown if pregnant within past year

33B. DATE OF DELIVERY: MONTH DAY YEAR

For use by physician or institution:
NAME OF DECEDENT
DATE OF DEATH:
TIME OF DEATH: AM/PM