

State of Idaho  
**DEATH CERTIFICATE WORKSHEET**

<b>DECEDENT</b>	* 1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix)				2. SEX		3. SOCIAL SECURITY NUMBER			
TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN	4a. AGE-Last Birthday (Years)		4b. UNDER 1 YEAR Months: _____ Days: _____		4c. UNDER 1 DAY Hours: _____ Minutes: _____		5. DATE OF BIRTH (Mo/Day/Yr)		6. BIRTHPLACE (City and State, Territory, or Foreign Country)	
	* 14. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Other (Specify) _____			15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)			* 16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY			
<b>DISPOSITION</b>	* 17a. NAME OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH				* 17b. LICENSE NUMBER (Of licensee)			18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**INSTRUCTIONS FOR MEDICAL CERTIFIER OF RECORD**

Please complete/verify the information listed below. By completing this worksheet and affixing your signature on item #39a, you hereby give permission for the funeral home of record as listed in item #16 to enter said information on your behalf into the Idaho Electronic Death Registration System (EDRS) for the deceased individual associated with this worksheet.

**In lieu of funeral home staff entering medical information on your behalf, you may enroll and participate directly in the Idaho EDRS by contacting Idaho Vital Statistics at (208) 334-5978.**

<b>PLACE OF DEATH</b>	<b>PLACE OF DEATH (19-22)</b>							
	* 19a. IF DEATH OCCURRED IN A HOSPITAL:				* 19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL:			
	<input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify) _____							
	* 20. FACILITY NAME (if not facility, give street and number)			* 21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE			* 22. COUNTY OF DEATH	
<b>DATE OF DEATH</b>	* 23. DATE OF DEATH (Mo/Day/Yr) (Spell month)		24. TIME OF DEATH (24hr)		25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month)		26. TIME PRONOUNCED DEAD (24hr)	
<b>CAUSE OF DEATH</b>	<b>27. CAUSE OF DEATH</b>							
	PART I. Enter the <u>chain of events</u> -- 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:							
	IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. DUE TO (or as a consequence of):		b. DUE TO (or as a consequence of):		c. DUE TO (or as a consequence of):	
	Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death)		d. DUE TO (or as a consequence of):				Approximate Interval: Onset to Death	
	PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I				28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No		28b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	29. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		30. IF FEMALE (Aged 10-54): <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		31. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined			
	32. DATE OF INJURY (Mo/Day/Yr) (Spell month)		33. TIME OF INJURY (24hr)		34. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.)			35. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
	36. LOCATION OF INJURY: State _____ City/Town or County _____ Zip Code _____ Street and Number or Location _____ Apartment Number _____							
	37. DESCRIBE HOW INJURY OCCURRED. IF TRANSPORTATION INJURY, STATE THE TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable							
	TRANSPORTATION INJURY ONLY		38a. WAS DECEDENT: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		38b. WHAT SAFETY DEVICE(S) DID DECEDENT USE/EMPLOY? <input type="checkbox"/> Seat Belt <input type="checkbox"/> Child safety seat <input type="checkbox"/> Helmet <input type="checkbox"/> Air bag <input type="checkbox"/> None <input type="checkbox"/> Unknown			
<b>CERTIFIER</b>	39a. CERTIFIER (Check only one, based on official capacity for this certificate) <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> ADVANCED PRACTICE PROFESSIONAL NURSE - To the best of my knowledge, death occurred at the time, date, and place, and due to the <u>natural</u> cause(s)/manner stated. <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 stated.						39b. LICENSE NUMBER	
	Signature and Title of Certifier ▶						39c. DATE SIGNED ____ / ____ / ____ MM    DD    YYYY	
	* 39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print)							

RETURN COMPLETED WORKSHEET TO:

IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE