

FAX BACK TO 1-801-983-7350 - DO NOT SEND A COVER SHEET

STATE OF ARIZONA DEPARTMENT OF HEALTH SERVICES - OFFICE OF VITAL RECORDS CERTIFICATION OF CAUSE OF DEATH							
V E R I F Y	1	DECEDENT'S LEGAL NAME (FIRST, MIDDLE, LAST)			AKA'S (IF ANY)		DATE OF DEATH:
	2	SEX:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	UNDER 1 YEAR: MONTHS: DAYS:	UNDER 1 DAY: HOURS: MINUTES:
	3	PLACE OF DEATH - HOSPITAL: <input type="checkbox"/> INPATIENT <input type="checkbox"/> E.R./OUTPATIENT <input type="checkbox"/> DEAD ON ARRIVAL			PLACE OF DEATH - OTHER THAN HOSPITAL: <input type="checkbox"/> NURSING HOME OR LONG TERM CARE FACILITY <input type="checkbox"/> RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER _____ <input type="checkbox"/> UNKNOWN		
	4	FACILITY NAME (OR STREET ADDRESS IF NOT A FACILITY):			CITY, TOWN & ZIP CODE OR LOCATION OF DEATH:		COUNTY OF DEATH:
MEDICAL CERTIFICATION SECTION CAUSE OF DEATH PART I							
C O M P L E T E T H I S S E C T I O N	5	IMMEDIATE CAUSE OF DEATH	A.				APPROXIMATE INTERVAL:
	6	DUE TO OR AS A CONSEQUENCE OF:	B.				APPROXIMATE INTERVAL:
	7	DUE TO OR AS A CONSEQUENCE OF:	C.				APPROXIMATE INTERVAL:
	8	DUE TO OR AS A CONSEQUENCE OF:	D.				APPROXIMATE INTERVAL:
CAUSE OF DEATH PART II							
M E O N L Y	9	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSES GIVEN ABOVE:					TIME OF DEATH: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> MILITARY
	10	DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN	IF FEMALE: <input type="checkbox"/> NOT PREGNANT WITHIN LAST 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 43 DAYS TO 1 YEAR BEFORE DEATH <input type="checkbox"/> UNKNOWN IF PREGNANT WITHIN LAST YEAR	WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
MEDICAL EXAMINER USE ONLY - DID DEATH RESULT FROM AN INJURY OF ANY KIND? - LEAVE BLANK IF NOT AN INJURY							
M E O N L Y	11	TIME OF INJURY: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> MILITARY	DID THE INJURY OCCUR AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	PLACE OF INJURY (EG: DECEDENT'S HOME, CONSTRUCTION SITE, RESTAURANT, WOODED AREA, ETC)			
	12	LOCATION OF INJURY (ADDRESS, CITY AND STATE):		IF TRANSPORTATION INJURY (SPECIFY): <input type="checkbox"/> DRIVER / OPERATOR <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> PASSENGER <input type="checkbox"/> OTHER (SPECIFY) _____			
	13	DESCRIBE HOW THE INJURY OCCURRED:					
CAUSE AND MANNER OF DEATH CERTIFICATION							
C O M P L E T E	14	MANNER OF DEATH: <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> COULD NOT BE DETERMINED					
	15	<input type="checkbox"/> Certifying Physician/Nurse Practitioner - To the best of my knowledge, death occurred due to the cause(s) and manner stated.			SIGNATURE & TITLE OF PERSON COMPLETING CAUSE OF DEATH: (MD, DO, CI, CNP)		DATE CERTIFIED:
	16	<input type="checkbox"/> Medical Examiner/Tribal Law Enforcement Authority - 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.			CERTIFIER'S ADDRESS:		



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