PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

NAME OF DECEDENT: FOR USE BY PHYSICIAN OR INSTITUTION ONLY

1. NAME – FIRST MIDDLE LAST | 2. SEX | 3. DATE OF DEATH (Month, day, year)

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number) | 4b. CITY, TOWN, OR LOCATION OF DEATH

5a. AGE – LAST BIRTHDAY (Years) | 5b. UNDER 1 YEAR: MONTHS, DAYS | 5c. UNDER 1 DAY: HOURS, MIN. | 6. DATE OF BIRTH (Month, day, year) | 7. BIRTHPLACE (City and State or Foreign Country)

8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR | 9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin) | 9b. RACE (List all that apply)

10. SOCIAL SECURITY NUMBER (Decedent's) | 11a. USUAL OCCUPATION (Do NOT use retired) | 11b. KIND OF BUSINESS OR INDUSTRY

12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner

12b. SPOUSE / PARTNER (Give maiden name, if applicable)

13a. RESIDENCE ADDRESS (House number and street name) | 13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE

14. MAILING ADDRESS – If different from residence address (Number, Street name, City or Town, State, and Zip Code) | 15. EDUCATION (Decedent's)

PARENTS

16. FATHER / PARENT – FIRST NAME MIDDLE LAST / MAIDEN NAME | 17. MOTHER / PARENT – FIRST NAME MIDDLE LAST / MAIDEN NAME

18a. INFORMANT – FULL NAME | 18b. MAILING ADDRESS (Number, Street name, City or Town, State, and Zip Code)

DISPOSITION

19a. BURIAL CREMATION, DONATION, OTHER (Specify) | 19b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CITY OR TOWN STATE

20a. SIGNATURE OF FUNERAL HOME LICENSEE | 20b. FUNERAL HOME – NAME | 20c. FUNERAL HOME LICENSE NUMBER

ITEMS BELOW TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY

20d. FUNERAL HOME – ADDRESS (Number, Street name, City or Town, State, and Zip Code)

PHYSICIAN

RI law requires the name of the physician and the cause of death to be PRINTED or TYPED in **BLACK INK**. Signatures must also be in **BLACK INK**.

21a. To the best of my knowledge, death occurred at the time, date and place and was due to the cause(s) stated. DEGREE (MD, DO, PA, or NP)

(Signature)

21b. R.I. LICENSE NUMBER | 21c. DATE SIGNED (Month, day, yr) | 21d. HOUR OF DEATH (If unknown, so state)

21f. NAME & ADDRESS OF CERTIFIER **(Type or Print)**

21e. **WAS DEATH REFERRED TO MEDICAL EXAMINER?** ☐ **Yes** ☐ **No**

21g. HOSPITAL DEATH? ☐ YES (Check a box below) ☐ NO (See 21h)
☐ Inpatient ☐ Emer. Room/Outpatient ☐ DOA

21h. NON-HOSPITAL DEATH?
☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Hospice at Home ☐ Other (Specify):

21i. NAME AND ADDRESS OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER IN **21f (Type or Print)** | 21j. LENGTH OF ATTENDANCE (Specify days, wks, months, yrs)

REGISTRAR

22a. REGISTRAR

(Signature)

22b. FILE DATE - DATE RECEIVED BY REGISTRAR (Month, day, yr)

CAUSE OF DEATH

Print or type legibly in **BLACK INK**.

23. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac / respiratory arrest or ventricular fibrillation without showing the etiology. | Approximate Interval Between Onset & Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a.

Sequentially list conditions, if any, leading to the cause listed on line a.

DUE TO (OR AS A CONSEQUENCE OF)
b.

Enter the **UNDERLYING CAUSE** (Disease or injury that initiated the events resulting in death) **LAST**

DUE TO (OR AS A CONSEQUENCE OF)
c.

DUE TO (OR AS A CONSEQUENCE OF)
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 24a. AUTOPSY PERFORMED? ☐ Yes ☐ No | 24b. Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No

25a. TOBACCO USE – DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ No ☐ Probably ☐ Unknown

25b. PREGNANCY – IF FEMALE. THE DECEDENT WAS:
☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days – 1 year before death ☐ Unknown if pregnant within past year

26. MANNER OF DEATH | 27. DATE OF INJURY? (month, day year) | 28. HOUR OF INJURY? | 29. INJURY AT WORK? ☐ Yes ☐ No | 30. PLACE OF INJURY (e.g., decedent's home, construction site, wooded area, restaurant, etc.)

31. LOCATION OF INJURY STREET & HOUSE NUMBER CITY/TOWN STATE ZIP CODE

32. DESCRIBE HOW INJURY OCCURRED

VS-2
Rev 2/2015

R.I. Law requires Funeral Director to file this certificate with the City or Town Clerk at the Place of Death within 7 days.