(INSTRUCTIONS ON REVERSE SIDE)

FOR USE BY PHYSICIANS AND MEDICAL EXAMINERS

The Commonwealth of Massachusetts

STANDARD CERTIFICATE OF DEATH

REGISTRY OF VITAL RECORDS AND STATISTICS

REGISTERED NUMBER | STATE USE ONLY

STATE USE ONLY
4c Hosp
5 Type
6 Hisp / Race
10 Age
15 Resid
15 Out-State
23 Disp
31-32 Autop
34 Manner
35c Work Inj
35f Place
36-37 Cert
40a Pron

DECEDENT

1 DECEDENT - NAME (FIRST, MIDDLE, LAST) | 2 SEX | 3 DATE OF DEATH (Mo., Day, Yr.)

4a PLACE OF DEATH (City/Town): | 4b COUNTY OF DEATH | 4c HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)

5 PLACE OF DEATH (Check only one): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA | OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

6 SOCIAL SECURITY NUMBER | 7 IF US WAR VETERAN SPECIFY WAR

8a WAS DECEDENT OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.) ☐ NO ☐ YES Specify:

8b RACE (e.g. White, Black, American Indian, etc.) (Specify)

9 DECEDENT'S EDUCATION (Highest Grade Completed) Elementary Sec (0-12) | College (1-4, 5+)

10a AGE - Last Birthday (Yrs.) | UNDER 1 YEAR MOS. b | DAYS | UNDER 1 DAY HOURS c | MINS

10d DATE OF BIRTH (Mo., Day, Yr.)

11 BIRTHPLACE (City and State or Foreign Country)

12 MARRIED, NEVER MARRIED, WIDOWED OR DIVORCED

13 LAST SPOUSE (If wife, give maiden name)

14a USUAL OCCUPATION (Prior - If Retired)

14b KIND OF BUSINESS OR INDUSTRY

15a RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY

15b ZIP CODE

16 FATHER - FULL NAME

17 STATE OF BIRTH (If not in US, name country)

18 MOTHER - NAME (GIVEN) (MAIDEN)

19 STATE OF BIRTH (If not in the US, name country)

INFORMANT

20 INFORMANT'S NAME

21 MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE

22 RELATIONSHIP

DISPOSITION

23 METHOD OF IMMEDIATE DISPOSITION ☐ BURIAL ☐ CREMATION ☐ ENTOMBMENT ☐ REMOVAL FROM STATE ☐ DONATION ☐ OTH. SPEC.

24 FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE | LICENSE #

25

26a PLACE OF DISPOSITION (Name of Cemetery, Crematory or other)

26b LOCATION (City/Town, State)

27 DATE OF DISPOSITION (Mo., Day, Yr.)

28a/b NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE

CERTIFIER

29 PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d) PRINT OR TYPE LEGIBLY.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____ DUE TO (OR AS A CONSEQUENCE OF)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

b. _____ DUE TO (OR AS A CONSEQUENCE OF)

c. _____ DUE TO (OR AS A CONSEQUENCE OF)

d. _____

30 PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.

Our fax 617 926 7888

31 WAS AUTOPSY PERFORMED? (Yes or No)

32 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)

33 MED. EXAM. NOTIFIED? (Yes or No)

34 MANNER OF DEATH ☐ NATURAL ☐ HOMICIDE ☐ COULD NOT BE DETERMINED ☐ ACCIDENT ☐ SUICIDE ☐ PENDING INVESTIGATION

35a DATE OF INJURY (Mo., Day, Yr.)

35b TIME OF INJURY M

35c INJURY AT WORK (Yes or No)

35d DESCRIBE HOW INJURY Ooccurred

35e PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.,) Specify

35f LOCATION (No. & St., City/Town, State)

To be Completed by CERTIFYING PHYSICIAN ONLY

36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title)

36b DATE SIGNED (Mo., Day, Yr.)

36c HOUR OF DEATH M

36d NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER

To be Completed by MEDICAL EXAMINER ONLY

37a 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) stated. (Signature and Title)

37b DATE SIGNED (Mo., Day, Yr.)

37c HOUR OF DEATH M

37d PRONOUNCED DEAD (Mo., Day, Yr.)

37e PRONOUNCED DEAD (Hr) M

38 NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print)

39 LICENSE NO. OF CERTIFIER

40a WAS THERE A PRONOUNCEMENT FORM? (Yes or No)

40b IF YES, DATE PRONOUNCED

40c IF YES, TIME PRONOUNCED M

40d NAME OF PRONOUNCER

TITLE ☐ R.N. ☐ P.A. ☐ N.P.

41 DATE BURIAL PERMIT ISSUED / SIGNATURE-BD. OF HEALTH AGENT

42 RECEIVED IN THE CITY/TOWN OF / CLERK'S SIGNATURE

43 DATE OF RECORD

Pronouncement of Death Form (R-302) on File: ☐

PERMANENT BLACK INK ONLY

R-301-08