WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION OFFICE
PHYSICIAN'S / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301

STATE FILE NUMBER

NAME OF DECEDENT

FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last) | 2. SEX | 3. SOCIAL SECURITY NUMBER

4a. AGE (Last Birthday) (Years) | 4b. IF UNDER 1 YEAR: Months, Days | 4c. IF UNDER 1 DAY: Hours, Minutes | 5. DATE OF BIRTH (Mo/Day/Yr) | 6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE (STATE) | 7b. COUNTY | 7c. CITY OR TOWN

7d. STREET AND NUMBER | 7e. APT. NO. | 7f. ZIP CODE | 7g. INSIDE CITY LIMITS? ☐ Yes ☐ No

7h. 2nd LEGAL RESIDENCE - PROBATE USE ONLY - OPT. | STREET & NUMBER | APT. NO. | CITY OR TOWN | COUNTY | STATE

8. EVER IN US ARMED FORCES? ☐ Yes ☐ No

9. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown

10. SURVIVING SPOUSE'S NAME (Give name prior to first marriage.)

11. FATHER'S / PARENT 1'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

12. MOTHER'S / PARENT 2'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

13a. INFORMANT'S NAME | 13b. RELATIONSHIP TO DECEDENT | 13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

14. PLACE OF DEATH (Check only one: see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):

15. FACILITY NAME (If not institution, give street & number) | 16. CITY OR TOWN, STATE, AND ZIP CODE | 17. COUNTY OF DEATH

18. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Entombment ☐ Donation ☐ Removal from State ☐ Other (Specify):

19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)

20. LOCATION (CITY, TOWN, AND STATE) | 21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶ | 23. LICENSE NUMBER (Of Licensee)

LICENSED HEALTH PROFESSIONAL OR CORONER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr) | 25. TIME PRONOUNCED DEAD

26. SIGNATURE AND TITLE OF PERSON PRONOUNCING DEATH (Only when pronouncer IS NOT also the certifier.) ▶ | 27. DATE SIGNED (Mo/Day/Yr)

DATE OF DEATH →

PHYSICIAN, QUALIFIED APRN, OR NON-PHYSICIAN CORONER

28. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) | 29. ACTUAL OR PRESUMED TIME OF DEATH | 30. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ No ☐ Yes | IF YES, MEDICAL EXAMINER CASE #

CAUSE OF DEATH

31. PART I. Enter the chain of events -- 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. Enter only one cause on a line. Add additional lines if necessary.

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 the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause in PART I.

32a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

32b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

33. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

34. IF FEMALE ☐ 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 to 1 year before death ☐ Unknown if pregnant within the last year

35a. CAUSE/MANNER PENDING ? ☐ Pending Investigation ☐ Date Amended _____ See 35b. for Final Manner of Death

35b. FINAL MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

TYPE/PRINT IN PERMANENT BLACK INK

MEDICAL EXAMINER OR CORONER ONLY

36a. DATE OF INJURY (Mo/Day/Yr) | 36b. TIME OF INJURY | 36c. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, office building, wooded area) | 36d. INJURY AT WORK? ☐ Yes ☐ No

36e. LOCATION OF INJURY: Street & Number: | Apt No.: | City or Town: | State or Country: | Zip Code:

36f. DESCRIBE HOW INJURY OCCURRED

36g. IF TRANSPORTATION INJURY: ROLE: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

SEATBELT RESTRAINT STATUS: ☐ Restrained ☐ No restraint ☐ Unknown

HELMET STATUS: ☐ Helmet ☐ No helmet ☐ Unknown

PHYSICIAN, QUALIFIED APRN, OR CORONER ONLY

37a. CERTIFIER (Check only one):

☐ Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred due to the cause(s) and manner stated.

☐ Pronouncing & Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

☐ Medical Examiner/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.

Signature of Certifier ▶ _____ Date Certified _____

37b. NAME, ADDRESS, AND ZIP CODE OF PERSON CERTIFYING TO CAUSE OF DEATH (Item 31.)

37c. TITLE OF CERTIFIER ☐ MD ☐ DO ☐ APRN ☐ Non-Physician Coroner ☐ Other, specify _____

OFFICE USE ONLY

38. FOR OFFICIAL REGISTRAR USE ONLY- SIGNATURE OF REGISTRAR ▶

39. FOR OFFICIAL REGISTRAR USE ONLY- DATE FILED

FORM VS-002
(Rev. 5/2017)