Form R-360 07012014

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

DEATH CERTIFICATE MEDICAL CERTIFIER WORKSHEET

Please complete the information pertaining to the decedent as well as the cause of death information as this document will be used to create the legal death certificate. ***PLEASE PRINT NEATLY TO HELP WITH DATA ENTRY.***

DECEDENT – NAME FIRST MIDDLE LAST GENERATIONAL ID

DATE OF DEATH (Month DD, YYYY)	SEX	PLACE OF DEATH – CITY/TOWN	DATE OF BIRTH (Month DD, YYYY)

MEDICAL RECORD NUMBER

PLACE OF DEATH
☐ Hospital-Inpatient ☐ Hospital-ER/Outpatient ☐ Hospital-DOA ☐ Decedent's Residence ☐ Hospice Facility
☐ Nursing Home/Long Term Care ☐ Assisted Living Facility or Rest Home ☐ Other _____

HOSPITAL OR OTHER INSTITUTION – NAME (*If not in either, provide street and number*)

PART I – CAUSE OF DEATH – SEQUENTIALLY LIST IMMEDIATE CAUSE THEN ANTECEDENT CAUSES THEN UNDERLYING CAUSE | APPX INTERVAL

a) Immediate Cause _____
b) Due to _____
c) Due to _____
d) Due to _____

PART II – OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH

M.E. NOTIFIED? ☐ Yes ☐ No

AUTOPSY PERFORMED? ☐ M.E. ☐ Priv ☐ No

AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETING CAUSE OF DEATH? ☐ Yes ☐ No

MANNER OF DEATH
☐ Natural **ALL OTHER MANNER OF DEATH CASES ARE REQUIRED TO BE REFERRED TO THE MEDICAL EXAMINER**

M.E. CASE NUMBER

M.E. SECTION ONLY

MANNER OF DEATH
☐ Accident ☐ Homicide ☐ Suicide ☐ Pending investigation
☐ Therapeutic Complication ☐ Could not be determined
☐ Other (Specify) _____

INJURY AT WORK? ☐ Yes ☐ No

DATE OF INJURY (Month DD, YYYY)

TIME OF INJURY ☐ AM ☐ PM ☐ Mil.

APPX TIME OF DEATH ☐ AM ☐ PM ☐ Mil.

PLACE OF INJURY

TRANSPORTATION INJURY
☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Not Applicable
☐ Other (Specify) _____

LOCATION/ADDRESS OF INJURY

M.E. DATE PRONOUNCED (Month DD, YYYY)

DESCRIBE HOW INJURY OCCURRED

M.E. TIME PRONOUNCED ☐ AM ☐ PM ☐ Military

IF FEMALE, PREGNANCY STATUS AT TIME OF DEATH
☐ Not pregnant within the past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant within 43 days to 1 year before death ☐ Unknown, if pregnant in past year

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

MEDICAL CERTIFIER INFORMATION – NAME/TITLE

HOUR OF DEATH ☐ AM ☐ PM ☐ Military

MEDICAL CERTIFIER INFORMATION – ADDRESS

LICENSE #

MEDICAL CERTIFIER DESIGNATION
☐ Certifier in attendance at time of death ☐ Physician in charge of patient's care ☐ Nurse Practitioner in attendance at time of death
☐ Nurse Practitioner in charge of patient's care ☐ Medical Examiner

MEDICAL CERTIFIER FAX NUMBER TO RECEIVE ATTESTATION FORM

MEDICAL CERTIFIER TELEPHONE NUMBER

PROVIDER IN CHARGE OF PATIENT'S CARE – NAME/TITLE

RN/ PA/ NP PRONOUNCEMENT? ☐ Yes ☐ No

IF YES, DATE (Month DD, YYYY)

IF YES, TIME ☐ AM ☐ PM ☐ Mil.

PRONOUNCER INFORMATION – NAME TITLE ☐ R.N. ☐ P.A. ☐ N.P.

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.

DATE SIGNED (Month DD, YYYY)

←
Signature and Title of Medical Certifier Required.