Ohio Department of Health
VITAL STATISTICS

CERTIFICATE OF DEATH

State File No.

Type or print in permanent blue or black ink

DECEDENT

1.Decedent's Legal Name (First, Middle, Last, Suffix) (Include AKA's if any) | 2. Sex | 3. Date of Death (Mo/Day/Year)

4. Social Security Number | 5a. Age (Years) | 5b. Under 1 Year Months / Days | 5c. Under 1 day Hours / Minutes | 6. Date of Birth(Mo/Day/Year) | 7. Birthplace(City and State or Foreign Country)

8a. Residence State | 8b. County | 8c. City or Town

8d. Street and Number | 8e. Apt. No. | 8f. Zipcode | 8g. Inside City Limits?

9. Ever in US Armed Forces? | 10. Marital Status at Time of Death | 11. Surviving Spouse's Name (If wife, give name prior to first marriage)

12. Decedent's Education | 13. Decedent of Hispanic Origin | 14. Decedent's Race

15. Father's Name | 16. Mother's Name (prior to first marriage)

17a. Informant's Name | 17b. Relationship to Decedent | 17c. Mailing Address (Street and Number, City, State, Zip Code)

18a. Place of Death

18b. Facility Name (If not Institution, give street & number) | 18c. City or Town, State and Zip Code | 18d. County of Death

DISPOSITION

19. Signature of Funeral Service Licensee or Other Agent | 20. License Number (of licensee) | 21. Name and Complete Address of Funeral Facility

22a. Method of Disposition | 22b. Date of Disposition (Mo/Day/Year)

22c. Place of Disposition (Name of Cemetery, Crematory, or other place) | 22d. Location (City/Town and State)

REGISTRAR

23. Registrar's Signature | 24. Date Filed (Mo/Day/Year)

25a. Name of Person Issuing Disposition Permit | 25b. District No. | 25c. Date Disposition Permit Issued (Mo/Day/Year)

CERTIFIER

26a. Certifier (Check only one)

☐ Certifying Physician
To the best of my knowledge, death occurred at the time, date, and place; and due to the cause(s) and manner stated.

☐ Coroner or Medical Examiner
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.

26b. Time of Death | 26c. Date Pronounced Dead (Mo/Day/Year) | 26d. Was the Medical Examiner or Coroner Contacted?

26e. Signature and Title of Certifier | 26f. License number | 26g. Date Signed (Mo/Day/Year)

27. Name (First, Middle, Last) and Address of Person who Completed Cause of Death

CAUSE OF DEATH

28. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Type or print in permanent blue or black ink.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in a death)	b. Due to (or as Consequence of)	
	c. Due to (or as Consequence of)	
	d. Due to (or as Consequence of)	

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

29a. Was An Autopsy Performed? ☐ Yes ☐ No

29b. Were Autopsy Findings Available Prior To Completion Of Cause of Death? ☐ YES ☐ NO ☐ Not Applicable

30. Did Tobacco Use Contribute to Death? ☐ Yes ☐ Unknown ☐ No ☐ Probably

31. If Female, Pregnancy Status
☐ 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 past year

32. Manner of Death
☐ Natural ☐ Homicide
☐ Accident ☐ Pending Investigation
☐ Suicide ☐ Could not be determined

33a. Date of Injury (Mo/Day/Year) | 33b. Time of Injury | 33c. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area) | 33d. Injury at Work? ☐ Yes ☐ No

33e. Location of Injury (Street and Number or Rural Route Number, City or Town, State)

33f. Describe How Injury Occurred:

33g. If Transportation Injury, Specify:
☐ Driver/Operator ☐ Pedestrian ☐ Passenger
☐ Other:

HEA 2724