MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

CERTIFICATE OF DEATH

STATE FILE NUMBER

124 -

VS 300 MO 580-2211 (1-10)

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix)	2. SEX	3. IF FEMALE, LAST NAME PRIOR TO FIRST MARRIAGE	4. ACTUAL OR PRESUMED DATE OF DEATH (Month, Day, Year)

5. SOCIAL SECURITY NUMBER	6a. AGE - Last Birthday (Years)	6b. UNDER 1 YEAR MONTHS / DAYS	6c. UNDER 1 DAY HOURS / MINUTES	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (City and State or Foreign Country)

9a. RESIDENCE *(COUNTRY)*	*(STATE, TERRITORY or PROVINCE)*	9b. COUNTY	9c. CITY, TOWN, OR LOCATION

9d. STREET AND NUMBER	9e. APARTMENT NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS?
			☐ Yes ☐ No

10. WAS DECEDENT EVER IN U.S. ARMED FORCES?	11. MARITAL STATUS AT TIME OF DEATH	12. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage.)
☐ Yes ☐ No	☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown	

13. FATHER'S NAME (First, Middle, Last, Suffix)	14. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)

15a. INFORMANT'S NAME (First, Middle, Last, Suffix)	15b. RELATIONSHIP TO DECEDENT	15c. MAILING ADDRESS (Street and Number, City, State, ZIP Code)

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

IF DEATH OCCURRED IN A HOSPITAL

☐ Inpatient ☐ Emergency Room/Outpatient ☐ DOA

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL

☐ Hospice Facility ☐ Nursing Home/Long Term Care Facility ☐ Decedent's Home ☐ Other (Specify)

17. FACILITY NAME (If not institution, give street and number)	18. CITY OR TOWN, STATE AND ZIP CODE	19. COUNTY OF DEATH

20a. METHOD OF DISPOSITION	20b. DATE OF DISPOSITION (Month, Day, Year)	21. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)	22. LOCATION (City or Town, State)
☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)			

23. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY	24. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER PERSON ACTING AS SUCH	25. FUNERAL ESTABLISHMENT LICENSE NUMBER
	▶	

26. ACTUAL OR PRESUMED TIME OF DEATH	27. WAS MEDICAL EXAMINER/CORONER CONTACTED?
M	☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples in handbook)

28. **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. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval : Onset to 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 given in PART I.	29. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No 30. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

31. DID TOBACCO USE CONTRIBUTE TO DEATH?	32. IF FEMALE	33. MANNER OF DEATH
☐ Yes ☐ No ☐ Probably ☐ Unknown	☐ 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	☐ Natural ☐ Homicide ☐ Accident ☐ Pending investigation ☐ Suicide ☐ Could not be determined

34. DATE OF INJURY (Month, Day, Year) (Spell Month)	35. TIME OF INJURY M	36. PLACE OF INJURY (e.g., decedent's home; construction site; restaurant; wooded area)	37. INJURY AT WORK?
			☐ Yes ☐ No

38a. LOCATION OF INJURY - STATE	38b. COUNTY	38c. CITY OR TOWN	38d. STREET AND NUMBER	38e. ZIP CODE

39. DESCRIBE HOW INJURY OCCURRED	40. IF TRANSPORTATION ACCIDENT (SPECIFY)
	☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. 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.

☐ 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 ▶

42. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 28)	43. TITLE OF CERTIFIER

44. CERTIFIER MO LICENSE NUMBER	45. CERTIFIER NPI NUMBER	46. DATE CERTIFIED (Month, Day, Year)

47. REGISTRAR'S SIGNATURE	48. **FOR REGISTRAR ONLY** - DATE FILED (Month, Day, Year)
▶	

49. DECEDENT'S EDUCATION *(Check the box that best describes the highest degree or level of school completed at time of death.)*	50. DECEDENT OF HISPANIC ORIGIN? *(Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.)*	51. DECEDENT'S RACE *(Check one or more races to indicate what the decedent considered himself or herself to be.)*
☐ 8th grade or less ☐ 9th - 12th grade; no diploma ☐ High school graduate or GED completed ☐ Some college credit, but no degree ☐ Associate degree (e.g., AA, AS) ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng, MeD, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, LLB, JD)	☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (Specify) _____	☐ White ☐ Black or African American ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (Specify) _____ ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (Specify) _____ ☐ Other (Specify) _____ ☐ Unknown

52. DECEDENT'S USUAL OCCUPATION (INDICATE TYPE OF WORK DONE DURING MOST OF WORKING LIFE. **DO NOT USE "RETIRED".**)	53. KIND OF BUSINESS/INDUSTRY

STATEMENT BY LICENSED EMBALMER

☐ **EMBALMED** ☐ **NOT EMBALMED**

I hereby certify that the deceased named above was embalmed by me, _____
(Name and Licensee Number)

or by student _____ on _____ working under my personal supervision.
(Name and Licensee Number) *(Date)*

_____
City or Town *State*

NOTE: Failure to comply with embalming requirements constitutes grounds for revocation of license.

_____
Date Certified (Month, Day, Year)