Rhode Island Department of Health
Instructions to Complete a Death Certificate
For Physician's & Funeral Home Director's

Presented by

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Table of Contents

- i. Purpose of Death Certificate Page 3
- ii. Decedent Information Page 5
- iii. Physician Certification Page 6
- iv. Burial Transit Permit Page 17
- v. Legal/Demographic Information Page 18
- vii. Supplemental Form Page 36
- viii. Appendix A (39 City/Towns) Page 37
- ix. Appendix B (24 hour clock) Page 38
- x. R.I.G.L. 23-3-16 Page 39
- xi. Contact Information Page 40

Purpose of Death Certificate

1) **Legal/Demographic Uses**

- **Used to register the Vital Events of Death**
- **Claiming Life Insurance Proceeds**
- **Pension or SSA Benefits**
- **Estate Settlement**
- **Medicaid Benefits**
- **Future Marriage (Free to Marry)**

2) Medical & Statistical

Is used to generate official mortality statistics such as:

- **Life Expectancy**
- **Leading Causes of Death**
- **Infant and maternal mortality rates**
- **Tracking the progress of a pandemic, epidemic or endemic disease**
- **Providing information for the Cancer Registry**
- **Assessing the general health of the population**
- **Examining medical problems among specific groups of people**
- **Indicating areas where medical research may have the greatest impact**
- **Allocating medical services to various State Health Programs and Federal Agencies based on the data**

Decedent Information

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER — STATE FILE NUMBER

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

NAME OF DECEDENT: ____
FOR USE BY PHYSICIAN OR INSTITUTION ONLY

DECEDENT

1. NAME – FIRST MIDDLE LAST
2. SEX
3. DATE OF DEATH (Month, day, year)
4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)
4b. CITY, TOWN, OR LOCATION OF DEATH
5a. AGE – LAST BIRTHDAY (Years)
5b. UNDER 1 YEAR: MONTHS, DAYS
5c. UNDER 1 DAY: HOURS, MIN.
6. DATE OF BIRTH (Month, day, year)
7. BIRTHPLACE (City and State or Foreign Country)
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR
9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)
9b. RACE (List all that apply)
10. SOCIAL SECURITY NUMBER (Decedent's)
11a. USUAL OCCUPATION (Do NOT use retired)
11b. KIND OF BUSINESS OR INDUSTRY
12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner
12b. SPOUSE / PARTNER (Give maiden name, if applicable)
13a. RESIDENCE ADDRESS (House number and street name)
13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE
14. MAILING ADDRESS – If different from residence address (Number, Street name, City or Town, State, and Zip Code)
15. EDUCATION (Decedent's)

PARENTS

16. FATHER / PARENT – FIRST NAME MIDDLE LAST / MAIDEN NAME
17. MOTHER / PARENT – FIRST NAME MIDDLE LAST / MAIDEN NAME
18a. INFORMANT – FULL NAME
18b. MAILING ADDRESS (Number, Street name, City or Town, State, and Zip Code)

DISPOSITION

19a. BURIAL CREMATION, DONATION, OTHER (Specify)
19b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CITY OR TOWN STATE
20a. SIGNATURE OF FUNERAL HOME LICENSEE
20b. FUNERAL HOME – NAME
20c. FUNERAL HOME LICENSE NUMBER
20d. FUNERAL HOME – ADDRESS (Number, Street name, City or Town, State, and Zip Code)

ITEMS BELOW TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY

PHYSICIAN

21a. To the best of my knowledge, death occurred at the time, date and place and was due to the cause(s) stated. (Signature) DEGREE (MD, DO, PA, or NP)
21b. R.I. LICENSE NUMBER
21c. DATE SIGNED (Month, day, yr)
21d. HOUR OF DEATH (If unknown, so state)
21e. WAS DEATH REFERRED TO MEDICAL EXAMINER? ☐ Yes ☐ No
21f. NAME & ADDRESS OF CERTIFIER (Type or Print)

RI law requires the name of the

<u>Left Hand Margin</u> - Certifying Physician is to enter **Name of Decedent**

3. <u>Date of Death</u> - Date of Death must be entered by the Certifying Physician.

Physician Certification Information

PHYSICIAN

RI law requires the name of the physician and the cause of death to be PRINTED or TYPED in **BLACK INK**. Signatures must also be in **BLACK INK**.

21a. To the best of my knowledge, death occurred at the time, date and place and was due to the cause(s) stated. DEGREE (MD, DO, PA, or NP)

(Signature)

21b. R.I. LICENSE NUMBER

21c.DATE SIGNED (Month, day, yr)

21d. HOUR OF DEATH (If unknown, so state)

21e. WAS DEATH REFERRED TO MEDICAL EXAMINER? ☐ Yes ☐ No

21f. NAME & ADDRESS OF CERTIFIER **(Type or Print)**

21g. HOSPITAL DEATH? ☐ YES (Check a box below) ☐ NO (See 21h)

☐ Inpatient ☐ Emer. Room/Outpatient ☐ DOA

21h. NON-HOSPITAL DEATH?

☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Hospice at Home ☐ Other (Specify):

21i. NAME AND ADDRESS OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER IN **21f (Type or Print)**

21j. LENGTH OF ATTENDANCE (Specify days, wks, months, yrs)

21a. <u>Signature and Title of Certifier</u> – Certifier to sign in Black Ink and enter title

21b. <u>Rhode Island License Number</u> – Certifier to enter RI License Number

21c. <u>Date Signed</u> – Certifier to enter date that Death Certificate is signed

21d. <u>Hour of Death</u> – Certifier to enter Hour of Death. If it cannot be obtained, enter "Unknown"

Physician Certification Information Cont…

PHYSICIAN

RI law requires the name of the physician and the cause of death to be PRINTED or TYPED in **BLACK INK**. Signatures must also be in **BLACK INK**.

21a. To the best of my knowledge, death occurred at the time, date and place and was due to the cause(s) stated. DEGREE (MD, DO, PA, or NP)

(Signature)

21b. R.I. LICENSE NUMBER

21c.DATE SIGNED (Month, day, yr)

21d. HOUR OF DEATH (If unknown, so state)

21e. WAS DEATH REFERRED TO MEDICAL EXAMINER? ☐ **Yes** ☐ **No**

21f. NAME & ADDRESS OF CERTIFIER **(Type or Print)**

21g. HOSPITAL DEATH? ☐ YES (Check a box below) ☐ NO (See 21h)

☐ Inpatient ☐ Emer. Room/Outpatient ☐ DOA

21h. NON-HOSPITAL DEATH?

☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Hospice at Home ☐ Other (Specify):

21i. NAME AND ADDRESS OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER IN **21f (Type or Print)**

21j. LENGTH OF ATTENDANCE (Specify days, wks, months, yrs)

21e. Was Death Referred to Medical Examiner? Yes or No

The following Deaths Must be referred to the M.E.'s Office if:

- Suspicion of Accident, Homicide, Suicide or Trauma of any nature
- Hip fracture or other trauma in elderly
- Death is sudden or in a public place
- Death is from a drug or toxic substance
- Death is sudden and the patient has not been attended by a physician
- Death is from an infection capable of causing a epidemic
- Death is related to a job or workplace environment
- Death occurs within 24 hours of hospitalization or ER care
- Death occurs during or immediately after surgery, diagnostic, therapeutic procedure

Physician Certification Information Cont…

PHYSICIAN

RI law requires the name of the physician and the cause of death to be PRINTED or TYPED in **BLACK INK**. Signatures must also be in **BLACK INK**.

21a. To the best of my knowledge, death occurred at the time, date and place and was due to the cause(s) stated.

(Signature)

DEGREE (MD, DO, PA, or NP)

21b. R.I. LICENSE NUMBER

21c.DATE SIGNED (Month, day, yr)

21d. HOUR OF DEATH (If unknown, so state)

21e. WAS DEATH REFERRED TO MEDICAL EXAMINER? ☐ **Yes** ☐ **No**

21f. NAME & ADDRESS OF CERTIFIER **(Type or Print)**

21g. HOSPITAL DEATH? ☐ YES (Check a box below) ☐ NO (See 21h)

☐ Inpatient ☐ Emer. Room/Outpatient ☐ DOA

21h. NON-HOSPITAL DEATH?

☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Hospice at Home ☐ Other (Specify):

21i. NAME AND ADDRESS OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER IN **21f (Type or Print)**

21j. LENGTH OF ATTENDANCE (Specify days, wks, months, yrs)

21f. **Name & Address of Certifier** **-** Certifier must type or legibly print full name & address.

21g. Hospital Death? If Yes, Select one of the following:

- ☐ Inpatient
- ☐ Emergency Room/Outpatient
- ☐ DOA

If No, check "No" and proceed to 21h

21h. If Non-Hospital Death, Select one of the following:

- ☐ Hospice Facility
- ☐ Nursing Home
- ☐ Decedent's Home
- ☐ Hospice at Home
- ☐ Other: Please Specify

Physician Certification Information Cont…

PHYSICIAN

RI law requires the name of the physician and the cause of death to be PRINTED or TYPED in **BLACK INK**. Signatures must also be in **BLACK INK**.

21a. To the best of my knowledge, death occurred at the time, date and place and was due to the cause(s) stated. DEGREE (MD, DO, PA, or NP)

(Signature)

21b. R.I. LICENSE NUMBER

21c.DATE SIGNED (Month, day, yr)

21d. HOUR OF DEATH (If unknown, so state)

21e. WAS DEATH REFERRED TO MEDICAL EXAMINER? ☐ **Yes** ☐ **No**

21f. NAME & ADDRESS OF CERTIFIER **(Type or Print)**

21g. HOSPITAL DEATH? ☐ YES (Check a box below) ☐ NO (See 21h)

☐ Inpatient ☐ Emer. Room/Outpatient ☐ DOA

21h. NON-HOSPITAL DEATH?

☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Hospice at Home ☐ Other (Specify):

21i. NAME AND ADDRESS OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER IN **21f (Type or Print)**

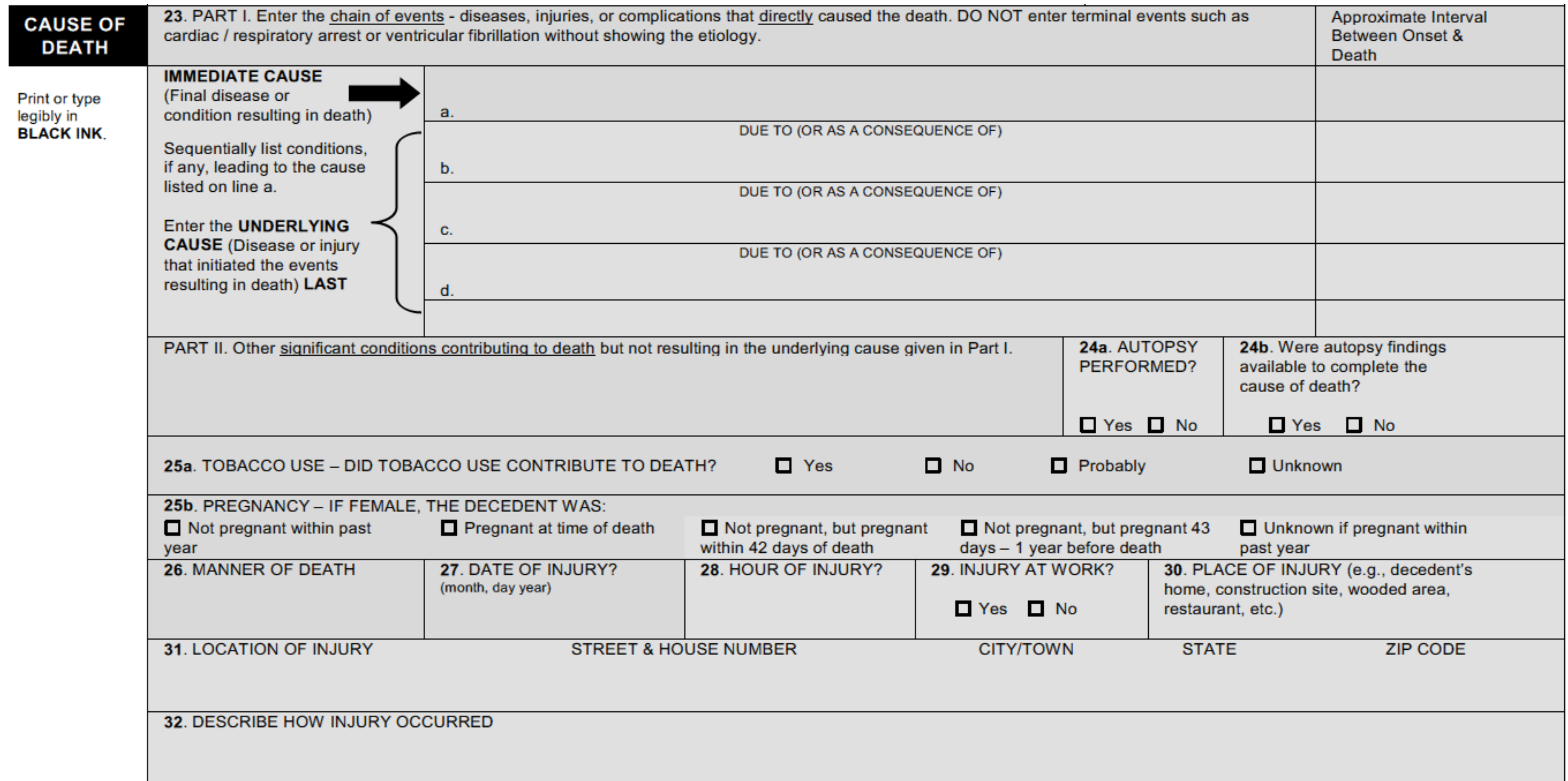
21j. LENGTH OF ATTENDANCE (Specify days, wks, months, yrs)

21i. **Name & Address of Attending Physician, if other than Certifier in 21f.**

Only fill out if Attending Physician is Different than the Certifying Physician in Field 21f.

21j. **Length of Attendance -** Specify Days, Weeks, Months, Years

Cause of Death: Immediate, Underlying & Other Significant Conditions



CAUSE OF DEATH

Print or type legibly in **BLACK INK**.

23. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac / respiratory arrest or ventricular fibrillation without showing the etiology.

Approximate Interval Between Onset & Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.

DUE TO (OR AS A CONSEQUENCE OF)

b.

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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**

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

24a. AUTOPSY PERFORMED? ☐ Yes ☐ No

24b. Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No

25a. TOBACCO USE – DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ No ☐ Probably ☐ Unknown

25b. PREGNANCY – IF FEMALE, THE DECEDENT WAS:
☐ 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 – 1 year before death ☐ Unknown if pregnant within past year

26. MANNER OF DEATH	**27**. DATE OF INJURY? (month, day year)	**28**. HOUR OF INJURY?	**29**. INJURY AT WORK? ☐ Yes ☐ No	**30**. PLACE OF INJURY (e.g., decedent's home, construction site, wooded area, restaurant, etc.)

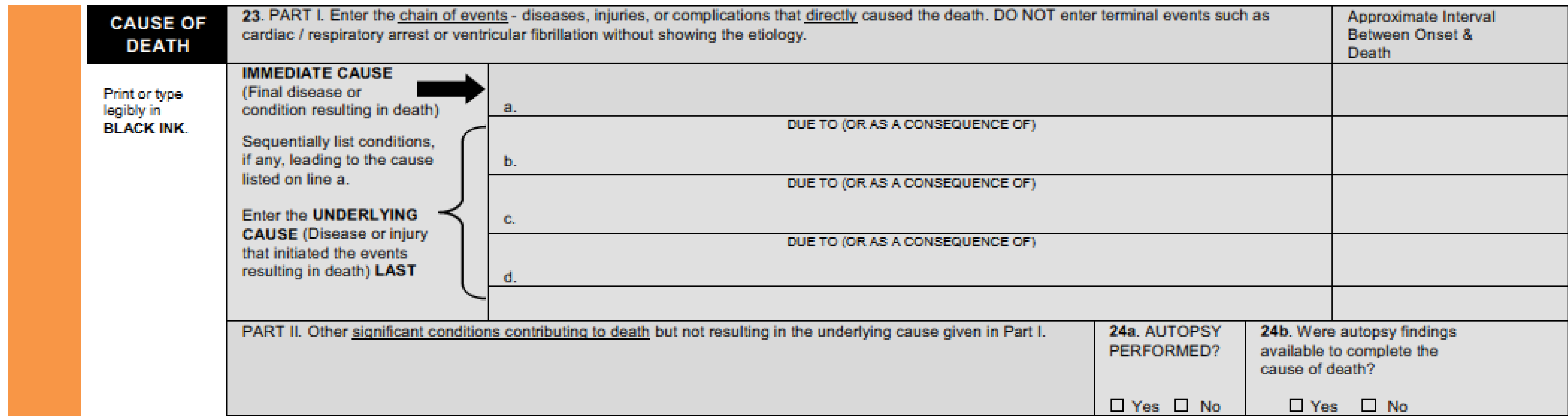
31. LOCATION OF INJURY	STREET & HOUSE NUMBER	CITY/TOWN	STATE	ZIP CODE

32. DESCRIBE HOW INJURY OCCURRED

Fields #'s 23-32 are to be completed by Certifying Physician

Cause of Death Cont…

- The Cause of Death section consists of two parts.
- **PART I: The IMMEDIATE & UNDERLYING CAUSE OF DEATH**
- **PART II: The OTHER SIGNIFICANT CONDITIONS contributing to Death**



CAUSE OF DEATH

Print or type legibly in **BLACK INK**.

23. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac / respiratory arrest or ventricular fibrillation without showing the etiology.

Approximate Interval Between Onset & 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. b.

DUE TO (OR AS A CONSEQUENCE OF)

Enter the **UNDERLYING CAUSE** (Disease or injury that initiated the events resulting in death) **LAST** c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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

24a. AUTOPSY PERFORMED? ☐ Yes ☐ No

24b. Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No

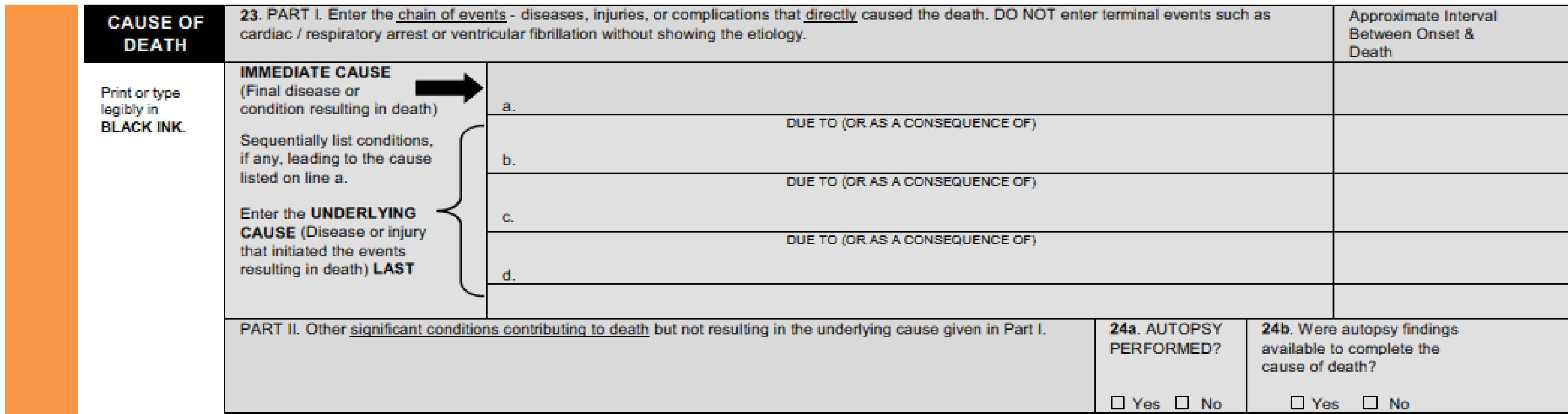
23. Part I. The **IMMEDIATE CAUSE** of Death on **Line a** is the final disease, or condition resulting in death

23. Part I Lines b, c, d - **UNDERLYING CAUSE(s)** OF DEATH is/are the disease(s) or injury that initiated the chain of morbid events that led directly and inevitably to death

The Certifying Physician should sequentially list conditions, if any, leading to the **IMMEDIATE CAUSE of DEATH** listed in **Line a**.

For each condition reported, give the interval between the presumed onset of the condition and the date of death. Acceptable Terms: minutes, hours, days, years, approximately and unknown

Cause of Death Cont…



CAUSE OF DEATH

Print or type legibly in BLACK INK.

23. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac / respiratory arrest or ventricular fibrillation without showing the etiology.

Approximate Interval Between Onset & 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. b.

DUE TO (OR AS A CONSEQUENCE OF)

Enter the **UNDERLYING CAUSE** (Disease or injury that initiated the events resulting in death) **LAST** c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

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

24a. AUTOPSY PERFORMED? ☐ Yes ☐ No

24b. Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No

PART II & AUTOPSY INFORMATION

23. Part II. **Other significant conditions:** conditions or diseases that were present at the time of death and that may have contributed to death, but were not directly related to the underlying cause of death.

24a. Autopsy Performed: Enter "Yes" if either a partial or full autopsy was performed. Otherwise enter "No". Do Not leave Blank.

24b. Autopsy Findings: Enter "Yes" if autopsy findings were available to complete the cause of death: Otherwise enter "No". Leave item blank if no autopsy was performed.

Cause of Death Cont…

25a. TOBACCO USE – DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ No ☐ Probably ☐ Unknown				
25b. PREGNANCY – IF FEMALE, THE DECEDENT WAS: ☐ 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 – 1 year before death	☐ Unknown if pregnant within past year
26. MANNER OF DEATH	27. DATE OF INJURY? (month, day year)	28. HOUR OF INJURY?	29. INJURY AT WORK? ☐ Yes ☐ No	30. PLACE OF INJURY (e.g., decedent's home, construction site, wooded area, restaurant, etc.)
31. LOCATION OF INJURY	STREET & HOUSE NUMBER	CITY/TOWN	STATE	ZIP CODE
32. DESCRIBE HOW INJURY OCCURRED				

25a. **Tobacco Use** - Understanding that tobacco use may contribute to a wide variety of diseases, Check Yes, if in your opinion, the use of tobacco contributed to death. Do Not leave Blank.

25b. Pregnancy Status - If the decedent was a female, check the appropriate box. If the female is either too young or too old to be fecund, check the "Not pregnant within past year" box. If the decedent is a male, leave the item "Blank".

Cause of Death Cont…

25a. TOBACCO USE – DID TOBACCO USE CONTRIBUTE TO DEATH?	☐ Yes	☐ No	☐ Probably	☐ Unknown
25b. PREGNANCY – IF FEMALE, THE DECEDENT WAS: ☐ 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 – 1 year before death	☐ Unknown if pregnant within past year
26. MANNER OF DEATH	27. DATE OF INJURY? (month, day year)	28. HOUR OF INJURY?	29. INJURY AT WORK? ☐ Yes ☐ No	30. PLACE OF INJURY (e.g., decedent's home, construction site, wooded area, restaurant, etc.)
31. LOCATION OF INJURY	STREET & HOUSE NUMBER	CITY/TOWN	STATE	ZIP CODE
32. DESCRIBE HOW INJURY OCCURRED				

26. MANNER OF DEATH

Write in one of the following:

- **Natural**
- **Accident**
- **Suicide**
- **Homicide**
- **Undetermined**
- **Pending**

Any Death other than Natural, will be a Medical Examiner referral and can only be completed by the M.E.'s Office. Do Not leave blank.

Cause of Death Cont..

25a. TOBACCO USE – DID TOBACCO USE CONTRIBUTE TO DEATH?	☐ Yes	☐ No	☐ Probably	☐ Unknown
25b. PREGNANCY – IF FEMALE, THE DECEDENT WAS: ☐ 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 – 1 year before death	☐ Unknown if pregnant within past year
26. MANNER OF DEATH	27. DATE OF INJURY? (month, day year)	28. HOUR OF INJURY?	29. INJURY AT WORK? ☐ Yes ☐ No	30. PLACE OF INJURY (e.g., decedent's home, construction site, wooded area, restaurant, etc.)
31. LOCATION OF INJURY	STREET & HOUSE NUMBER	CITY/TOWN	STATE	ZIP CODE
32. DESCRIBE HOW INJURY OCCURRED				

Injury Information:

27. Date of Injury – Enter the actual or presumed date of injury. Enter Date of Injury If Accident contributed to Death. The Date of Injury may not necessarily be the same as the Date of Death. Estimates may be provided with “Approx” placed before the Date.

28. Hour of Injury - Enter the exact time (hour and minute using a 24-hour clock) when the injury occurred. If the exact time is “unknown” the time should be approximated by the Certifier.

29. Injury at Work - Enter “Yes” if the injury occurred at work. Otherwise enter “No”. An Injury may occur at work regardless of whether the injury occurred in the course of the decedent’s usual occupation.

30. Place of Injury - Enter the general type of place (such as a restaurant, vacant lot, baseball field, construction site, or decedent’s home) where the injury occurred. DO NOT enter firm or Organization names.

Cause of Death Cont…

25a. TOBACCO USE – DID TOBACCO USE CONTRIBUTE TO DEATH?	☐ Yes	☐ No	☐ Probably	☐ Unknown
25b. PREGNANCY – IF FEMALE, THE DECEDENT WAS: ☐ 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 – 1 year before death	☐ Unknown if pregnant within past year
26. MANNER OF DEATH	27. DATE OF INJURY? (month, day year)	28. HOUR OF INJURY?	29. INJURY AT WORK? ☐ Yes ☐ No	30. PLACE OF INJURY (e.g., decedent's home, construction site, wooded area, restaurant, etc.)
31. LOCATION OF INJURY	STREET & HOUSE NUMBER	CITY/TOWN	STATE	ZIP CODE
32. DESCRIBE HOW INJURY OCCURRED				

Injury Information Cont…

31. <u>Location of Injury</u> - Enter the complete address where the injury took place including Zip Code.

32. <u>Injury Description</u> - Enter in Narrative Form, a brief but specific and clear description of how the injury occurred. (Example: “Fell off ladder while painting house”)

Burial Transit Permit (Physician Requirements)

PERMIT MUST Accompany Remains to DESTINATION

SEXTON must return permit to City or Town Clerk at Place of Disposal on Fifth of Next Month

BURIAL – TRANSIT PERMIT **RHODE ISLAND DEPARTMENT OF HEALTH**

Permit number

DECEASED – FIRST NAME	MIDDLE	LAST	SEX	DATE OF DEATH (Month, day, year)
RACE	AGE	PLACE OF DEATH (City or town, state)		
BURIAL, CREMATION, DONATION, OTHER (Specify)	PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	CITY OR TOWN	STATE	
FUNERAL HOME – LICENSEE Signature	FUNERAL HOME – Name and Address (Number, Street name, City or Town, State, and Zip Code)			
CERTIFICATION: I certify that death occurred from natural causes. that (see Reverse Side) referral to the Medical Examiner is NOT required, and that permission is hereby granted to dispose of this body. Signature of Physician	Degree or title	Date signed		
Authorized disposition as state above occurred on (Date)	Tomb	Lot	Signature of Sexton or Person in Charge of Place of Disposition	

THIS PERMIT VALID ONLY IF SIGNED BOTH BY THE PHYSICIAN AND BY FUNERAL HOME LICENSEE

SEE OTHER SIDE

Physician is to Sign and Date the two shaded areas of the Burial Transit Permit when filling out the Death Certificate. The Physician is certifying that the Decedent died from Natural Causes and that a referral to the M.E. Examiner is not required.

Legal/Demographic Information

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER — STATE FILE NUMBER

DECEDENT

1. NAME – FIRST / MIDDLE / LAST
2. SEX
3. DATE OF DEATH (Month, day, year)

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)
4b. CITY, TOWN, OR LOCATION OF DEATH

5a. AGE – LAST BIRTHDAY (Years)
5b. UNDER 1 YEAR: MONTHS / DAYS
5c. UNDER 1 DAY: HOURS / MIN.
6. DATE OF BIRTH (Month, day, year)
7. BIRTHPLACE (City and State or Foreign Country)

8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR
9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)
9b. RACE (List all that apply)

10. SOCIAL SECURITY NUMBER (Decedent's)
11a. USUAL OCCUPATION (Do NOT use retired)
11b. KIND OF BUSINESS OR INDUSTRY

12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner
12b. SPOUSE / PARTNER (Give maiden name, if applicable)

13a. RESIDENCE ADDRESS (House number and street name)
13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE

14. MAILING ADDRESS – If different from residence address (Number, Street name, City or Town, State, and Zip Code)
15. EDUCATION (Decedent's)

PARENTS

16. FATHER / PARENT – FIRST NAME / MIDDLE / LAST / MAIDEN NAME
17. MOTHER / PARENT – FIRST NAME / MIDDLE / LAST / MAIDEN NAME

18a. INFORMANT – FULL NAME
18b. MAILING ADDRESS (Number, Street name, City or Town, State, and Zip Code)

DISPOSITION

19a. BURIAL CREMATION, DONATION, OTHER (Specify)
19b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CITY OR TOWN STATE

20a. SIGNATURE OF FUNERAL HOME LICENSEE
20b. FUNERAL HOME – NAME
20c. FUNERAL HOME LICENSE NUMBER

ITEMS BELOW TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY

20d. FUNERAL HOME – ADDRESS (Number, Street name, City or Town, State, and Zip Code)

ECEDENT: Y PHYSICIAN OR INSTITUTION ONLY

All **Unshaded** Fields (1-20d, excluding Field 3) must be completed by the Funeral Home Director including the Burial Transit Permit.

Decedent Information

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

DECEDENT

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ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST | MIDDLE | LAST
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3. DATE OF DEATH (Month, day, year)
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5b. UNDER 1 YEAR: MONTHS | DAYS
5c. UNDER 1 DAY: HOURS | MIN.
6. DATE OF BIRTH (Month, day, year)
7. BIRTHPLACE (City and State or Foreign Country)
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR
9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)
9b. RACE (List all that apply)
10. SOCIAL SECURITY NUMBER (Decedent's)
11a. USUAL OCCUPATION (Do NOT use retired)
11b. KIND OF BUSINESS OR INDUSTRY
12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner
12b. SPOUSE / PARTNER (Give maiden name, if applicable)

1. **Name of Decedent (First, Middle, Last) -** Type or print the full first, middle, and last names of the decedent. Do not abbreviate. Alias or "also known as" names should also be entered above the legal name or in parentheses (for example, AKA-Smith). This item is used to identify the decedent.

2. **Sex: Male or Female -** Do not abbreviate or use other symbols. If sex cannot be determined after verification with medical records, inspection of the body or other sources, enter "unknown." Do not leave this item blank.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

LOCAL FILE NUMBER

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT	1. NAME – FIRST MIDDLE LAST					2. SEX	3. DATE OF DEATH (Month, day, year)
TYPE OR PRINT IN BLACK INK.	4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)					4b. CITY, TOWN, OR LOCATION OF DEATH	
ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.	5a. AGE – LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR		5c. UNDER 1 DAY		6. DATE OF BIRTH (Month, day, year)	7. BIRTHPLACE (City and State or Foreign Country)
		MONTHS	DAYS	HOURS	MIN.		

Place of Death

4a. Hospital or other Institution - Name

If the death occurred in a hospital, enter the full name of the hospital.
If death occurred en route to or upon arrival at a hospital, enter the full name of the hospital. Deaths that occur in an ambulance or emergency squad vehicle en route to a hospital fall in this category.

Non-hospital deaths

If the death occurred in a nursing home or other institution, enter the name of the nursing home or institution.
If the death occurred at home, enter the house number and street name.
If the death occurred at some place other than those described above, enter the number and street name of the place.

4b. City, Town or Location of Death

Enter the name of the City or Town where death occurred. Do not use village names.
See **Appendix A** herein for a list of the 39 cities and towns in Rhode Island.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER — STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Month, day, year)
4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)			4b. CITY, TOWN, OR LOCATION OF DEATH	
5a. AGE – LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR: MONTHS / DAYS	5c. UNDER 1 DAY: HOURS / MIN.	6. DATE OF BIRTH (Month, day, year)	7. BIRTHPLACE (City and State or Foreign Country)
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR	9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)		9b. RACE (List all that apply)	

5a. **<u>Age- Last Birthday (Years)</u>** - Enter the decedent's exact age in years at his or her last birthday.
If the decedent was under 1 year of age, leave this item blank.

5b. **<u>Age Under 1 Year</u>** - Enter the exact age in either months or days at time of death for infants surviving at least 1 month.
If the infant was 1-11 months of age inclusive, enter the age in <u>completed</u> months.
If the infant was less than 1 month old, enter the age in <u>completed</u> days.
If the infant was over 1 year or under 1 day of age, leave this item blank.

5c. **<u>Age Under 1 Day</u> -** Enter the exact number of hours or minutes the infant lived for infants who did not survive an entire day.
If the infant lived 1-23 hours inclusive, enter the age in <u>completed</u> hours.
If the infant was less than 1 hour old, enter the age in minutes.
If the infant was more than 1 day old, leave this item blank.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Month, day, year)

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)	4b. CITY, TOWN, OR LOCATION OF DEATH

5a. AGE – LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR		5c. UNDER 1 DAY		6. DATE OF BIRTH (Month, day, year)	7. BIRTHPLACE (City and State or Foreign Country)
	MONTHS	DAYS	HOURS	MIN.		

8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR	9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)	9b. RACE (List all that apply)

10. SOCIAL SECURITY NUMBER (Decedent's)	11a. USUAL OCCUPATION (Do NOT use retired)	11b. KIND OF BUSINESS OR INDUSTRY

6. **Date of Birth -** Enter the exact month, day, and year that the decedent was born.

7. **Birthplace -** If the decedent was born in the United States, enter the name of the city/town and state. Always enter state of birth; an entry of "Providence" without "RI" is not acceptable. If the city/town of birth is not known, enter the name of the state only. If the state is unknown, enter "U.S.-unknown". If not born in the U.S., enter name of country.

8. **Ever in Armed Forces?** - If the decedent ever served in the U.S. Armed Forces, enter "Yes", as well as the names of any wars in which the decedent served. If not, enter "No". If you cannot determine whether the decedent served in the U.S. Armed Forces, enter "Unknown". Do not leave this item blank.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST | MIDDLE | LAST | 2. SEX | 3. DATE OF DEATH (Month, day, year)

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number) | 4b. CITY, TOWN, OR LOCATION OF DEATH

5a. AGE – LAST BIRTHDAY (Years) | 5b. UNDER 1 YEAR: MONTHS, DAYS | 5c. UNDER 1 DAY: HOURS, MIN. | 6. DATE OF BIRTH (Month, day, year) | 7. BIRTHPLACE (City and State or Foreign Country)

8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR | 9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin) | 9b. RACE (List all that apply)

10. SOCIAL SECURITY NUMBER (Decedent's) | 11a. USUAL OCCUPATION (Do NOT use retired) | 11b. KIND OF BUSINESS OR INDUSTRY

12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner

12b. SPOUSE / PARTNER (Give maiden name, if applicable)

9a. Hispanic Origin - The choices are as follows:

☐ **No**

or

☐ **Yes**, Mexican, Mexican American, Chicano
☐ **Yes**, Puerto Rican
☐ **Yes**, Cuban
☐ **Yes**, Other Spanish/Hispanic/Latino (Specify) ________________

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

DECEDENT	1. NAME – FIRST MIDDLE LAST	2. SEX	3. DATE OF DEATH (Month, day, year)
TYPE OR PRINT IN BLACK INK.	4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)	4b. CITY, TOWN, OR LOCATION OF DEATH	
ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.	5a. AGE – LAST BIRTHDAY (Years) / 5b. UNDER 1 YEAR MONTHS DAYS / 5c. UNDER 1 DAY HOURS MIN. / 6. DATE OF BIRTH (Month, day, year)	7. BIRTHPLACE (City and State or Foreign Country)	
	8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR / 9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)	9b. RACE (List all that apply)	
	10. SOCIAL SECURITY NUMBER (Decedent's) / 11a. USUAL OCCUPATION (Do NOT use retired)	11b. KIND OF BUSINESS OR INDUSTRY	

9b. **Race -** Ask the informant what the decedent felt his/her race was. Enter the Race of the decedent as stated by the informant. The choices are as follows:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) ________________
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify)__________
- ☐ Other (Specify) _____________________

For Asians and Pacific Islanders, enter the national origin of the decedent, such as Chinese, Japanese, Korean, Filipino, or Hawaiian. If the informant indicates that the decedent was of mixed race, enter both races.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER — STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (Month, day, year)

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)	4b. CITY, TOWN, OR LOCATION OF DEATH

5a. AGE – LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR MONTHS	5b. UNDER 1 YEAR DAYS	5c. UNDER 1 DAY HOURS	5c. UNDER 1 DAY MIN.	6. DATE OF BIRTH (Month, day, year)	7. BIRTHPLACE (City and State or Foreign Country)

8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR	9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)	9b. RACE (List all that apply)

10. SOCIAL SECURITY NUMBER (Decedent's)	11a. USUAL OCCUPATION (Do NOT use retired)	11b. KIND OF BUSINESS OR INDUSTRY

12a. MARITAL STATUS ☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed ☐ Divorced ☐ Civil Union ☐ Domestic Partner	12b. SPOUSE / PARTNER (Give maiden name, if applicable)

10. <u>Social Security Number</u> - Enter the decedent's 9-digit Social Security Number (SSN). Read the number back to the informant, or check against the document from which it is being copied. However, if the decedent was a recent immigrant or a person visiting from a foreign country and did not have a SSN, enter "None."
If the deceased's SSN is not known, enter "Unknown".

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST / MIDDLE / LAST	2. SEX	3. DATE OF DEATH (Month, day, year)
4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)	4b. CITY, TOWN, OR LOCATION OF DEATH	
5a. AGE – LAST BIRTHDAY (Years) / 5b. UNDER 1 YEAR: MONTHS, DAYS / 5c. UNDER 1 DAY: HOURS, MIN. / 6. DATE OF BIRTH (Month, day, year)	7. BIRTHPLACE (City and State or Foreign Country)	
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR / 9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)	9b. RACE (List all that apply)	
10. SOCIAL SECURITY NUMBER (Decedent's)	11a. USUAL OCCUPATION (Do NOT use retired)	11b. KIND OF BUSINESS OR INDUSTRY

11a. **Usual Occupation** - Enter the usual occupation of the decedent. This is not necessarily the last occupation of the decedent. "Usual occupation" is the kind of work the decedent did most of his or her working life, such as claim adjuster, farmhand, coal miner, janitor, store manager, college professor or civil engineer.

- Do Not enter "retired" .
- Enter "Student" if the decedent was a student at the time of death and was never regularly employed or employed full time during his or her working life.
- If the decedent was disabled, enter "disabled".
- If decedent was a homemaker at the time of death but had worked outside the household during his or her working life, enter that occupation. If the decedent was a homemaker during most of his or her working life and never worked outside the household, enter "Homemaker."
- If the decedent never worked, enter "never worked". If decedent's usual occupation is not known, enter "unknown".

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

DECEDENT	1. NAME – FIRST / MIDDLE / LAST						2. SEX	3. DATE OF DEATH (Month, day, year)
TYPE OR PRINT IN BLACK INK.	4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)						4b. CITY, TOWN, OR LOCATION OF DEATH	
ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.	5a. AGE – LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR MONTHS	5b. UNDER 1 YEAR DAYS	5c. UNDER 1 DAY HOURS	5c. UNDER 1 DAY MIN.	6. DATE OF BIRTH (Month, day, year)	7. BIRTHPLACE (City and State or Foreign Country)	
	8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR		9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)				9b. RACE (List all that apply)	
	10. SOCIAL SECURITY NUMBER (Decedent's)			11a. USUAL OCCUPATION (Do NOT use retired)			11b. KIND OF BUSINESS OR INDUSTRY	

11b. <u>Kind of Business or Industry</u> - Enter the kind of business or industry to which the occupation listed in 11a is related, such as insurance, farming, coal mining, hardware store, retail clothing, university, or government. Do not enter firm or organization names unless the kind of business or industry is unknown.

If the decedent was a homemaker during his or her working life and "homemaker" is entered as the decedent's usual occupation in item 11a, enter "Own Home" or "Someone else's home", whichever is appropriate.

If the decedent was a student at the time of death and "Student" is entered as the decedent's usual occupation in item 11a, enter the type of school, such as high school or college, in item 11b.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER
STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST / MIDDLE / LAST
2. SEX
3. DATE OF DEATH (Month, day, year)
4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)
4b. CITY, TOWN, OR LOCATION OF DEATH
5a. AGE – LAST BIRTHDAY (Years)
5b. UNDER 1 YEAR: MONTHS / DAYS
5c. UNDER 1 DAY: HOURS / MIN.
6. DATE OF BIRTH (Month, day, year)
7. BIRTHPLACE (City and State or Foreign Country)
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR
9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)
9b. RACE (List all that apply)
10. SOCIAL SECURITY NUMBER (Decedent's)
11a. USUAL OCCUPATION (Do NOT use retired)
11b. KIND OF BUSINESS OR INDUSTRY
12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner
12b. SPOUSE / PARTNER (Give maiden name, if applicable)

12a. Marital Status - Enter the **Marital Status** of the decedent at the time of death. Specify one of the following: **Never Married, Married, Married but Separated, Widowed, Divorced, Civil Union or Domestic Partner.** A person is legally married even if separated. A person is no longer legally married when the divorce papers are signed by a judge and the final decree is entered in court.

If marital status cannot be determined, enter "Unknown". Do not leave this item blank.

12b. Spouse/Partner Name - If the decedent was married at the time of death, enter the full name of the surviving spouse.

If the surviving spouse is the wife, enter her full maiden name.

If decedent was legally divorced at death, there is no spouse. Leave spouse's name blank.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST | MIDDLE | LAST | 2. SEX | 3. DATE OF DEATH (Month, day, year)

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number) | 4b. CITY, TOWN, OR LOCATION OF DEATH

5a. AGE – LAST BIRTHDAY (Years) | 5b. UNDER 1 YEAR: MONTHS, DAYS | 5c. UNDER 1 DAY: HOURS, MIN. | 6. DATE OF BIRTH (Month, day, year) | 7. BIRTHPLACE (City and State or Foreign Country)

8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR | 9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin) | 9b. RACE (List all that apply)

10. SOCIAL SECURITY NUMBER (Decedent's) | 11a. USUAL OCCUPATION (Do NOT use retired) | 11b. KIND OF BUSINESS OR INDUSTRY

12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner
| 12b. SPOUSE / PARTNER (Give maiden name, if applicable)

13a. RESIDENCE ADDRESS (House number and street name) | 13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE

13a. Residence Address - Enter the house number and street name of the place where the decedent lived. If this place has no house number and street name, enter the Rural Route number or box number.

13b. Residence City - Enter the name of the city or town and state in which the decedent lived. This may differ from the mailing address. If the decedent was a resident of Rhode Island, the city or town of the residence item should list the municipality where the decedent paid taxes. Village names such as Hope and Saunderstown should not be listed in this item. The 39 cities and towns in Rhode Island are included in **APPENDIX A.** If the Decedent lived outside the U.S., enter the country of residence.

Decedent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST MIDDLE LAST
2. SEX
3. DATE OF DEATH (Month, day, year)
4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)
4b. CITY, TOWN, OR LOCATION OF DEATH
5a. AGE – LAST BIRTHDAY (Years)
5b. UNDER 1 YEAR MONTHS DAYS
5c. UNDER 1 DAY HOURS MIN.
6. DATE OF BIRTH (Month, day, year)
7. BIRTHPLACE (City and State or Foreign Country)
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR
9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)
9b. RACE (List all that apply)
10. SOCIAL SECURITY NUMBER (Decedent's)
11a. USUAL OCCUPATION (Do NOT use retired)
11b. KIND OF BUSINESS OR INDUSTRY
12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner
12b. SPOUSE / PARTNER (Give maiden name, if applicable)
13a. RESIDENCE ADDRESS (House number and street name)
13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE
14. MAILING ADDRESS – If different from residence address (Number, Street name, City or Town, State, and Zip Code)
15. EDUCATION (Decedent's)

14. Mailing Address - Enter the address where the decedent received mail if different from the address listed in item 13a.

15. Education - Write in one of the following choices that corresponds to the highest level of Education that the decedent completed.

- ☐ Doctorate or Professional Degree
- ☐ Master's Degree
- ☐ Bachelor's Degree
- ☐ Associate Degree
- ☐ Some College, but no degree
- ☐ High School Diploma or GED
- ☐ If the decedent did not graduate high school, put the highest grade completed

Parent Information

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST | MIDDLE | LAST
2. SEX
3. DATE OF DEATH (Month, day, year)
4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)
4b. CITY, TOWN, OR LOCATION OF DEATH
5a. AGE – LAST BIRTHDAY (Years)
5b. UNDER 1 YEAR: MONTHS | DAYS
5c. UNDER 1 DAY: HOURS | MIN.
6. DATE OF BIRTH (Month, day, year)
7. BIRTHPLACE (City and State or Foreign Country)
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR
9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)
9b. RACE (List all that apply)
10. SOCIAL SECURITY NUMBER (Decedent's)
11a. USUAL OCCUPATION (Do NOT use retired)
11b. KIND OF BUSINESS OR INDUSTRY
12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner
12b. SPOUSE / PARTNER (Give maiden name, if applicable)
13a. RESIDENCE ADDRESS (House number and street name)
13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE
14. MAILING ADDRESS – If different from residence address (Number, Street name, City or Town, State, and Zip Code)
15. EDUCATION (Decedent's)

PARENTS

16. FATHER / PARENT – FIRST NAME | MIDDLE | LAST / MAIDEN NAME
17. MOTHER / PARENT – FIRST NAME | MIDDLE | LAST / MAIDEN NAME

16. Father/Parent - Type or print the first, middle, and last name (maiden surname where applicable) of the father/parent of the decedent.

17. Mother/Parent - Type or print the first, middle and last (maiden surname where applicable) of the mother/parent of the decedent. This is the name given at birth or adoption, not a name acquired by marriage.

Parent Information Cont…

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

DECEDENT

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

1. NAME – FIRST | MIDDLE | LAST

2. SEX

3. DATE OF DEATH (Month, day, year)

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)

4b. CITY, TOWN, OR LOCATION OF DEATH

5a. AGE – LAST BIRTHDAY (Years)

5b. UNDER 1 YEAR: MONTHS | DAYS

5c. UNDER 1 DAY: HOURS | MIN.

6. DATE OF BIRTH (Month, day, year)

7. BIRTHPLACE (City and State or Foreign Country)

8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR

9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)

9b. RACE (List all that apply)

10. SOCIAL SECURITY NUMBER (Decedent's)

11a. USUAL OCCUPATION (Do NOT use retired)

11b. KIND OF BUSINESS OR INDUSTRY

12a. MARITAL STATUS
☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed
☐ Divorced ☐ Civil Union ☐ Domestic Partner

12b. SPOUSE / PARTNER (Give maiden name, if applicable)

13a. RESIDENCE ADDRESS (House number and street name)

13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE

14. MAILING ADDRESS – If different from residence address (Number, Street name, City or Town, State, and Zip Code)

15. EDUCATION (Decedent's)

PARENTS

16. FATHER / PARENT – FIRST NAME | MIDDLE | LAST / MAIDEN NAME

17. MOTHER / PARENT – FIRST NAME | MIDDLE | LAST / MAIDEN NAME

18a. INFORMANT – FULL NAME

18b. MAILING ADDRESS (Number, Street name, City or Town, State, and Zip Code)

18a. <u>Informant Full Name</u> – Enter the name of the person who supplied the personal facts about the decedent.

18b. **<u>Mailing Address</u> -** Enter the complete mailing address of the informant whose name appears in item.

Disposition

	DISPOSITION	19a. BURIAL CREMATION, DONATION, OTHER (Specify)	19b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CITY OR TOWN STATE	
ECEDENT: Y PHYSICIAN OR INSTITUTION		20a. SIGNATURE OF FUNERAL HOME LICENSEE	20b. FUNERAL HOME – NAME	20c. FUNERAL HOME LICENSE NUMBER
		ITEMS BELOW TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY	20d. FUNERAL HOME – ADDRESS (Number, Street name, City or Town, State, and Zip Code)	

19a. <u>Burial, Cremation, Donation or Other</u> - If the body is to be used by a hospital or a medical or mortuary school for scientific or educational purposes, enter "Donation" and specify the name and location of the institution in item 19b. "Donation" refers only to the entire body, not to individual organs.
If body is being shipped out of country, enter the final disposition if known.
If unknown, enter: Other- removed from State.

19b. **<u>Place of Disposition</u>** - Enter the Name of the cemetery, crematory, or other place of disposition.
If the body is removed from the state, specify the name of the cemetery, crematory, or other place of disposition to which the body is removed.

Enter the name of the city or town and the state where the place of disposition is located.
If the body is to be used by a hospital, medical facility or a mortuary school for scientific or educational purposes, give the name of that institution, as well as the city or town and the state where the institution is located.

Disposition Cont…

DISPOSITION	19a. BURIAL CREMATION, DONATION, OTHER (Specify)	19b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) CITY OR TOWN STATE	
	20a. SIGNATURE OF FUNERAL HOME LICENSEE	20b. FUNERAL HOME – NAME	20c. FUNERAL HOME LICENSE NUMBER

20a. <u>Signature</u> - The funeral home licensee or other person first assuming custody of the body and charged with the responsibility for completing the death certificate should sign in permanent black ink.

20b. <u>Funeral Home Name</u> - Enter the Name of the funeral home handling the body prior to burial or other disposition. In the case where a Rhode Island licensed funeral home works with an out-of-state funeral home, the Rhode Island licensed funeral home should be entered on the certificate.

20c. <u>Funeral Home License Number</u> - Enter the state License Number of the funeral home.

Registrar Information

PHYSICIANS MUST COMPLETE SHADED AREAS ONLY. FUNERAL HOME MUST COMPLETE UNSHADED AREAS.

RHODE ISLAND DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER — STATE FILE NUMBER

DECEDENT

1. NAME – FIRST | MIDDLE | LAST
2. SEX
3. DATE OF DEATH (Month, day, year)

TYPE OR PRINT IN BLACK INK.

ADDITIONAL INSTRUCTIONS ON REVERSE SIDE.

4a. HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, give street and number)
4b. CITY, TOWN, OR LOCATION OF DEATH
5a. AGE – LAST BIRTHDAY (Years)
5b. UNDER 1 YEAR: MONTHS | DAYS
5c. UNDER 1 DAY: HOURS | MIN.
6. DATE OF BIRTH (Month, day, year)
7. BIRTHPLACE (City and State or Foreign Country)
8. EVER IN U.S. ARMED FORCES? (Specify Yes or No) NAME WAR
9a. HISPANIC ORIGIN (Yes or No. If Yes, Specify Origin)
9b. RACE (List all that apply)
10. SOCIAL SECURITY NUMBER (Decedent's)
11a. USUAL OCCUPATION (Do NOT use retired)
11b. KIND OF BUSINESS OR INDUSTRY
12a. MARITAL STATUS ☐ Never Married ☐ Married ☐ Married, but Separated ☐ Widowed ☐ Divorced ☐ Civil Union ☐ Domestic Partner
12b. SPOUSE / PARTNER (Give maiden name, if applicable)
13a. RESIDENCE ADDRESS (House number and street name)
13b. CITY OR TOWN OF RESIDENCE, STATE & ZIP CODE
14. MAILING ADDRESS – If different from residence address (Number, Street name, City or Town, State, and Zip Code)
15. EDUCATION (Decedent's)

PARENTS

16. FATHER / PARENT – FIRST NAME | MIDDLE | LAST / MAIDEN NAME
17. MOTHER / PARENT – FIRST NAME | MIDDLE | LAST / MAIDEN NAME
18a. INFORMANT – FULL NAME
18b. MAILING ADDRESS (Number, Street name, City or Town, State, and Zip Code)

DISPOSITION

19a. BURIAL CREMATION, DONATION, OTHER (Specify)
19b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | CITY OR TOWN | STATE
20a. SIGNATURE OF FUNERAL HOME LICENSEE
20b. FUNERAL HOME – NAME
20c. FUNERAL HOME LICENSE NUMBER
20d. FUNERAL HOME – ADDRESS (Number, Street name, City or Town, State, and Zip Code)

ITEMS BELOW TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY

NAME OF DECEDENT: ______ FOR USE BY PHYSICIAN OR INSTITUTION ONLY

PHYSICIAN

21a. To the best of my knowledge, death occurred at the time, date and place and was due to the cause(s) stated. DEGREE (MD, DO, PA, or NP) (Signature)
21b. R.I. LICENSE NUMBER
21c. DATE SIGNED (Month, day, yr)
21d. HOUR OF DEATH (If unknown, so state)
21e. WAS DEATH REFERRED TO MEDICAL EXAMINER? ☐ Yes ☐ No
21f. NAME & ADDRESS OF CERTIFIER (Type or Print)
21g. HOSPITAL DEATH? ☐ YES (Check a box below) ☐ NO (See 21h) ☐ Inpatient ☐ Emer. Room/Outpatient ☐ DOA
21h. NON-HOSPITAL DEATH? ☐ Hospice Facility ☐ Nursing Home ☐ Decedent's Home ☐ Hospice at Home ☐ Other (Specify):
21i. NAME AND ADDRESS OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER IN 21f (Type or Print)
21j. LENGTH OF ATTENDANCE (Specify days, wks, months, yrs)

RI law requires the name of the physician and the cause of death to be PRINTED or TYPED in BLACK INK. Signatures must also be in BLACK INK.

REGISTRAR

22a. REGISTRAR (Signature)
22b. FILE DATE – DATE RECEIVED BY REGISTRAR (Month, day, yr)

22a. <u>**Registrar Signature**</u> - To be signed upon receipt by the City/Town Registrar

22b. <u>File Date</u> - Filing Date is the date that the Certificate was received by the City/Town Registrar.

Supplemental Cause of Death Form (VS-218)

Rhode Island Department of Health, Center for Vital Records
Three Capitol Hill, Providence. RI 02908

Supplemental Report for Cause of Death

____
Date

____
Name of Decedent

____
City/Town of Death

____
Date of Death

Dear Registrar:
To complete the previously submitted death certificate on the above decedent, I am submitting the following arrangement of the cause(s) of death based on additional information, autopsy, or other findings.

23. PART I. Enter the chain of events – diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac / respiratory arrest or ventricular fibrillation without showing the etiology.		Approximate Interval Between Onset & Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	
	DUE TO (OR AS A CONSEQUENCE OF) b.	
Sequentially list conditions, if any, leading to the cause listed on line a.	DUE TO (OR AS A CONSEQUENCE OF) c.	
Enter the **UNDERLYING CAUSE** (Disease or injury that initiated the events resulting in death) **LAST**.	DUE TO (OR AS A CONSEQUENCE OF) d.	

23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	**24a.** AUTOPSY PERFORMED? ❑ Yes ❑ No	**24b.** Were autopsy findings available to complete the cause of death? ❑ Yes ❑ No

25a. TOBACCO USE – DID TOBACCO USE CONTRIBUTE TO DEATH? ❑ Yes ❑ No ❑ Probably ❑ Unknown

25b. PREGNANCY – IF FEMALE, THE DECEDENT WAS:
❑ 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 – 1 year before death ❑ Unknown if pregnant within past year

26. MANNER OF DEATH	**27.** DATE OF INJURY? (month, day, year)	**28.** HOUR OF INJURY	**29.** INJURY AT WORK? ❑ Yes ❑ No	**30.** PLACE OF INJURY (e.g. decedent's home, construction site, wooded area, restaurant, etc.)

31. LOCATION OF INJURY	STREET & HOUSE NUMBER	CITY/TOWN	STATE	ZIP CODE

32. DESCRIBE HOW INJURY OCCURRED

APPENDIX A: 39 City & Towns

- Barrington
- Bristol
- Burrillville
- Central Falls
- Charlestown
- Coventry
- Cranston
- Cumberland
- East Greenwich
- East Providence
- Exeter
- Foster
- Glocester
- Hopkinton
- Jamestown
- Johnston
- Lincoln
- Little Compton
- Middletown
- Narragansett
- Newport
- New Shoreham
- North Kingstown
- North Providence
- North Smithfield
- Pawtucket
- Portsmouth
- Providence
- Richmond
- Scituate
- Smithfield
- South Kingstown
- Tiverton
- Warren
- Warwick
- Westerly
- West Greenwich
- West Warwick
- Woonsocket

APPENDIX B: 24 Hour Clock

24-hour clock	12-hour
0000 (medical facilities)	12:00 midnight
2400 (military facilities)	
0100	1:00 am
0200	2:00 a.m.
0300	3:00 a.m.
0400	4:00 a.m.
0500	5:00 a.m.
0600	6:00 a.m.
0700	7:00 a.m.
0800	8:00 a.m.
0900	9:00 a.m.
1000	10:00 a.m
1100	1:00 a.m.
1200	12:00 noon
1300	1:00 p.m.
1400	2:00 p.m.
1500	3:00 p.m.
1600	4:00 p.m.
1700	5:00 p.m.
1800	6:00 p.m.
1900	7:00 p.m.
2000	8:00 p.m.
2100	9:00 p.m.
2200	10:00 p.m.
2300	11:00 p.m

§ 23-3-16 Death registration. – (a) A death certificate for each death which occurs in this state shall be filed with the state registrar of vital records or as otherwise directed by the state registrar within seven (7) calendar days after death and prior to removal of the body from the state, and shall be registered if it has been completed and filed in accordance with this section; provided:

(1) That if the place of death is unknown, a death certificate shall be filed with the state registrar of vital records or as otherwise directed by the state registrar within seven (7) calendar days after the occurrence; and

(2) That if death occurs in a moving conveyance, a death certificate shall be filed with the state registrar of vital records or as otherwise directed by the state registrar.

(b) The funeral director, his or her duly authorized agent, or person acting as agent, who first assumes custody of a dead body, shall file the death certificate. He or she shall obtain the personal data from the next of kin or the best qualified person or source available. He or she shall obtain the medical certification of cause of death from the person responsible for certification.

(c) A physician, after the death of a person whom he or she has attended during his or her last illness, or the physician declaring that person dead, or if the death occurred in a hospital, a registered hospital medical officer duly appointed by the hospital director or administrator, shall immediately furnish for registration a standard certificate of death to a funeral director or other authorized person or any member of the family of the deceased, stating to the best of his or her knowledge and belief the name of the deceased, the disease of which he or she died, where it was contracted, the duration of the illness from which he or she died, when last seen alive by the physician, or, if death occurs in a hospital, when last seen alive by a physician and the date of death.

(d) When death occurred without medical attendance as set forth in subsection (c) or when inquiry is required by chapter 4 of this title, the medical examiner shall investigate the cause of death and shall complete and sign the medical certification within forty-eight (48) hours after taking charge of the case.

History of Section.
(G.L. 1896, ch. 100, §§ 7, 9; P.L. 1897, ch. 452, § 1; G.L. 1909, ch. 121, §§ 7, 9; P.L. 1910, ch. 575, § 2; G.L. 1923, ch. 166, § 6; G.L. 1938, ch. 268, § 6; impl. am. P.L. 1939, ch. 660, §§ 180, 182; P.L. 1960, ch. 24, § 1; G.L. 1956, §§ 23-3-9 to 23-3-11; G.L. 1956, § 23-3-16; P.L. 1961, ch. 87, § 1; P.L. 1975, ch. 293, § 1; P.L. 1977, ch. 110, § 1; P.L. 2000, ch. 164, § 1.)

Contact Information

- **William Lyons– Death Registration**
- **(401)222-2804**
- **William.Lyons@health.ri.gov**

- **Richard Missaghian – Death & Fetal Death Registration Manager**
- **(401)222-8051**
- **Richard.Missaghian@health.ri.gov**