

Form R-360 07012014		 Commonwealth of Massachusetts Registry of Vital Records and Statistics DEATH CERTIFICATE MEDICAL CERTIFIER WORKSHEET		
<i>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.</i>				
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				M.E. CASE NUMBER
☐ Natural ALL OTHER MANNER OF DEATH CASES ARE REQUIRED TO BE REFERRED TO THE MEDICAL EXAMINER				
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.