

Minnesota Documentation of Death

SFN

Deceased Name (First, Middle, Last, Suffix)		Last Name Before First Marriage Also Known As	
Date of Death MM DD YYYY		Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	Social Security Number - - - <input type="radio"/> None <input type="radio"/> Unknown <input type="radio"/> Not Obtainable
Date of Birth <input type="radio"/> Unknown MM DD YYYY	Age (in years)	Under 1 Year months days	Under 1 Day hours minutes
Birth Country <input type="radio"/> Born in the United States <input type="radio"/> Not U.S. Specify _____ <input type="radio"/> Unknown		State/Province	City/Town
Deceased's Residence Address <input type="radio"/> U.S. Address <input type="radio"/> Foreign country _____ <input type="radio"/> Unknown		State/Province	County
		City/Town	Street & Number, Zip Code
		Inside City Limits? <input type="radio"/> Yes <input type="radio"/> No	
Education (highest completed) <input type="radio"/> Unknown <input type="radio"/> 8th grade or less <input type="radio"/> 9th - 12th grade; no diploma <input type="radio"/> High School graduate or GED completed <input type="radio"/> Some college credit but no degree		<input type="radio"/> Associate degree (e.g. AA,AS) <input type="radio"/> Bachelor's degree (e.g., BA,AB, BS) <input type="radio"/> Master's degree (e.g., MA, MS, MEng, Med, MSW, MBA) <input type="radio"/> Doctorate (e.g., MD, DDS, DVM,	Ever In Armed Forces? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
		Deceased's Usual Occupation Kind of Business or Industry	
Hispanic Origin <input type="radio"/> No, Not Spanish/Hispanic/Latino <input type="radio"/> Yes, Hispanic Origin Known <input type="checkbox"/> Mexican, Mexican American, Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other, specify _____ <input type="radio"/> Unknown if Spanish/Hispanic/Latino	Race <input type="radio"/> Unknown <input type="checkbox"/> White African American <input type="checkbox"/> Black/African American <input type="checkbox"/> Ethiopian <input type="checkbox"/> Liberian <input type="checkbox"/> Ghanaian <input type="checkbox"/> Other African Specify _____	<input type="checkbox"/> American Indian or Alaska Native Name of the Enrolled or Principal Tribe _____ Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian Specify _____ <input type="checkbox"/> Kenyan <input type="checkbox"/> Sudanese <input type="checkbox"/> Nigerian <input type="checkbox"/> Somali	Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other Pacific Islander Specify _____ <input type="checkbox"/> Other Race Specify _____
Marital Status at time of Death <input type="radio"/> Married But Separated <input type="radio"/> Married <input type="radio"/> Never Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Unknown <input type="radio"/> Not Obtainable		Spouse's Name (First, Middle, Last, Suffix) Last name before first marriage	
Father/Parent Two Name (First, Middle, Last, Suffix)		Mother / Parent One Name (First, Middle, Suffix) Last Name Before First Marriage	
Informant's Name (First, Middle, Last or Institution)		Relationship to Deceased Address(Street & Number, City, State, Zip)	
Place of Death Hospital <input type="radio"/> Inpatient <input type="radio"/> Emergency Room/Outpatient <input type="radio"/> Dead on Arrival		Other than a Hospital <input type="radio"/> Hospice <input type="radio"/> Nursing home/Long term care <input type="radio"/> Deceased's home <input type="radio"/> Other _____	
		County _____ Facility Name and Address (Street & Number, City, State, Zip)	
Physician/ME Providing Cause of Death Information (First, Middle, Last) License # Title		Funeral Home/Other Institution, Estab. # Funeral Director Name (First, Middle, Last)	
Method of Disposition <input type="radio"/> Burial <input type="radio"/> Cremation <input type="radio"/> Donation <input type="radio"/> Entombment <input type="radio"/> Removal from State <input type="radio"/> Other (Specify) _____			
Disposition Facility		State/Province City/Town	
Cemetery		State/Province City/Town	

The information on this form is correct to the best of my knowledge

Signature

Date

Minnesota Cause of Death Worksheet

SFN

Deceased Name (First, Middle, Last, Suffix)		Also Known As	
Physician/Medical Examiner providing this information		Title	License #
Date of Birth MM DD YYYY	Date of Death MM DD YYYY	Time of Death	
Was the Medical Examiner Contacted? <input type="radio"/> Yes <input type="radio"/> No		Date last saw deceased:	
Did INJURY or TRAUMA contribute to the cause of death? <input type="radio"/> Yes <input type="radio"/> No If Yes, please explain:			
Is there any reason to postpone final disposition? <input type="radio"/> Yes <input type="radio"/> No If Yes, please explain:			
Cause of Death			Approximate interval: Onset to death
Part I Enter the chain of events-diseases, injuries, or complications that directly caused death. Do not enter terminal events such as cardiac arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause per line. Add additional lines if necessary.			
IMMEDIATE CAUSE (final disease or condition resulting in death) Sequentially list conditions, if any, leading to the immediate cause. Enter the UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	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.	Due to (or as a consequence of)	
Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I			
Was an autopsy performed? <input type="radio"/> Yes <input type="radio"/> No		Autopsy Results Available to complete the cause of death? <input type="radio"/> Yes <input type="radio"/> No	
Did Tobacco use contribute to death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Probably <input type="radio"/> Unknown	If Female <input type="radio"/> Not pregnant within past year <input type="radio"/> Pregnant at time of death <input type="radio"/> Not pregnant, but pregnant within 42 days of death <input type="radio"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="radio"/> Unknown if pregnant within the past year	Manner of Death <input type="radio"/> Natural <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Pending Investigation <input type="radio"/> Could not be determined	
Complete Injury Information below if Manner of Death is not Natural			
Date of Injury MM DD YYYY	Time of Injury <input type="radio"/> AM <input type="radio"/> PM <input type="radio"/> Military	Injury at work? <input type="radio"/> Yes <input type="radio"/> No	If Transportation Injury, Specify (specify) <input type="radio"/> Driver/Operator <input type="radio"/> Passenger <input type="radio"/> Pedestrian <input type="radio"/> Other
Place of Injury (e.g. Deceased's home, construction site, restaurant, wooded area)			
Location of Injury (Street & Number, Apt. #, City or Town, State, Zip Code)			
Describe How Injury Occurred			

Completed by Physician: _____
Print Name

Signature

Date