2s Errata for Year 2005

Page Number	Content to be Corrected	Corrections
23	Second paragraph: Changed wording	Corrected page attached
31	Changed Data year to 2003	Corrected page attached

If more than one entry for Part II is listed on the certificate, enter the information in the order it appears on the certificate. Try to duplicate the information exactly as it is reported, using whatever punctuation is used on the certificate.

All abbreviations and symbols listed in Appendix D and E apply to Cause of Death, Part II.

Was an Autopsy Performed? – Enter the single-character code for whether an autopsy was performed or not. Typing a question mark {?} will display the following pick-list of valid choices:

N No
Y Yes
U Unknown
Blank

Use the arrow keys to highlight the desired entry and press {ENTER} to select it.

Were Autopsy Findings Available? – Enter the single-character code for whether any autopsy findings were available. Typing a question mark {?} will display the following pick-list of valid choices:

N No
Y Yes
U Unknown
Blank

Use the arrow keys to highlight the desired entry and press {ENTER} to select it.

Tobacco Use Contribute to Death? – Enter the single-character code for whether or not tobacco use contributed to death. Typing a question mark {?} will display the following pick-list of valid choices:

N No
Y Yes
P Probably
U Unknown
C Not on certificate
Blank

Use the arrow keys to highlight the desired entry and press {ENTER} to select it.

Pregnancy: – Enter the single-character code for any conditions of pregnancy of the decedent. Typing a question mark {?} will display the following pick-list of valid choices: Use the arrow key to highlight the desired entry and press {ENTER} to select it.

1 Not pregnant within past year
2 Pregnant at time of death
3 Not pregnant, but pregnant within 42 days of death
4 Not pregnant, but pregnant 43 days to 1 year before death
7 Not on certificate
8 Not applicable
9 Unknown if pregnant within last year
Blank

D. Exercise 2: Entering Information from Death Certificates

In the exercise, create a new file and enter the following records. After the records have been entered, do a sequence check to determine that all 16 have been entered. (See page 48 – 50)

File Name: TEST002

Header Information:

Shipment Number:	002	
Lot Number;		0002
Section Number:		1
Data Year:		2003
State Code:	AL	(or post office abbreviation for any state)
Coder Status:		1

Enter today's date as the date of death for the examples.

Exercise 2

DRAFT 07/08/2002

U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO.

STATE FILE NO. 000001

NAME OF DECEDENT

To Be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)
2. SEX: F
3. SOCIAL SECURITY NUMBER
4a. AGE-Last Birthday (Years): 68
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF BIRTH (Mo/Day/Yr)
6. BIRTHPLACE (City and State or Foreign Country)
RESIDENCE-STATE
7b. COUNTY
7c. CITY OR TOWN
7d. STREET AND NUMBER
7e. APT. NO.
7f. ZIP CODE
7g. INSIDE CITY LIMITS? ☐ Yes ☐ No
8. EVER IN US ARMED FORCES? ☐ Yes ☐ No
9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)
11. FATHER'S NAME (First, Middle, Last)
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)
13a. INFORMANT'S NAME
13b. RELATIONSHIP TO DECEDENT
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)
14. PLACE OF DEATH (Check only one: see instructions)
IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):
15. FACILITY NAME (If not institution, give street & number)
16. CITY OR TOWN, STATE, AND ZIP CODE
17. COUNTY OF DEATH
18. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify):
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)
20. LOCATION-CITY, TOWN, AND STATE
21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT
23. LICENSE NUMBER (Of Licensee)

To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr)
25. TIME PRONOUNCED DEAD
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)
27. LICENSE NUMBER
28. DATE SIGNED (Mo/Day/Yr)
29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month): 01/01/2003
30. ACTUAL OR PRESUMED TIME OF DEATH
31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. 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. Cerebral thrombosis	7 wks
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. Renal failure — Due to (or as a consequence of):	4 wks
	c. Pneumonia — Due to (or as a consequence of):	1 wk
	d. — Due to (or as a consequence of):	

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

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☑ Yes ☐ Probably ☐ No ☐ Unknown
36. IF FEMALE: ☒ 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
37. MANNER OF DEATH: ☑ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined
38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)
39. TIME OF INJURY
40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)
41. INJURY AT WORK? ☐ Yes ☐ No
42. LOCATION OF INJURY: State: City or Town: Street & Number: Apartment No.: Zip Code:
43. DESCRIBE HOW INJURY OCCURRED:
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)
45. CERTIFIER (Check only one):
☒ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & 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 of certifier: John Smith MD
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32)
47. TITLE OF CERTIFIER: Physician
48. LICENSE NUMBER: PHS67
49. DATE CERTIFIED (Mo/Day/Yr)
50. FOR REGISTRAR ONLY- DATE FILED (Mo/Day/Yr)