

# June 7, 2011 FOR IMMEDIATE RELEASE

Revised death certificate effective July 1

# DES MOINES, IA – Iowa physicians are being advised that the Iowa Department of Public Health will be using a revised certificate of death, effective July 1, to conform with new legislation recently signed into law by Governor Terry Branstad.

The legislation, which was approved by the General Assembly earlier this year, allows physician assistants (PA) and advanced registered nurse practitioners (ARNP), in addition to medical physicians (MD) and osteopathic physicians (DO), to certify the cause of death.

Revisions to the certificate are:

* **Box 26 (Name of person pronouncing death)** – Parentheses were added to remind the user that only the following professional titles may be listed – MD, DO, PA, ARNP, RN (registered nurse), LPN (licensed practical nurse).
* **Box 31b (If yes, medical examiner contacted)** – Revised from a yes/no option to a blank space for the medical examiner case number to be entered if “yes,” the medical examiner was contacted.
* **Box 34 (Autopsy findings available)** – The words “if yes” were added in the label.

# **Box 45 (Certifier)** – The first box now says “Certifying MD, DO, PA, ARNP” to conform with the new law and the second box now has “MD, DO” added after the words “medical examiner.”

The revised certificate (see sample below) and instructions are available at this website: <http://www.idph.state.ia.us/apl/deathreg.asp>

The Iowa Department of Public Health began using a new certificate on January 1, incorporating standards developed by the National Center for Health Statistics.

State law requires the certificate to be completed promptly so that families can close out the estate of the deceased person and begin to settle business and personal affairs.



## NON-NATURAL DEATHS

**144.28 Medical Certification.**

1. *a*. For the purposes of this [Iowa Code] section, “non-natural cause of death” means the death is a direct or indirect result of physical, chemical, thermal, or electrical trauma, or drug or alcohol intoxication or other poisoning.
   1. Unless there is a non-natural cause of death, the medical certification shall be completed and signed by the physician, physician assistant,\* or advanced registered nurse practitioner\* in charge of the patient’s care for the illness or condition which resulted in death within seventy- two hours after receipt of the death certificate from the funeral director or individual who initially assumes custody of the body.
   2. If there is a non-natural cause of death, the county or state medical examiner shall be notified and shall conduct an inquiry.
   3. If the decedent was an infant or child and the cause of death is not known, the medical examiner’s inquiry shall be conducted and an autopsy performed as necessary to exclude a non-natural cause of death.
   4. If upon inquiry into a death, the county or state medical examiner determines that a pre- existing natural disease or condition was the likely cause of death and that the death does not affect the public interest as described in [Iowa Code] section 331.802, subsection 3, the medical examiner may elect to defer to the physician, physician assistant,\* or advanced registered nurse practitioner\* in charge of the patient’s pre-existing condition the certification of the cause of death.
   5. When an inquiry is required by the county or state medical examiner, the medical examiner shall investigate the cause and manner of death and shall complete and sign the medical certification within seventy-two hours after determination of the cause and manner of death.
2. The person completing the medical certification of cause of death shall attest to its accuracy either by signature or by an electronic process approved by rule.

**NOTE:**

On the death certificate, the Medical Examiner should enter their case number in item #31b if the death falls within the jurisdiction of the Medical Examiner.

If the Medical Examiner is deferring certification back to the physician, physician assistant,\* or advanced registered nurse practitioner\* in charge of the patient’s care or condition that resulted in death, the ME should provide the physician, physician assistant,\* or advanced registered nurse practitioner\* with the case number to be entered in item #31b on the death certificate form.

\* Effective with July 1, 2011, death events pursuant to H.F. 393, 2011 legislative session.

## DEATHS THAT FALL UNDER THE JURISDICTION OF A MEDICAL EXAMINER

Deaths that have an impact on the “public’s interest” are routinely investigated by the County Medical Examiners under the guidance of the Iowa Office of the State Medical Examiner.

Deaths affecting the public’s interest include deaths that are:

Sudden, Unexpected, Violent, Suspicious, or Unattended

Deaths that come under the jurisdiction of the Medical Examiner’s Office are outlined in Iowa Code section 331.802(3) and generally include, but are not limited to:

1. Violent death, including homicide, suicide, or accidental death resulting from physical.
2. Death caused by mechanical, thermal, electrical, or radiation injury.
3. Death caused by criminal abortion, including self-induced, or by sexual abuse.
4. Death related to disease thought to be virulent or contagious that may constitute a public hazard.
5. Death that occurred unexpectedly or from an unexplained cause.
6. Death of a person confined in a prison, jail, or correctional institution.
7. Death of a person who was pre-diagnosed as a terminal or bedfast case who did not have a physician in attendance within the preceding thirty days; or death of a person who was admitted to and had received services from a hospice program as defined in Code section 135J.1, if a physician or registered nurse employed by the program was not in attendance within thirty days preceding death.
8. Death of a person if the body is not claimed by a person authorized to control the deceased person’s remains under section 144C5, or a friend.
9. Death of a person if the identity of the deceased is unknown or the body is unclaimed.
10. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.
11. Death of a person committed or admitted to a state mental health institute, a state resource center, the state training school, or the Iowa juvenile home.
12. Death of a person under the age of 55 who died suddenly when in apparent good health;
13. Death due to suspicious circumstances.
14. Death due to unknown or obscure causes.
15. Custody deaths.

BIRTH NUMBER

STATE OF IOWA

IOWA DEPARTMENT OF PUBLIC HEALTH

**CERTIFICATE OF DEATH**

**DECEDENT**

**114-**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.** DECEDENT’S FULL NAME |  | | | FIRST | |  | |  | |  | | |  | MIDDLE | |  | | | | |  | | | LAST | | | | |  | | |  | | | |  | | | | SUFFIX, | | if | any |
| **2.** SEX | **3a.** AGE – | | LAST | | BIRTHDAY  Years | | **3b.** | | UNDER | | | 1 YEAR | | **3c.** UNDER 1 DAY | | | | | **4.** DATE | | OF | BIRTH (Month, | | | Day, | | | Year) | | **5.** COUNTY | | | OF | | DEATH | | | | | | | | |
| Months | | | | Days | | | Hours | | Minutes | | |
| **6.** PLACE OF BIRTH (City & State, or Foreign Country) | | | | | | | | | | | | | | **7.** SOCIAL SECURITY NUMBER | | | | | | | | | **8.** CITIZEN | | | | | | | OF WHAT | COUNTRY? | | | | | | | | 1. EVER ARMED    * Yes | | IN U.S. FORCES?   * No | | |
| **10a.** MARITAL STATUS AT TIME OF DEATH   * Married  Married but separated  Widowed * Divorced  Never Married  Unknown | | | | | | | **10b.** DECEDENT’S LAST NAME PRIOR TO ANY  MARRIAGE (If ever married) | | | | | | | | | | | | | | **11.** SURVIVING SPOUSE (Full name prior to any marriage) | | | | | | | | | | | | | | | | | | | | | | |
| **12a.** RESIDENCE-STATE | | **12b.** RESIDENCE-COUNTY | | | | | | | | | | | **12c.** RESIDENCE-CITY OR TOWN | | | | | | | **12d.** RESIDENCE-STREET & NUMBER, ZIP CODE | | | | | | | | | | | | | | | | | | | | **12e.** INSIDE CITY LIMITS?   * Yes  No | | | |
| **13.** FATHER’S NAME | FIRST | | MIDDLE | | | | |  | |  | | | LAST | | | **14.** MOTHER’S NAME PRIOR  TO ANY MARRIAGE | | | | | FIRST | | | MIDDLE | | | | | | |  | | | | | LAST | | | |  | | | |
| **15a.** INFORMANT’S NAME | | | | | | | **15b.** INFORMANT’S MAILING ADDRESS (Street & Number, City, State, Zip Code) | | | | | | | | | | | | | | | | | | | | | | | | | **15c.** RELATIONSHIP TO DECEDENT | | | | | | | | | | | |
| **16. PLACE OF DEATH** (Check only one) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IF DEATH OCCURRED IN A HOSPITAL   * Inpatient  ER/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) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **17a.** FACILITY NAME (If not institution, give street and number) | | | | | | | | | | | | | | | **17b.** CITY, TOWN, OR LOCATION & ZIP CODE OF DEATH | | | | | | | | | | | | | | | | | | | | | **17c.** INSIDE CITY LIMITS?   * Yes  No | | | | | | | |
| **DISPOSITION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **18.** METHOD OF DISPOSITION   * Burial  Cremation  Donation  Entombment  Removal from State * Other (Specify) | | | | | | | | | | | | | | | **19.** PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **20.** LOCATION OF DISPOSITION (City or Town & State) | | | | | | | | | | **21.** NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **22a.** FUNERAL DIRECTOR – Printed Name | | | | | | | | | | | | | | | **22b.** FUNERAL DIRECTOR – Signature | | | | | | | | | | | | | | | | | | | **23**. LICENSE NUMBER | | | | | | | | | |
| **PRONOUNCEMENT, CERTIFICATION AND CAUSE OF DEATH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ITEMS 24 – 28 REQUIRED TO BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH** | | | | | | | | **24.** DATE PRONOUNCED DEAD (Month, Day, Year) (Spell out month) | | | | | | | | | | | | | | | | | | | | **25.** TIME PRONOUNCED DEAD  TIME  AM  PM  Military | | | | | | | | | | | | | | | |
| **26.** NAME OF PERSON PRONOUNCING DEATH (If different than certifier) (Type or print legibly) (MD, DO, PA, ARNP, RN, LPN) | | | | | | | | | | | | | | | | | | **27.** TITLE | | | | | | **28.** LICENSE NUMBER | | | | | | | | | | **31a.** MEDICAL EXAMINER CONTACTED?  Yes  No  **31b. If Yes,** M.E. case number | | | | | | | | | |
| **29.** ACTUAL OR PRESUMED DATE OF DEATH (Month, Day, Year) (Spell out month) | | | | | | | | | | | | | | | | | | **30.** ACTUAL OR PRESUMED TIME OF DEATH  TIME  AM  PM  Military | | | | | | | | | | | | | | | |
| **CAUSE OF DEATH (See instructions and examples)**  **32a. 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.  IMMEDIATE CAUSE (Final disease or a.  condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to b.  the cause listed on line a. Enter the Due to (or as a consequence of):  **UNDERLYING CAUSE** (disease or injury that c.  initiated the events resulting in death) **LAST** Due to (or as a consequence of):  d.  Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **32b.** Approximate interval between onset and death | | | | | |
| **32c.** 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. If yes,** WERE AUTOPSY FINDINGS AVAILABLE TO  COMPLETE CAUSE OF DEATH?  Yes  No | | | | | | | | | | | | | | | | |
| 1. DID TOBACCO USE CONTRIBUTE TO DEATH?    * Yes  Probably    * No  Unknown | | | | 1. IF FEMALE:    * Not pregnant within past year  Not pregnant, but pregnant within 42 days of death    * Pregnant at time of death  Not pregnant, but pregnant 43 days to 1 year before death      + Unknown if pregnant within the past year | | | | | | | | | | | | | | | | | | | | | | | 1. MANNER OF DEATH    * Natural  Homicide    * Accident  Pending Investigation    * Suicide  Could not be Determined | | | | | | | | | | | | | | | | |
| **38.** DATE OF INJURY (Month, Day, Year) (Spell out month) | | | | | | | | | | **39.** TIME OF INJURY  AM  PM  TIME  Military | | | | | | | **40.** PLACE OF INJURY (e.g., home, farm, street, roadway, etc.) | | | | | | | | | | | | | | | | | | | | 1. INJURY AT WORK?    * Yes  No | | | | | | |
| **42.** LOCATION OF INJURY: (Complete physical address – Street & Number, Apt. #, City or Town, State, Zip Code) | | | | | | | | | | | | | | | | | | | | | | | | | | | **43.** IF TRANSPORTATION INJURY, SPECIFY:   * Driver/Operator  Passenger  Pedestrian * Other (Specify) | | | | | | | | | | | | | | | | |
| **44.** DESCRIBE HOW INJURY OCCURRED: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **45. CERTIFIER**  Certifying MD, DO, PA, ARNP – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.  (Check only one)  Medical Examiner (MD, DO) – On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, & place, and due to the cause(s) & manner stated.  Signature **46.** TITLE **47.** DATE CERTIFIED (Month, Day, Year) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **48.** NAME & COMPLETE MAILING ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or print legibly) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **49.** LICENSE NUMBER | | | | | | | | | |
| **50. FOR REGISTRAR ONLY** – REGISTRAR SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | **50a**. DATE RECEIVED BY REGISTRAR (Month, Day, Year) | | | | | | | | | | | | | | | | | |

**CERTIFIER**

**DATE**

**DISPOSITION**

**PLACE**

**CAUSE OF DEATH**