Date of Death:_____
AKA:

STATE OF HAWAII DEATH CERTIFICATE WORKSHEET

To Be Completed By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (First, Middle, Last)				2. SEX	3. SOCIAL SECURITY NO.
4a. AGE-Last Birthday (Years)	4b. UNDER 1 YEAR: Months / Days	4c. UNDER 1 DAY: Hrs. / Min.	5. DATE OF BIRTH (Mo/Day/Yr)	6a. STATE OF BIRTH (If not in USA, name Country)	6b. CITIZEN OF WHAT COUNTRY
7. PLACE OF DEATH (Check only one: see instructions)	IF DEATH OCCURRED IN A HOSPITAL: ☐ Emergency Room/Outpatient ☐ Inpatient ☐ Dead on Arrival	IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice Facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other(Specify) _____			
8. FACILITY NAME (If not institution, give street & number)	9. CITY OR TOWN, STATE, AND ZIP CODE		10a. COUNTY OF DEATH	10b. ISLAND OF DEATH	
11. EVER IN US ARMED FORCES? ☐ Yes ☐ No ☐ Unknown	12. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Never Married ☐ Unknown ☐ Divorced ☐ Widowed	13. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)			
14a. RESIDENCE STATE	14b. COUNTY	14c. CITY OR TOWN			
14d. STREET AND NUMBER	14e. APT. NO.	14f. ZIP CODE	14g. INSIDE CITY LIMITS? ☐ Yes ☐ No		
15. DECEDENT'S EDUCATION (highest grade or degree completed)	16. DECEDENT OF HISPANIC ORIGIN? ☐ No ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Unknown ☐ Other _____	17. DECEDENT'S RACE (Enter races, separated by commas)			
18. DECEDENT'S USUAL OCCUPATION (work done during most of working life. DO NOT USE RETIRED)		19. KIND OF BUSINESS OR INDUSTRY			
20. FATHER'S NAME (First, Middle, Last)		21. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)			
22a. INFORMANT'S NAME	22b. RELATIONSHIP TO DECEDENT	22c. MAILING ADDRESS (Street and Number, City, State, Zip Code)			
23. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Removal ☐ Entombment ☐ Medical Science ☐ Other	24a. PLACE OF DISPOSITION (Name of cemetery, crematory, other)				
25. LOCATION-CITY, TOWN AND STATE	26. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY				
27a. DATE OF DISPOSITION (Mo/Day/Yr)	27b. SIGNATURE OF FUNERAL DIRECTOR				

To Be Completed By: MEDICAL CERTIFIER

Name of Decedent:

ITEMS 28-32 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH OR ME/CORONER	28. DATE PRONOUNCED DEAD (Mo/Day/Yr)	29. TIME PRONOUNCED DEAD	
	30. NAME / TITLE OF PERSON PRONOUNCING DEATH (Only when applicable)	31. LICENSE NUMBER	32. DATE SIGNED (Mo/Day/Yr)
33. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month).	34. ACTUAL OR PRESUMED TIME OF DEATH		35. WAS ME/CORONER CONTACTED? ☐ Yes ☐ No

36. CAUSE OF DEATH (See instructions & examples)-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.

		Approx interval Onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death →)	(a)	
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	DUE TO OR AS A CONSEQUENCE OF: (b)	
	DUE TO OR AS A CONSEQUENCE OF: (c)	
	DUE TO OR AS A CONSEQUENCE OF: (d)	

PART II. Enter other SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not resulting in the underlying cause given in PART I.

37. WAS AN AUTOPSY PEFORMED? ☐ Yes ☐ No

38. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? ☐ Yes ☐ No

39. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown	40. IF FEMALE ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Unknown if pregnant within the past year ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 yr before death ☐ Not pregnant, but pregnant within past yr (time unknown)	41. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

42. DATE OF INJURY (Mo/Day/Yr)	43. TIME OF INJURY	44. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	45. INJURY AT WORK? ☐ Yes ☐ No

46. LOCATION OF INJURY: Street Address: Apartment No:

City or Town: State: Zip Code:

47. DESCRIBE HOW INJURY OCCURRED:	48. TRANSPORTATION INJURY SPECIFY ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

49. CERTIFIER (Check only one):	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 the 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

50. NAME, ADDRESS, AND ZIP CODE OF PHYSICIAN COMPLETING CAUSE OF DEATH (Item 36)

51. TITLE OF CERTIFIER	52. LICENSE NUMBER	53. DATE CERTIFIED (Mo/Day/Yr)	

rev (1/2006)