COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF HEALTH • VITAL RECORDS

# Medical Certification Worksheet

***Medical Certifier:*** *Enter all information in the items listed below and return to funeral director of record. This form may be faxed or scanned to the funeral director or personally picked-up by the funeral director.*

| 1. Decedent's Legal Name (First, Middle, Last, Suffix) | 4. Date of Death (Mo/Day/Yr) (Spell Mo) |
|---|---|
| Marie E. Morris | March 27, 2021 |

**15a. Place of Death (Check only one)**

If Death Occurred in a Hospital: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

If Death Occurred Somewhere Other Than a Hospital: ☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify) _____

| 15b. Facility Name (If not institution, give street and number) | 15c. City or Town, State, and Zip Code | 15d. County of Death |
|---|---|---|
| 9207 Exter Rd. | Philadelphia PA 19114 | Philadelphia |

| 23a - 23d MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH | 23a. Date Pronounced Dead (Mo/Day/Yr) | 23b. Signature of Person Pronouncing Death (Only when applicable) | 23c. License Number |
|---|---|---|---|
| 23d. Date Signed (Mo/Day/Yr) 3/30/21 | 24. Time of Death 10:20 | 25. Was Medical Examiner or Coroner Contacted? ☐ Yes ☒ No | |

## CAUSE OF DEATH

26. 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. CARDIOPULMONARY ARREST | |
| | Due to (or as a consequence of): | |
| | b. PULMONARY ANTONY DISEASE | |
| 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): | |
| | c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | |
| | Due to (or as a consequence of): | |
| | d. CEREBRAL INSUFFICIENCY | |
| | Due to (or as a consequence of): | |

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

DIABETES MELLITUS

27. Was an autopsy performed? ☐ Yes ☒ No

28. Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No

29. 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

30. Did Tobacco Use Contribute to Death?
☐ Yes ☐ Probably ☐ No ☐ Unknown

31. Manner of Death
☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

32. Date of Injury (Mo/Day/Yr) (Spell Month)

33. Time of Injury

34. Place of Injury (e.g. home; construction site; farm; school)

35. Location of Injury (Street and Number, City, County, State, Zip Code)

36. Injury at Work
☐ Yes ☐ No

37. If Transportation Injury, Specify:
☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify) _____

38. Describe How Injury Occurred:

39a. Certifier - physician, certified nurse practitioner, medical examiner/coroner (Check only one):
- ☐ Certifying only - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
- ☐ Pronouncing & Certifying - 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: _____ Title of certifier: D.O. License Number: OS-063442-L

| 39b. Name, Address and Zip Code of Person Completing Cause of Death (Item 26) | 39c. Date Signed (Mo/Day/Yr) |
|---|---|
| RICHARD STRELSON 3131 PRINCETON AVE PHILA PA 19149 | 3/30/21 |

To Be Completed By: MEDICAL CERTIFIER

***FOR FUNERAL DIRECTOR USE ONLY:***

Printed Certifier Name, Title and License Number: _____

EDRS Case ID Number: _____ Disposition Permit No. _____