Form R-362-07012014

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

DEATH CERTIFICATE ATTESTATION

DECEDENT – NAME FIRST | MIDDLE | LAST | GENERATIONAL ID

DATE OF DEATH	SEX	PLACE OF DEATH – CITY/TOWN	DATE OF BIRTH

MEDICAL RECORD NUMBER	PLACE OF DEATH

HOSPITAL OR OTHER INSTITUTION – NAME

• Verify date and time of death and all items below. Sign below if correct.

PART I – CAUSE OF DEATH – SEQUENTIALLY LIST IMMEDIATE CAUSE THEN ANTECEDENT CAUSES THEN UNDERLYING CAUSE	APPX INTERVAL
a) Immediate Cause	
b) Due to	
c) Due to	
d) Due to	

PART II – OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH	M.E. NOTIFIED?	AUTOPSY PERFORMED?
	AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETING CAUSE OF DEATH?	

MANNER OF DEATH	M.E. CASE NUMBER	DATE OF INJURY	TIME OF INJURY	INJURY AT WORK?

PLACE OF INJURY	TRANSPORTATION INJURY

LOCATION/ADDRESS OF INJURY

DESCRIBE HOW INJURY OCCURRED	DID TOBACCO USE CONTRIBUTE TO DEATH?
	APPX TIME OF DEATH

IF FEMALE, PREGNANCY STATUS AT TIME OF DEATH	M.E. DATE PRONOUNCED	M.E. TIME PRONOUNCED

MEDICAL CERTIFIER INFORMATION – NAME/TITLE	HOUR OF DEATH

MEDICAL CERTIFIER INFORMATION - ADDRESS	LICENSE #

MEDICAL CERTIFIER DESIGNATION

MEDICAL CERTIFIER FAX NUMBER TO RECEIVE ATTESTATION FORM	MEDICAL CERTIFIER TELEPHONE NUMBER

PROVIDER IN CHARGE OF PATIENT'S CARE – NAME/TITLE

RN/ PA/ NP PRONOUNCEMENT?	IF YES, DATE	IF YES, TIME	PRONOUNCER INFORMATION – NAME/TITLE

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) stated.

DATE SIGNED (Month/DD/YYYY)

←

Signature and Title of Medical Certifier Required. Do not write outside the heavy line.