

SUPPLEMENTAL REPORT OF CAUSE OF DEATH

IMPORTANT NOTE: Please be sure to transfer **ALL** data from the original certificate that you intend to be reported as the **final cause(s)/conditions and events of the death.**

DECEDENT	DECEDENT'S LEGAL NAME					
	FIRST	MIDDLE	LAST	SUFFIX	LAST NAME PRIOR TO FIRST MARRIAGE	
TYPE/PRINT IN PERMANENT BLACK, BLUE-BLACK OR BLUE INK	aka	aka	aka			
	SEX	DECEDENT'S RACE	COUNTY OF DEATH	DATE OF DEATH (Month/Day/Year)		
MEDICAL CERTIFICATION	23. Part I. Enter the <u>chain of events</u> (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 on lines b, c and/or d. Enter only one cause on a line. DO NOT ABBREVIATE.				Approximate interval: Onset to death	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____ Due to (or as a consequence of)					
	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. _____ Due to (or as a consequence of)					
c. _____ Due to (or as a consequence of)						
d. _____						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.			24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No Sent to South Carolina for autopsy at the request of the Lancaster County Coroner	24b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending <input type="checkbox"/> Suicide <input type="checkbox"/> Cannot be determined		26a. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> Yes <input type="checkbox"/> No	27. TIME OF DEATH (Approximate)	28. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	29. IF FEMALE: <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	
26b. IF YES <input type="checkbox"/> Declined by Medical Examiner	30. DATE PRONOUNCED (Month/Day/Year)	31a. DATE OF INJURY (Month/Day/Year)	31b. TIME OF INJURY	31c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	31d. PLACE OF INJURY—at home, farm, street, factory, office, building, etc.	31e. IF TRANSPORTATION INJURY SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____
30. DATE PRONOUNCED (Month/Day/Year)			31f. DESCRIBE HOW INJURY OCCURRED			31g. LOCATION OF INJURY (Street/Number/City/State)
MEDICAL EXAMINER ONLY						
CERTIFIER						
32. CERTIFIER (Check only one) <input type="checkbox"/> Certifying physician/nurse practitioner/physician assistant – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner – 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.						
33a. SIGNATURE AND TITLE OF CERTIFIER			33b. LICENSE NUMBER	33c. DATE SIGNED (Month/Day/Year)		
33a. NAME AND ADDRESS OF CERTIFIER (Print legibly)						

This form is for use by **Certifiers and Medical Examiners** to report Cause of Death. Information obtained through autopsy and/or investigation after the Death Certificate has been filed.