

Ministry of Government and Consumer Services
Office of the Registrar General

Handbook on Medical Certification of Death

Prepared for:
Registered Nurses (Extended Certificate)

“It may truthfully be said that virtually every large-scale problem in preventive medicine has been brought to light – in part at least – by statistics of death, and further that the adequacy of remedial or curative action is, in the last analysis, reflected in these same statistics.”

United Nations Handbook of Vital Statistics Methods, 1955

Preamble

The purpose of this guide is to provide a useful tool to registered nurses holding an extended certificate of registration [RN(EC)] who, in prescribed circumstances, are permitted to certify deaths in Ontario. It has been designed to provide instruction for the accurate completion of the Medical Certificate of Death and to serve as a reference.

The handbook is specifically designed for this limited user group. It is expected that this handbook will be studied by registered nurses holding an extended certificate of registration [RN(EC)] before completing and signing a Medical Certificate of Death in the prescribed circumstances.

If you have any comments, suggestions or questions regarding the content, format or distribution of this handbook or require this handbook in another format, you may contact:

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The College of Nurses of Ontario

Sources

This handbook is modeled on a number of other handbooks, including the 1947 Edition of the Dominion Bureau of Statistics' Vital Statistics Handbook, the U.S. Department of Health and Human Services' 1987 Physicians' Handbook on Medical Certification of Death, the Australian Bureau of Statistics booklet Cause of Death Certification, the World Health Organization's 1979 handbook Medical Certification of Death, and the British Columbia Ministry of Health and Ministry Responsible for Seniors' Physicians' and Coroners' Handbook on Medical Certification of Death.

To obtain the Medical Certificate of Death – Form 16

- Fax a request to (807) 343-7459
- Email a request to ORGID@ontario.ca
- Call the Medical Coding Division at (807) 343-7458

Preface

This handbook was prepared to guide registered nurses who hold an extended certificate of registration under the Nursing Act, 1991 in completing the Medical Certificate of Death, Form 16 (medical certificate) as prescribed under the Vital Statistics Act, R.S.O. 1990, c.V.4 (VSA). It explains the principles and concepts involved in medical certification as well as the nature and uses of the information.

Physicians and coroners share the responsibility for completing the medical certificate. By extending this role to the RN(EC)¹ in certain circumstances, it is expected that they will be able to ease the burden on families where a person dies at home, in a long-term care facility or in other circumstances where the deceased's physician is not available².

For the purposes of this handbook a registered nurse who holds an extended certificate of registration will be referred to as a RN(EC).

RN(EC)s will be able to complete and sign a medical certificate, in the form approved by the Registrar General and stating the cause of death, only where all the five (5) following circumstances are met:

- the RN(EC) has had the primary responsibility for the care of the deceased during the last illness of the deceased;
- the death was expected during the last illness of the deceased;
- there was a documented medical diagnosis of a terminal disease for the deceased made by a legally qualified medical practitioner during the last illness of the deceased;
- there was a predictable pattern of decline for the deceased during the last illness of the deceased; and
- there were no unexpected events or unexpected complications during the last illness of the deceased.

If any one of the above circumstances was not met, then a physician or a coroner must complete the medical certificate. The VSA has an expectation that deaths due to causes other than natural disease must be reported to a coroner for investigation.

- The form required by the Registrar General under the authority of the VSA is the Medical Certificate of Death - Form 16.

¹ According to the College of Nurses of Ontario RN(EC)s are Nurse Practitioners (NPs), and the titles "RN(EC)" and "NP" are interchangeable. Both "RN(EC)" and "NP" are legally protected under Ontario Regulation 275/94 and they can only be used by nurses registered in the extended class.

² Registered Practical Nurses are not legally authorized to complete and sign a medical certificate

- The causes of death required by the Registrar General are from the International Statistical Classification of Diseases and Related Health Problems published by the World Health Organization adopted by reference in section 70 of Reg. 1094 under the VSA.

The quality and value of the statistical data derived from death registration forms has been for many decades, and continues to be, dependent on the certifier's care and judgment in providing complete and accurate information on the medical certificate.

The medical certificate is a part of the death registration form and is an important legal document detailing the fact and circumstance of death. It is the source of information used in Canada, and most other countries, for the preparation of statistics on causes of death. These statistics are indispensable, locally and nationally, in public health surveillance, health education and promotion, in medical research and health planning.

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I. Introduction

Purpose of Handbook

This handbook was developed under the auspices of the Vital Statistics Council for Canada to promote the reporting of reliable information on the medical certificate, with particular emphasis on the medical details of cause and circumstances of death. Intended as a reference for RN(EC)s the handbook gives an overview of the uses and value of the information and provides guidelines for completing the medical certificates. This handbook has been adapted for use in Ontario to meet the particular needs of this province.

Importance of Death Registration

Death registration serves two purposes. First, the completed death registration form is a permanent legal record of the fact of death of an individual and records the personal information about the deceased and details of the circumstances of death that are, in most jurisdictions, legally required to issue a burial permit. Death certificates and certified copies of death registrations are commonly required to settle the estate and for insurance and pension purposes. Second, death registration forms, specifically the medical certificate, are the source of mortality statistics which form the basis of the oldest and most extensive public health surveillance system. They provide information on characteristics of the deceased and the vitally important information on the cause of death.

These statistical data are used by federal, provincial and local governments, researchers and clinicians, educational institutions and many others for many purposes including:

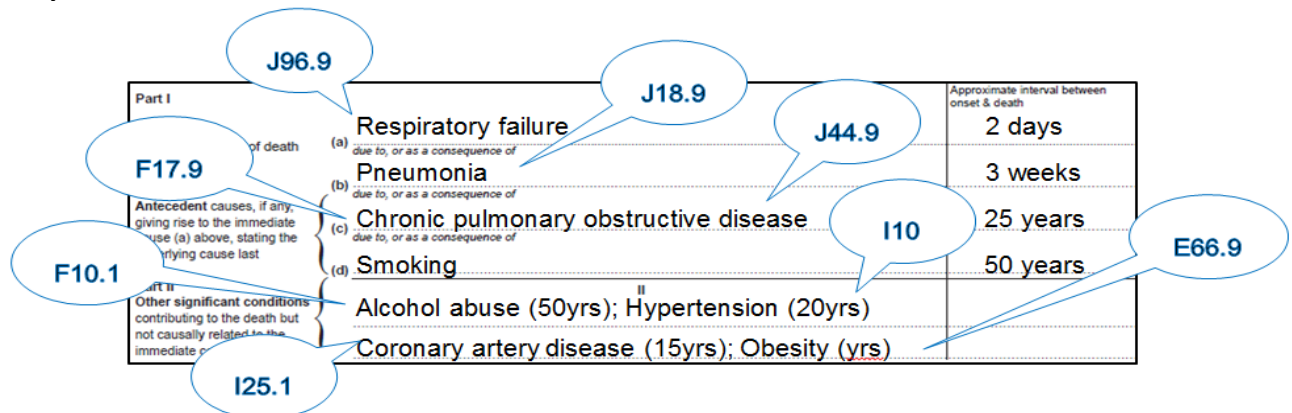
- to assess the health status of the population and determine changes in status over time;
- to identify regional differences in death rates and investigate reasons for these differences;
- to monitor trends in public health issues such as infant and maternal mortality, infectious diseases, accidents and suicides;
- to identify risks associated with environmental and occupational factors and lifestyle;
- to determine health research and health care priorities and allocate resources;
- to plan health facilities, services and manpower;
- to plan prevention and screening programs and assess the results of these programs; and
- to develop health promotion programs and evaluate their results.

Medical Coding

Medical classification is the process of transforming descriptions of medical diagnoses, surgical/medical procedures, a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, injuries and external causes, etc. from death registrations into standardized codes using the rules and conventions inherent to a classification system.

Mortality Classification Specialists of the Office of the Registrar General are trained and certified by Statistics Canada to analyze any clinical statements of death and assign standardized codes using the International Classification of Diseases (ICD). This classification system provides thousands of codes to classify most diseases, external causes and injuries and provides instructions for the assignment and selection of the underlying cause of death. The underlying cause of death is most often used for primary mortality tabulation. The medical certificate provides space for the certifier to record all relevant information pertaining to the deceased. This information is utilized to assign comprehensive cause of death codes.

Example:



Part I	Approximate interval between onset & death
Respiratory failure (a) due to, or as a consequence of	2 days
Pneumonia (b) due to, or as a consequence of	3 weeks
Chronic pulmonary obstructive disease (c) due to, or as a consequence of	25 years
Smoking (d)	50 years
Alcohol abuse (50yrs); Hypertension (20yrs)	
Coronary artery disease (15yrs); Obesity (yrs)	

Underlying Cause

- Using the international rules for selection J44.0 was selected as the underlying cause of death. J44.0 is a combination code of J44.9 (COPD) and J18.9 (pneumonia).

Multiple Causes

- Multiple causes include the selected underlying cause of death as well as the immediate, antecedent and contributory causes of death (J44.0, J96.9, J18.9, J44.9, F17.9, F10.1, I10, I25.1, E66.9).

The certifier who completed the medical certificate may be contacted by the Office of the Registrar General to seek clarification or further information regarding the cause(s) of death reported. This is one of the most important ways to improve the quality of cause-of-death data. The purpose of an inquiry is two-fold: (1) to obtain information needed to properly code and classify the underlying cause of death and (2) to provide guidance to the certifier on the proper method of completing medical certificates. If the cause of death is substantially changed as a result of an inquiry, the certifier will be requested to complete a revised medical certificate.

Reporting Deaths to the Coroner



Death Except by Disease

If there is reason to believe that a person has died as a result of any cause other than disease, or has died as a result of negligence, malpractice or misconduct on the part of others or under such circumstances as require investigation, do not complete the medical certificate; the death must be referred to a coroner.

Coroner's Investigation

Coroners in Ontario investigate certain deaths in order to determine the facts surrounding the death, to advance public safety and to make recommendations to prevent future deaths in similar circumstances. All health care professionals have a legal and professional responsibility to notify the coroner of cases that may require investigation. This responsibility to report is not restricted to physicians, as the Coroners Act says "...every person who has reason to believe...."



If the answer to any of the following questions is "Yes", the death shall be reported to the coroner. The Coroners Act allows the coroner some discretion in certain circumstances as to whether he/she will investigate the death. In other cases, an investigation and possibly an inquest may be mandatory.

Ask yourself the following:

- ? Is the **death due to non-natural causes** such as accident, homicide, or suicide? For example, an injury (e.g., hip fracture) that precedes a terminal medical event (e.g., pneumonia) may be considered to be non-natural, and therefore a coroner must be notified to determine if the death may be attributable to the initial injury. It may be helpful to consider why the person was initially admitted to hospital, rather than the immediate terminal event. If an accidental injury precipitated admission, then the coroner must be notified.
- ? Was the death **sudden and unexpected** (e.g., not reasonably foreseeable, an unexpected complication)? The sudden death of a terminally ill patient, a palliative patient, a "do not resuscitate" (DNR) patient or a person with multiple/complex medical diseases would generally not fit this category. The threshold for calling the coroner, however, should be relatively low.
- ? Are the events leading to the death **the subject of investigation** by police, the hospital, Children's Aid Society, Ministry of Labour, or any other investigative agency?
- ? Is trauma, including a fall in hospital, fracture, etc., **overdose, poisoning or intoxication** involved in this death?

- ? Have there been any **allegations of malpractice, negligence, or foul play or any treatment/medication errors**? This may include concerns voiced by other health care professionals, family members of the patient, or an attorney appointed under a Power of Attorney for Personal Care.
- ? Is this a **pregnancy-related maternal death**? This may include a death following an abortion, therapeutic or otherwise, or may include deaths in the post-partum period or even death of a pregnant woman from causes unrelated to her pregnancy.
- ? Is this a **neonatal death or stillbirth** where there are issues regarding care or injury? Neonatal deaths should generally be reported to the coroner. Stillbirths require reporting only where birth occurred outside the hospital or where concerns have been raised about antenatal care or management of labour and delivery.
- ? Have **family members expressed concerns or have there been controversies about treatment decisions**? Where family dynamics have created difficulties or concerns for hospital/health care facility staff, a coroner might be the appropriate independent “third party” to assist in diffusing contentious issues and volatile situations after the death.

As a general rule for certifiers, where the death is likely not due to natural causes or where trauma or injury, even if remote, may be contributing factors, a medical certificate should not be completed, and the death should be reported to a coroner.



Where a death has been reported to the coroner and has been accepted for investigation, the coroner will have the legal obligation to complete the medical certificate and where a medical certificate has already been completed by another certifier, the coroner will replace it with a revised medical certificate.

Confidentiality of Vital Records

The personal information on vital records is protected against unwarranted or indiscriminate disclosure under the VSA, the Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.F.31 and under the Statistics Act, R.S.C., 1985, c. S-19.

II. Principles of Medical Certification

RN(EC)s Responsibilities in Death Registration

In accordance with the VSA, it is the legal responsibility of a prescribed individual (prescribed by the regulations under the VSA) to complete and sign the medical certificate (Appendix I), which forms part of the complete death registration. The act of completing a medical certificate constitutes “certifying” the death, and the person signing is the “certifier”.

Uniform principles must be applied in the reporting of cause(s) of death, which then must be recorded on the form required by the Office of the Registrar General. The use of this form places the responsibility for indicating the correct sequence of events on the certifier. The quality of the mortality data base depends on accuracy, legibility and completeness when completing this document.

In the prescribed circumstances, if a RN(EC) attends the deceased during the deceased’s last illness, the RN(EC) must:

- ensure the medical certificate is an original, current version of the form supplied by the Office of the Registrar General³;
- be familiar with and fully understand sections 21, 22 and 26 of the VSA and subsections 35(3) and 35(3.1) of Regulation 1094 (see pages 3 and 4, Preface) which prescribe the specific circumstances under which a RN(EC) may complete and sign the medical certificate;
- be familiar with the correct method to complete the medical certificate according to the instructions in this handbook; and
- ensure that the completed and signed medical certificate is available to the funeral director promptly.

³ To obtain the Medical Certificate of Death – Form 16

- Fax a request to (807) 343-7459
- Email a request to ORGID@ontario.ca
- Call the Medical Coding Division at (807) 343-7458

The Value of Complete & Detailed Information

The certifying RN(EC) is the best person to complete and sign the medical certificate based on a documented medical history and diagnosis during the last illness of the deceased. The certifier thus has both the responsibility and the opportunity, by using care and attention in the completion of the medical certificate, to ensure mortality statistics reflect both the underlying cause of death and multiple causes of death.

An **important concept** in classifying causes of death is the **underlying cause of death**. The underlying cause is defined by the World Health Organization (WHO) as “***the disease or injury which initiated the train of morbid events leading directly or indirectly to death, or the circumstances of the accident or violence which produced the fatal injury***”. However, information on the other diseases or conditions that led to death and the other significant conditions that contributed to death are also important.

The cause of death section is thus designed to record information on all significant diseases or conditions of the deceased, whether or not they are the underlying cause. The analysis of all conditions on the medical certificate is especially important in studying diseases or conditions that are rarely the underlying causes of death, but often contribute to death, such as pneumonia or diabetes.

Also **important** is the **degree of detail** recorded on the cause of death section. Research based on mortality statistics is much more meaningful if all details in the deceased person’s medical records regarding the precise diagnoses are incorporated in the medical certificate. The ICD makes it possible to identify very precisely many varieties or sites of diseases and injuries and causal organisms. Although routinely published mortality statistics often list only broad classes of diseases, the statistical databases contain detailed information about the disease or injury. These detailed data are valuable for research into particular conditions and for special analytical studies.

For statistical and research purposes it is important that the causes of death, particularly the underlying cause of death or terminal illness, be reported as specifically and precisely as possible. Record diagnoses as precisely as the information permits, incorporating relevant details from histological reports

Causes of death are classified using the International Statistical Classification of Diseases and Related Health Problems, usually called by the short-form name International Classification of Diseases (ICD). The ICD is the global health information standard for mortality and morbidity statistics and is used in more than 100 countries around the world. For a closer look at this classification system please go to [World Health Organization ICD-10](#) and [ICD-10 Volume 2 Tabular List, 2016](#) and [ICD-10 Volume 3 Alphabetical Index, 2013.pdf](#).

III. Medical Certificate of Death

A. General Instructions

The medical certificate is a **permanent legal document** and record detailing the fact and circumstance of death and from which official copies are produced. Currently only physicians, coroners and, in prescribed circumstances, RN(EC)s are permitted to certify deaths in Ontario. The act of completing and signing a medical certificate constitutes “certifying” the death, and the person signing is the “certifier”.

Per the VSA, the form required by the Office of the Registrar General is the current medical certificate of death, form 16. A supply of medical certificates of death can be obtained by contacting the Office of the Registrar General. Uniform principles must be applied in the reporting of causes of death and the use of this standard form places the responsibility for indicating the correct sequence of events on the certifier⁴.

The Medical Certificate of Death is divided into three (3) main sections for the certifier to complete:

1. **Information about the Deceased**
2. **Cause of Death**
3. **Certification**

It is essential that:

- **the medical certificate be prepared accurately and be legible;**
- **the original medical certificate, not a reproduction, be provided to the funeral service provider or person taking responsibility for the remains;**
- **all entries on the medical certificate be typed whenever possible, or printed clearly using blue or black ink;**
- **any alterations be initialed.**

Once the medical certificate has been completed and signed by the RN(EC), the medical certificate must be provided when transferring the remains for burial, cremation or other disposition. According to the VSA, no person shall make, obtain or attempt to obtain copies or duplicates of a medical certificate which has been completed and signed.

⁴ Instructions on completing the Medical Certificate of Death, Form 16 are printed on the reverse of the form. Questions about completing this form that are not covered in this handbook should be referred to the Office of the Registrar General, P.O. Box 4600, Thunder Bay, ON P7B 6L8 or by telephone at 1-807-343-7458. Questions concerning a RN or a RN(EC)s scope of practice should be referred to the College of Nurses of Ontario at 1-800-387-5526.

B. Completing the Cause of Death Section

The CAUSE OF DEATH section provides spaces for the certifier to record pertinent information concerning the diseases and morbid conditions which either resulted in or contributed to death and includes sections 11-16.

The CAUSE OF DEATH section is designed for the certifier to report multiple causes of death and to facilitate the selection of the underlying cause of death for vital statistics.

When only one cause is reported, this cause is selected as the underlying cause of death for vital statistics. When multiple causes are recorded the certifier is expected to specify the originating or underlying cause of death.

The CAUSE OF DEATH section of Ontario's medical certificate is based on recommendation of the WHO.

Cause of Death		Approximate interval between onset and death
Cause of Death	11. Part I I Immediate cause of death (a) <i>due to, or as a consequence of</i> Antecedent causes, if any, (b) <i>due to, or as a consequence of</i> Underlying cause of death (c) (Stated last) <i>due to, or as a consequence of</i> (d) Part II II Other significant conditions contributing to the death but not resulting in the underlying cause given in Part I	
	12. If deceased was a female, did the death occur: <input type="checkbox"/> during pregnancy (including abortion and ectopic pregnancy) <input type="checkbox"/> within 42 days thereafter <input type="checkbox"/> between 43 days and 1 year thereafter	
	13. Was the deceased dead on arrival at the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Was there a surgical procedure within 28 days of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	15. Date of surgery (yyyy/mm/dd)	
	16. Condition necessitating surgery.	

The CAUSE OF DEATH section consists of two (2) main parts:

- **Part I - record a sequence of events leading directly or indirectly to death**
- **Part II - record other significant conditions that contributed to death**

In addition, there are questions designed to capture information to:

- **record pregnancy status in the case of a maternal death;**
- **record whether the deceased was dead upon arrival at the hospital;**
- **record recent surgical and medical procedures.**

Definitions

- i. A **cause of death** is the morbid condition or disease process, abnormality, injury, or poisoning leading directly or indirectly to death. It consists of a diagnostic entity, which is a single term or a composite term that is used to describe a disease, nature of injury, or other morbid condition.

Note: “Natural Causes” is not a cause of death; it is a manner (classification) of death and should not be reported in Part I or Part II.

Note: “Old Age” should not be recorded as a cause of death. The certifier should make efforts to determine, if possible, through a review of medical records, a clear and distinct etiological basis for cause of death for the elderly decedent. The age of the decedent is already captured on the medical certificate for statistical databases.

- ii. The **immediate cause of death** is the condition leading directly to death and is reported on line (a) in Part I.

Note: Do not report a mechanism or mode of death such as cardiac arrest, respiratory arrest, hypoxia, asphyxia shock, etc. A mode of dying is a statement not specifically related to the disease process; it merely attests to the fact of death and provides no additional information on the cause of death.

- iii. An **antecedent cause of death** is any intervening cause of death occurring between the immediate and the underlying cause of death.

- iv. The **underlying cause of death** is the disease which initiated the train or sequence of morbid events leading directly or indirectly to death.

- v. A reported **sequence** is two or more conditions entered on successive lines in Part I, each condition being an acceptable cause of the one on the line above it.

- vi. The words **“due to, or as a consequence of”** printed between the lines of Part I apply to sequences with an etiological or pathological basis and also to sequences where an antecedent condition is believed to have prepared the way for the more direct cause.

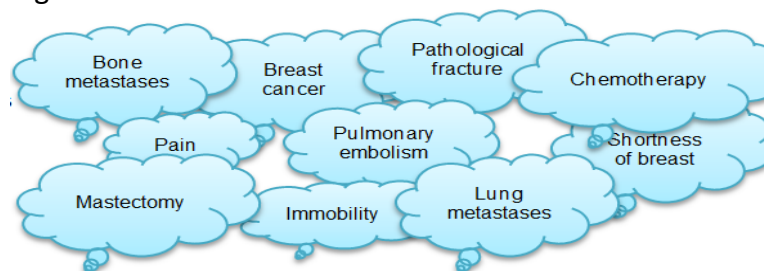
Completing Part I

Cause of Death		Approximate interval between onset and death
Cause of Death	11. Part I	I
	Immediate cause of death (a) _____ due to, or as a consequence of	
	Antecedent causes, if any, (b) _____ due to, or as a consequence of	
	Underlying cause of death (c) _____ (Stated last) due to, or as a consequence of	
	(d) _____	
	Part II	II
	Other significant conditions contributing to the death but not resulting in the underlying cause given in Part I	

Part I is designed for the certifier to report a sequence of conditions in ascending causal order, with the most recent or **immediate cause** on line (a), followed by **antecedent causes** (if any) on lines (b) and (c) and finally, the **underlying cause**. It is recommended only one condition be recorded per line.

The certifier is requested to arrange the causes of death on the form in this order to facilitate the selection of the underlying (originating) cause when two or more causes are reported for Ontario vital statistics.

First, the certifier must decide which, out of several or multiple conditions, to report on the certificate, and which conditions to discard; second, the certifier must determine which cause is an immediate, antecedent and underlying cause; and third, arrange the conditions in a sequence of ascending causal order.



If no clear immediate cause can be identified (e.g., where the death is expected but not witnessed by anyone) enter the medical diagnosis of a terminal illness on line (a).

- (a) **Primary breast carcinoma** 5 yrs.
 (b)
 (c)

If there is more than one step to report in the chain of events, an entry on multiple lines is required, in order, stating the underlying cause (e.g., terminal illness) last.

- (a) Pulmonary embolism 30 min
 (b) Pathological fracture 2 wks.
 (c) Multiple bone metastases 1 yr.
 (d) **Primary breast carcinoma** 5 yrs.

The Underlying Cause of Death

The **underlying cause** of a death is an extremely important concept in medical certification. It is defined by the WHO as “**the disease or injury that initiated the train of events leading directly to death or the circumstances of the accident or violence which produced the fatal injury**”.

When two or more causes are reported, the order in which the certifier is requested to arrange them on the certificate facilitates the selection of the underlying cause for Ontario vital statistics. The underlying cause of a death should be a **terminal illness that was previously diagnosed and documented by a physician**. If there is more than one terminal illness documented, it is up to the certifier to select and record in Part I the one which had the greatest impact resulting in death.

If Part I has been completed properly, the originating/underlying cause:

- ✓ will be reported alone on the lowest used line;
- ✓ will have caused all the conditions recorded on the lines above it;
- ✓ will have the longest duration; and
- ✓ is a ***terminal illness previously diagnosed and documented by a physician***.

Example: Atherosclerosis gave rise to ischemic heart disease and congestive heart failure which in turn led to a MI.

(a) Myocardial infarction	1 hour
(b) Congestive heart failure	10 years
(c) Ischemic heart disease	15 years
(d) Atherosclerosis	20 years (underlying cause)

Note: A common error or oversight frequently made by a certifier is recording the underlying or primary cause of the death in Part II, and sometimes not at all. The certifier should strive to record the primary condition (terminal illness) which started the chain of events in Part I on the lowest line on each medical certificate.

Organ Failure

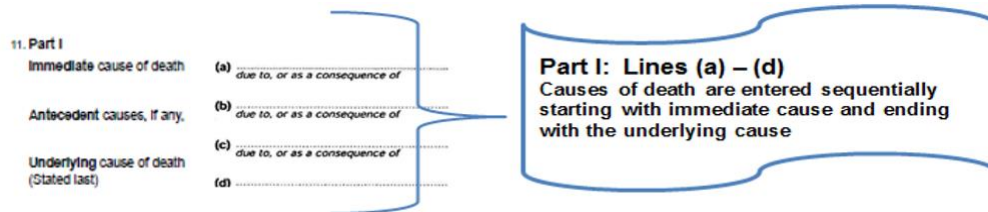
Failure of most organs (e.g., renal failure, hepatic failure, cardiac failure) must be due to an **underlying disease or condition**. If an organ or system failure is listed as a cause of death always report its etiology on the line(s) beneath.

Etiology

Provide additional information about the **underlying etiology** when processes such as the following are reported: *abscess, anoxia/hypoxia, anoxic encephalopathy, ascites, aspiration, brain damage, carcinomatosis, dehydration, embolism, hemorrhage, hypotension, infarction, malnutrition, metastases, pleural effusions, seizures, sepsis, shock*, etc. If the etiology of a process is unknown, undetermined, or unspecified, the certifier is requested to record this so the sequence appears complete (e.g., sepsis, source unclear; cerebral anoxia, cause unknown).

Reporting a Sequence

When more than one cause of death is needed in Part I the certifier is requested to report a “sequence”. The term “sequence” refers to two (or more) conditions entered on successive lines, each condition being an acceptable cause of the one entered on the line above it.



The words ***“due to, or as a consequence of”*** printed between lines, apply to the condition on the lower line; a condition is considered to be “due to” any entries entered below it.

Example:

a) Renal failure

“due to, or as a consequence of”

b) Chronic kidney disease

A death often results from the combined or cumulative effect of two (2) or more conditions; that is, one cause may lead to another which in turn leads to a third cause, etc. It is up to the certifier to decide the number of conditions to report in a sequence. Sometimes certifiers have a difficult time distinguishing between those conditions that should be included in the causal chain and those not in the chain but medically important and relevant.

Part I has four lines (a), (b), (c), (d). All lines need not be used, and the certifier is also not limited to four lines. Additional lines (more than the four printed) may be necessary to enter the complete sequence of events and the certifier may add lines (e.g., (e) and (f)) so all conditions related to the death are entered in Part I with only one condition to a line and with the terminal disease on the lowest line.

Example:

(a) Hypernatremia

(b) Dehydration

(c) Not eating or drinking

(d) Dementia

(e) End stage Alzheimer’s disease **(adding (e))**

(a) Dementia

(b) End stage Alzheimer’s disease

(c)

(d)

(all lines need not be used)

Note: At times there may appear to be two or more possible sequences resulting in death (e.g., multiple complex medical conditions in an elderly patient). The certifier must choose and report in Part I the sequence which had the greatest impact resulting in the death, and report conditions from the other sequence(s) in Part II.

Miscellaneous Instructions

A **neoplasm** can be malignant (primary or secondary), in situ, benign, or of uncertain or unknown behaviour. Therefore, it is important to include **morphology, behavior, and site** when a neoplasm is recorded as a cause of death.

Malignant Neoplasm

When reporting a malignant neoplasm, it is very important to specify **the organ or anatomic location first affected**, referred to as the “**primary**”. The “**primary**” is the cause selected for Ontario vital statistics and is important for research.

- (a) Use the term “**primary**” to specify the organ or anatomic location or part FIRST affected. This avoids confusion when reporting multiple sites. When the certifier is ambiguous in reporting the primary site, every effort is made to obtain clarification from the certifier.

- | | |
|---|--------|
| (a) Bone and liver metastases | 6 mths |
| (b) Primary non-small cell lung cancer | 5 yrs. |
| (c) | |

- (b) Use the term “**primary unknown**” or some other similar expression where there was no clear indication of the organ or anatomic part FIRST affected.

- | | |
|-------------------------------------|--------|
| (a) Metastatic pleura cancer | 6 mths |
| (b) Primary Unknown | 5 yrs. |
| (c) | |

- (d) As the term “**metastatic**” can be used in two ways: i) meaning a secondary neoplasm from a primary elsewhere, and ii) denoting a primary that has given rise to metastases, use the term “**primary**” to specify the organ or anatomic part FIRST affected to avoid confusion.

- | | |
|-------------------------------------|--------|
| (a) Metastatic pleura cancer | 6 mths |
| (b) Primary lung cancer | 5 yrs. |
| (c) | |

- Use terms such as “**secondary**”, “**metastases**”, “**spread**”, “**carcinomatosis**”, etc. to indicate a secondary neoplasm and use the term “**primary**” to specify the organ or anatomic part FIRST affected to avoid confusion.

- | | |
|--------------------------------------|--------|
| (a) Peritoneal carcinomatosis | 6 mths |
| (b) Primary ovarian cancer | 5 yrs. |
| (c) | |

- Show the presence of **more than one primary** neoplasm by recording the primary cancer responsible for the death in Part I and reporting any other primary cancers in Part II.

Benign Neoplasm

Benign tumors (e.g., lipoma, chondroma, adenomas, teratoma, etc.) usually lack the ability to invade neighboring tissue or metastasize and therefore are usually non-cancerous. It is important to **specify morphology and site** (e.g., lipoma of face). However, many types have the potential to become cancerous (e.g., malignant) and the certifier should specify the organ or anatomic part FIRST affected in these cases (e.g., malignant prostate adenoma).

Leukemia and Lymphoma

Record malignant neoplasms of lymphoid, hematopoietic and related tissue **by morphological type** such as B cell lymphoma, plasma cell leukemia, chronic lymphocytic leukemia.

Tumor

The term tumor is commonly used as a synonym for a neoplasm; however, a tumor is not considered synonymous with cancer. As tumors may be cancerous (malignant) or noncancerous (benign, unknown) it is important to **specify the morphological nature** of the tumor. If the nature is unknown or has not yet been identified report “not yet determined”, “not investigated” or some other similar expression. If a tumor is malignant, clearly indicate this as well as stating whether it was the primary site or not (e.g., brain tumor, probably malignant and primary).

Alcohol Related Disease

Clearly indicate the presence of alcohol. If applicable, report conditions such as cardiomyopathy, delirium, dementia, cirrhosis, hepatitis, liver failure or damage, Laennec’s or Korsakoff’s syndrome, seizure, etc. “due to” alcohol as these and other conditions may be alcoholic or non-alcoholic in nature.

HIV or AIDS

The underlying cause of death for persons with Acquired Immune Deficiency Syndrome (AIDS) may be from causes unrelated to Human Immunodeficiency Virus (HIV) infection such as cancer or heart disease. Because of improved treatment, survival after a diagnosis of AIDS has become longer, allowing a greater proportion of deaths of persons with AIDS to result from other causes. Advise if HIV has progressed to AIDS; report opportunistic and associated diseases and report HIV and/or AIDS in Part II if not causally related to the underlying cause of death recorded in Part I.

Note: HIV positive is not synonymous with HIV and AIDS.

Medical Assistance in Dying

Medical Assistance in Dying (MAID) is defined in federal legislation as:

- (a) the administering by a medical practitioner (i.e., a physician) or a RN(EC) of a substance to a person, at their request, that causes their death; or
- (b) the prescribing or providing by a medical practitioner or a RN(EC) of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

RN(EC)s who provide MAID will notify the coroner of the death and provide the coroner with any information about the facts and circumstances relating to the death as required. If the coroner is of the opinion that the death is to be investigated, the coroner is required to complete and sign the medical certificate. If the coroner is of the opinion that the death does not require an investigation, the RN(EC) will complete and sign the medical certificate.

For deaths involving MAID, **the illness, disease, or disability leading to the request for assistance is to be recorded as the cause of death.** This condition will be selected as the cause of death for vital statistics.

Example:

11. Part I		
Immediate cause of death	(a) Amyotrophic Lateral Sclerosis <small>due to, or as a consequence of</small>	5 years
Antecedent causes, if any.	(b) <small>due to, or as a consequence of</small>	
Underlying cause of death (Stated last)	(c) <small>due to, or as a consequence of</small>	
	(d) <small>due to, or as a consequence of</small>	
Part II Other significant conditions contributing to the death but not resulting in the underlying cause given in Part I		

Note: There should be no mention of the injection or ingestion of drugs and the accidental or violent death section is to be left blank.

Note: All prescribed circumstances as set out in subsections 35(3) and (4) of Regulation 1094 under the VSA must be met for the RN(EC) to complete the medical certificate. If any of the criteria do not exist, a physician or coroner must complete the medical certificate.

Completing Part II

Record in Part II any other significant condition which unfavorably influenced the course of the morbid process and thus contributed to the fatal outcome but was not related to the immediate cause of death. These conditions are not part of the sequence reported in Part I and would be conditions that pre-existed or co-existed prior to death. In this section, more than one condition can be reported per line.

Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	II	

- Do not enter a condition in Part II that belongs in Part I because of lack of space in Part I. The certifier is requested to add lines (e), (f), etc. to Part I to show the entire sequence.
- When there are **two or more possible sequences** resulting in death (multiple conditions among the elderly), the certifier must choose and report in Part I the sequence which had the greatest impact. Conditions from the other sequence(s) should be reported in Part I.
- It is of no benefit to enter in Part II multiple medical conditions that have no direct relationship to the death, have not contributed to the death, or were not significant. Limit your entries to those only of **appropriate significance** which contributed to the death.
- In Part II, where more than one condition may be reported per line, duration is required for each condition (e.g., using brackets or not).

Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	II	
	Portal hypertension (5yrs) Ascites (5yrs)	
	Hypercholesterolemia (20yrs)	

Any disease, abnormality, injury, or late effects of poisoning, believed to have adversely affected the decedent should be reported in Part II, including:

- use of alcohol and/or other substances;
- smoking history;
- environmental factors, such as exposure to toxic fumes, history of working in the mining industry, etc.;
- surgical information, if applicable.

Completing Interval between Onset and Death

At the extreme right portion of Part I and Part II is the area designated for the certifier to record the duration of each cause reported.

I		Approximate interval between onset & death
(a)	Upper gastrointestinal hemorrhage <small>due to, or as a consequence of</small>	3 days
(b)	Esophageal varices <small>due to, or as a consequence of</small>	2 months
(c)	Liver cirrhosis <small>due to, or as a consequence of</small>	10 years
(d)	Alcoholism	30 years
II		
Portal hypertension (5yrs) Ascites (5yrs)		
Hypercholesterolemia (20yrs)		

- The duration of each cause of death should be specified as to the unit of time: years, months, days and hours, even minutes or seconds.
- The form requests the “approximate interval” between onset and death. **It is important to approximate the duration or to enter “unknown” rather than leave it blank or use vague terms such as previous or prior.**
- The durations should **increase progressively** through lines (a) through (d). The cause reported on line (a) should have the shortest duration and the underlying cause of death reported alone on the lowest line should have the longest duration.
- In Part II, where more than one condition may be reported per line, duration is required for each condition.

Pregnancy

All maternal deaths, regardless of cause or whether directly related to the pregnancy or not must be reported to a coroner for investigation. The Office of the Chief Coroner for Ontario has established a policy to investigate and review all maternal deaths that occur after twenty (20) weeks gestation, during delivery, or immediately following delivery, and up to forty-two (42) days postpartum. The coroner is responsible for completing this section. Any person who is not a coroner shall not complete this section but refer the case to a coroner for investigation.

Surgical and Medical Procedures

If the deceased had undergone surgery (or a medical procedure) within twenty-eight (28) days of death or if one of the causes of death was a complication of surgery (regardless of date of surgery) the certifier is required to complete Sections 14, 15, and 16.

- Record in Part I any postoperative complications (described as postoperative)
- Box 14 - check off Yes or No
- Box 15 - record the date of surgery
- Box 16 - record the procedure (medical or surgical) by name, the reason for surgery and operative findings.

Cause of Death		Approximate interval between onset and death
Cause of Death	11. Part I	Postoperative hemorrhage
	Immediate cause of death (a) <small>due to, or as a consequence of</small>	48 hours
	Antecedent causes, if any, (b) <small>due to, or as a consequence of</small>	
	Underlying cause of death (c) <small>due to, or as a consequence of</small> (Stated last)	
	(d)	
	Part II Other significant conditions contributing to the death but not resulting in the underlying cause given in Part I	II Coronary heart disease (25yrs), Angina (5yrs) Smoking (50yrs), Hypertension (40yrs)
12. If deceased was a female, did the death occur: <input type="checkbox"/> during pregnancy (including abortion and ectopic pregnancy) <input type="checkbox"/> within 42 days thereafter <input type="checkbox"/> between 43 days and 1 year thereafter		
13. Was the deceased dead on arrival at the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		14. Was there a surgical procedure within 28 days of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
15. Date of surgery (yyyy/mm/dd)		May 3, 2019
16. Condition necessitating surgery: Coronary artery bypass graft (CABG) – occluded arteries		

Note: Complications of surgery may be current or late effects. It is important that the condition which necessitated the surgery is reported.

Note: When a patient dies in a hospital either the attending physician, coroner or RN(EC) will complete and sign a medical certificate.

Note: All prescribed circumstances as set out in subsection 35(3) or 35(3.1) of Regulation 1094 under the VSA must be met for the RN(EC) to complete the medical certificate. If any one criterion does not exist, a physician or coroner must complete the medical certificate.

Autopsy Particulars

Autopsy particulars	17. Autopsy being held?	18. Does the cause of death stated above take account of autopsy findings?	19. May further information relating to the cause of death be available later?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

It should be noted that this is a three-part question. The second and third part is dependent on the answer to the first part. Information from this section is collected for statistical purposes.

- ☒ **No** No further entries are required for this section.
- ☒ **Yes** Complete the entire section. If an autopsy is requested, the RN(EC) should ensure that all the prescribed circumstances have been met. If any one of the prescribed circumstances has not been met, then the RN(EC) must contact a physician or a coroner to complete the medical certificate.

Note: It is the certifier's responsibility to submit a supplemental medical certificate in cases where autopsy findings reveal the cause of death to be different from the one originally reported.

Traumatic or Violent Death Section

Traumatic or Violent Death (if applicable)	20. If accident, suicide, homicide or undetermined (specify)	21. Place of injury (e.g. home, farm, highway, etc.)	22. Date of injury (yyyy/mm/dd)
	23. How did injury occur? (describe circumstances)		

A coroner must be notified when a death appears to be **non-natural** (e.g., injury, fracture, poisoning, etc.). Any person who is not a coroner shall not complete this section but refer the case to a coroner for investigation. The coroner will decide whether an investigation is required.

If the coroner accepts the case, the coroner will be the person responsible for completing and signing the medical certificate. If, after consultation, the coroner does not accept the case and has determined the injury or poisoning sustained was not causally related to the death, the RN(EC) will be the person responsible for completing and signing the medical certificate. **The injury or poisoning should not be recorded, and this section should not be completed.** For further explanation on the requirements for reporting deaths to a coroner as mandated by Section 10 of the Coroners Act, see page 10 Reporting Deaths to the Coroner. If uncertain, discuss the case with a physician or coroner before proceeding.

Note: Certifiers should only complete sections with pertinent information. It is unnecessary for a certifier to record "N/A" or insert slashes through sections that are not applicable.

Reporting Dos and Don'ts

Dos

- ✓ Use only medical certificates supplied by the Office of the Registrar General. Do not photocopy or create your own medical certificate.
- ✓ Record all information in a neat and legible manner.
- ✓ Record a comprehensive sequence of events (summary) in Part I.
- ✓ Record one condition per line in Part I.
- ✓ Record duration for each condition reported in Part I and in Part II.
- ✓ Record the documented medical diagnosis of a terminal disease on the lowest line in Part I.
- ✓ Record the primary site of a neoplasm (e.g., the organ or anatomic part first affected).
- ✓ Correct minor errors by striking through the error and initialing.
- ✓ Correct major errors or multiple errors by starting over and completing a new medical certificate.
- ✓ Dead on Arrival - only select YES if patient was pronounced dead on arrival at a hospital. This does not refer to a RN(EC) arriving to find the patient deceased.

Don'ts

- ✗ Don't record a diagnostic LIST of conditions in Part I (record a sequence).
- ✗ Don't record conditions in a disorganized or unrelated order in Part I (record a sequence).
- ✗ Don't record multiple sequences in Part I (record one comprehensive sequence).
- ✗ Don't record the terminal disease in Part II.
- ✗ Don't record all possible diagnoses in Part II; record only significant conditions which contributed to the death.
- ✗ Don't record superfluous information (e.g., palliative care, oxygen-dependent, discontinuation of care, DNR).
- ✗ Don't use medical abbreviations. Some abbreviations can have multiple meanings and may be misinterpreted (e.g., "ARF" could denote "acute respiratory failure" or "acute renal failure").
- ✗ Don't use terms such as death, decomposition, multiple medical problems, noncompliance, sudden death, etc. These terms are not considered disease conditions and are not assigned cause of death codes for statistics.
- ✗ Don't record "N/A" or slashes in sections that are non-applicable to your case. Record information, a checkmark or an X in a box, or leave blank.

Examples of Certification

In all the following examples, the RN(EC) must have had the primary responsibility for the care of the deceased during the deceased's last illness; death was expected; there was a documented medical diagnosis of a terminal illness; a predictable pattern of decline and there were no unexpected events or complications. All the criteria must be met for the RN(EC) to complete the medical certificate. If any one criterion does not exist, a physician or coroner must complete the medical certificate.

Example 1

A 68-year-old female was diagnosed 6 months ago with carcinoma of the lung. She is cared for by a team of nurses and they do not "expect her to make it through the weekend". She has a 45-year history of smoking 2 packs per day, a 5-year history of chronic obstructive pulmonary disease with frequent bouts of pneumonia and bronchitis. She stops breathing and dies with the RN(EC) at her bedside.

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Pneumonia <small>due to, or as a consequence of</small>	4 days
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b) Metastases to abdomen and pleura <small>due to, or as a consequence of</small>	2 months
	(c) Bone metastases <small>due to, or as a consequence of</small>	2 months
	(d) Primary carcinoma of lung	6 years
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	Smoking (45 years), COPD (20 years)	

Note: Smoking is reported in Part II as a contributing factor and lung cancer is specified as primary (e.g., the organ or part FIRST affected).

Example 2

A 79-year-old female has suffered a hip fracture four months previous. Since the fracture her health declined to the point that it rendered her bedridden and immobile. She has a long history of osteoporosis.

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Pneumonia <small>due to, or as a consequence of</small>	6 days
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b) Immobility <small>due to, or as a consequence of</small>	4 months
	(c) Pathological hip fracture <small>due to, or as a consequence of</small>	4 months
	(d) Osteoporosis	30 years
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above		

Note: Pathological fractures are not considered to have occurred by an external cause therefore the coroner does not need to be notified.

Example 3

A 59-year-old female with a history of hypertension for 10 years was admitted to hospital for investigation following complaint of persistent headache for weeks. Exploratory craniotomy and biopsy revealed she was suffering from an inoperable astrocytoma of left temporal lobe. Patient wished to die at home. Palliative care was instituted through discussion with family, RN(EC), and primary care provider.

Part I		I	Approximate interval between onset & death
Immediate cause of death	(a)	Left temporal lobe Astrocytoma <i>due to, or as a consequence of</i>	6 months
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b)	<i>due to, or as a consequence of</i>	
	(c)	<i>due to, or as a consequence of</i>	
	(d)		
Part II	II		
Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	Hypertension (10 years)		

In some cases, a single disease or cause of death which describes completely the sequence of events or may be wholly responsible for the death, may be reported alone in Part I. The death may have been expected and occurred at home but not witnessed by anyone. In such cases, line (a) can serve as both the underlying and immediate cause of death. Hypertension was thought to have influenced the course of the illness unfavorably but was in no way related to the astrocytoma and, therefore, is reported in Part II.

Example 4

A 33-year-old male was diagnosed HIV positive 15 years ago. He was transferred to a hospice for palliative care after he developed AIDS and diagnosed with Pneumocystis Carinii Pneumonia.

Part I		I	Approximate interval between onset & death
Immediate cause of death	(a)	Weight loss <i>due to, or as a consequence of</i>	1 week
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b)	Pneumocystis Carinii pneumonia <i>due to, or as a consequence of</i>	3 week
	(c)	AIDS <i>due to, or as a consequence of</i>	2 years
	(d)	HIV	5 years
Part II	II		
Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	Kaposi's sarcoma		4 months

Example 5

A 52-year-old male, suffering from end-stage liver failure, dies while living in a group home. He has a well-known history of alcoholism and substance abuse and was diagnosed with cirrhosis two (2) years ago. He was also diagnosed with chronic Hepatitis B ten (10) years ago.

Part I		Approximate interval between onset & death
Immediate cause of death	(a) End stage liver failure <i>due to, or as a consequence of</i>	2 weeks
	(b) Cirrhosis of liver <i>due to, or as a consequence of</i>	2 years
	(c) Hepatitis B <i>due to, or as a consequence of</i>	10 years
	(d) _____	
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last		
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	Alcoholism (30yrs), Substance abuse (10yrs)	

Example 6

An 80-year-old female who was diagnosed with Alzheimer's disease seven (7) years ago is undergoing palliative care in a long-term care facility. One of the hallmarks of her senile dementia is her refusal to eat, which is especially pronounced in the last month. All attempts to feed her have failed and she dies of cardiac arrest.

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Malnutrition <i>due to, or as a consequence of</i>	2 weeks
	(b) Refused to eat and drink <i>due to, or as a consequence of</i>	1 month
	(c) Senile Dementia Alzheimer's type <i>due to, or as a consequence of</i>	7 years
	(d) _____	
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last		
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	Hypertension (45yrs), Congestive heart failure (10yrs)	

Note: The terms “palliative” and “palliative care” are not a disease condition or cause of death and should not be reported; cardiac arrest is a mode of death and should not be reported.

Example 7

A diabetic man, who had been under insulin control for many years, developed ischemic heart disease and died from a myocardial infarction. The following illustrates the importance of accurately stating the sequence of morbid conditions in order to allow selection of the “underlying” cause of death. Depending on the documented medical diagnosis, the following certifications are possible and would be acceptable:

- i. If the certifier considered that the heart condition resulted from the long-standing diabetes, the sequence would be:

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Myocardial infarction <i>due to, or as a consequence of</i>	1 hour
	(b) Chronic ischemic heart disease <i>due to, or as a consequence of</i>	5 years
	(c) Type II insulin dependent diabetes mellitus <i>due to, or as a consequence of</i>	25 years
	(d) _____	
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above		

- ii. If the certifier considered that the heart condition developed independently of the diabetes, the certification would be:

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Myocardial infarction <i>due to, or as a consequence of</i>	1 hour
	(b) Chronic ischemic heart disease <i>due to, or as a consequence of</i>	5 years
	(c) _____	
	(d) _____	
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above		
Type II insulin dependent diabetes mellitus		25 years

- iii. If the man had instead died from some other expected complication of the diabetes, such as nephropathy, the heart condition playing only a subsidiary part in the death, the physician being uncertain that it arose from the diabetes at all, the sequence would be:

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Acute renal failure <i>due to, or as a consequence of</i>	1 week
	(b) Nephropathy <i>due to, or as a consequence of</i>	4 years
	(c) Type II insulin dependent diabetes mellitus <i>due to, or as a consequence of</i>	25 years
	(d) _____	
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above		
Chronic ischemic heart disease		5 years

Example 8

The RN(EC) is visiting a 70-year-old patient with end stage Multiple Sclerosis. The RN(EC) is aware that the client is palliative and has a documented medical diagnosis and has been visiting frequently. The patient wishes to receive care at home. She becomes progressively short of breath has difficulty swallowing and develops pneumonia. She is found one morning with vital signs absent.

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Respiratory failure <small>due to, or as a consequence of</small>	2 hours
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b) Pneumonia <small>due to, or as a consequence of</small>	2 weeks
	(c) Dysphagia <small>due to, or as a consequence of</small>	3 weeks
	(d) Multiple Sclerosis	45 years
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	Chronic pain (yrs), Depression (yrs)	

Example 9

The medical certificate below has NOT been completed according to the instructions in this Handbook.

Part I		Approximate interval between onset & death
Immediate cause of death	(a) Prostate cancer <small>due to, or as a consequence of</small>	years
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b) Dementia <small>due to, or as a consequence of</small>	years
	(c) Diabetes <small>due to, or as a consequence of</small>	years
	(d) Renal failure	years
Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above	HTN, AF, CHF, Smoker^{II}, COPD, Emphysema, Breast cancer, pneumonia, osteoarthritis, PVD, hypothyroidism, CVA, GI hem, Obesity, Mitral and aortic insufficiency	

- ✗ A common error or oversight frequently made by a certifier is recording a shopping “LIST” of diseases or conditions in Part I. This is incorrect. The causes reported in Part I should form a comprehensive sequence which is pathologically and etiologically correct.
- ✗ Another common error is reporting all medical diagnoses the certifier may be aware of in Part II. This is incorrect. The causes reported in Part II should only be those conditions that are believed to have been contributory to the underlying cause listed in Part I and a duration (approximate) is required for each condition recorded.

C. Completing Information about the Deceased

Name of Deceased

Enter the deceased's full legal name including last name and all given names or single name, if only one name. Do not report alias, abbreviations or "also known as". Accuracy of the legal name may be very important for estate, insurance and pension purposes. Accurate sources of a person's legal name can be their birth certificate in conjunction with other forms of identification, citizenship card, health card or passport.

Date of Death (Month, Day, Year)

Enter the exact day, month and year that death occurred in item 2. For the month, enter the full or abbreviated name, e.g., "January" or "Jan". Pay particular attention to the entry of day, month or year when the death occurs around midnight or December 31. Consider a death at midnight to have occurred at the end of one day rather than the beginning of the next. For instance, the date for a death that occurs at midnight on December 31 should be recorded as December 31. Do not record time of death.

Sex

Provide **F** for female and **M** for male clearly and legibly.

Age

Calculate an accurate age at time of death from date of birth. For perinatal deaths (< than twenty-eight (28) days of age), provide gestation age and birth weight in either pounds or kilograms.

Place of Death

Enter the name of the long-term care facility, hospital, nursing home or other location where the deceased died. If the deceased died in a private residence, provide a street address or, in a rural area without a street address, the lot and concession. **It is not necessary to record a postal code or "Ontario"**. Check off the appropriate corresponding box. Enter the name of the city, town, village, or township and the regional municipality, county, or district.

Example:

Information About the Deceased							
1. Last name or single name Brown, Jane Anne				First and middle names		2. Date of death (yyyy/mm/dd) Jan 1, 2016	
3. Sex F	4. Age 83	5. If under 1 year Months Days	6. If under 1 day Hours Minutes	7. Gestation age		8. Birth weight	
9. Place of death (name of facility or location) 100-1234 Smith Street				<input type="checkbox"/> Hospital <input type="checkbox"/> Long term care <input checked="" type="checkbox"/> Private Residence <input type="checkbox"/> Other (specify)			
10. City, town, village or township Pembroke				Regional municipality, county or district Renfrew			

Note: Municipal restructuring has occurred over the years. Where municipal restructuring has occurred use the current municipal name (e.g., North York, Scarborough, Etobicoke, etc. amalgamated and are now known as the City of **Toronto**). If unsure of the current municipal name, contact your local municipal office or access the [Municipal Restructuring Table](#).

D. Completing Certification

All parts of this section (items 24 to 28) must be completed by the RN(EC) who, in prescribed circumstances, may be permitted to certify a death in Ontario. By signing you certify the information on this form is correct to the best of your knowledge.

Signature

Sign clearly in ink.

Date (Month, Day, Year)

Enter the exact month, day and year on which the death was certified.

Name

Print your name clearly; last name first, followed by given name(s), or single name if only one name.

Title

As a registered nurse with an extended certificate, check off box RN(EC). If using a form with an “other” box, check off “other” and specify the title RN(EC). Include your Registration Number.

Address


Record your complete mailing address (work); including facility name, street number and name, city, province, and postal code. An address stamp may be used. If required, information contained in this section will facilitate correspondence with the certifier by the Office of the Registrar General.

Example:

24. Your signature (physician, coroner, RN(EC)) <i>L.A. Smith</i>		25. Date (yyyy/mm/dd) Jan 1, 2016
26. Your name (last, first and middle names or single name) Smith, Linda Ann	27. Your title: <input type="checkbox"/> Physician <input type="checkbox"/> Coroner <input checked="" type="checkbox"/> RN(EC)	Registration number 1234567
28. Your address (street number and name, city, province, postal code) 321 Brown Street, Thunder Bay, ON P7K 1L8		

Note: Certifiers should only complete sections on the medical certificate relevant to the case. Do not record “N/A” or insert slashes (/) through sections that are not applicable.

APPENDIX I - Medical Certificate of Death

 Ontario		ServiceOntario		Office of the Registrar General		Medical Certificate of Death - Form 16	
Note: Form 8 must be completed for stillbirths. This form must be completed by the attending physician, coroner or RN(EC) before a burial permit can be issued. Please PRINT clearly in blue or black ink as it is a permanent legal record.							Office Use Only
Information About the Deceased							
1. Last name or single name				First and middle names		2. Date of death (yyyy/mm/dd)	
3. Sex	4. Age	5. If under 1 year Months Days	6. If under 1 day Hours Minutes	7. Gestation age		8. Birth weight	
9. Place of death (name of facility or location)				<input type="checkbox"/> Hospital <input type="checkbox"/> Long term care <input type="checkbox"/> Private Residence <input type="checkbox"/> Other (specify)			
10. City, town, village or township				Regional municipality, county or district			
Cause of Death							
Cause of Death	11. Part I						Approximate interval between onset and death
	Immediate cause of death (a) due to, or as a consequence of						
	Antecedent causes, if any, (b) due to, or as a consequence of						
	Underlying cause of death (c) due to, or as a consequence of (Stated last)						
	Part II (d)						
Other significant conditions contributing to the death but not resulting in the underlying cause given in Part I							
12. If deceased was a female, did the death occur: <input type="checkbox"/> during pregnancy (including abortion and ectopic pregnancy) <input type="checkbox"/> within 42 days thereafter <input type="checkbox"/> between 43 days and 1 year thereafter							
13. Was the deceased dead on arrival at the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No				14. Was there a surgical procedure within 28 days of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Date of surgery (yyyy/mm/dd)	
16. Condition necessitating surgery:							
Autopsy Particulars		17. Autopsy being held? <input type="checkbox"/> Yes <input type="checkbox"/> No		18. Does the cause of death stated above take account of autopsy findings? <input type="checkbox"/> Yes <input type="checkbox"/> No		19. May further information relating to the cause of death be available later? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		20. If accident, suicide, homicide or undetermined (specify)		21. Place of injury (e.g. home, farm, highway, etc.)		22. Date of injury (yyyy/mm/dd)	
Traumatic or Violent Death (if applicable)		23. How did injury occur? (describe circumstances)					
Certification							
By signing below, you certify that the information provided is correct to the best of your knowledge, according to instructions and requirements.							
24. Your signature (physician, coroner, RN(EC))						25. Date (yyyy/mm/dd)	
26. Your name (last, first and middle names or single name)				27. Your title: <input type="checkbox"/> Physician <input type="checkbox"/> Coroner <input type="checkbox"/> RN(EC) Registration number			
28. Your address (street number and name, city, province, postal code)							
To be Completed by the Division Registrar							
By signing below, I am satisfied that the information in this Medical Certificate of Death and in the corresponding Statement of Death is correct and sufficient and I agree to register the death.							
Signature				Date (yyyy/mm/dd)		Registration number	
						Div. reg. code no.	
For the use of the Office of the Registrar General only							
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APPENDIX II - Completed Sample

Ontario		ServiceOntario		Office of the Registrar General		Medical Certificate of Death - Form 16	
<p>Note: Form 16 must be completed for stillbirths. This form must be completed by the attending physician, coroner or RN(IE) before a burial permit can be issued. Please PRINT clearly in blue or black ink as it is a permanent legal record.</p>							
<p>Information About the Deceased</p>							
1. Last name or single name Brown, Jane Anne				2. Date of death (yyyy/mm/dd) Jan 1, 2016			
3. Sex F	4. Age 83	5. If under 1 year Months 83	6. If under 1 day Hours 83	7. Gestation age	8. Birth weight		
9. Place of death (name of facility or location) 100-1234 Smith Street				<input type="checkbox"/> Hospital <input type="checkbox"/> Long term care <input checked="" type="checkbox"/> Private Residence <input type="checkbox"/> Other (specify)			
10. City, town, village or township Pembroke				Regional municipality, county or district Renfrew			
Cause of Death							
Cause of Death	11. Part I Immediate cause of death (a) Respiratory Arrest <small>(due to, or as a consequence of)</small>			Approximate interval between onset and death 12 hours			
	Antecedent causes, if any, (b) Pneumonia <small>(due to, or as a consequence of)</small>			1 week			
	Underlying cause of death (c) COPD <small>(Stated last)</small>			30 years			
	Part II Other significant conditions contributing to the death but not resulting in the underlying cause given in Part I Chronic renal failure (5yrs) Smoking (50yrs)						
<p>12. If deceased was a female, did the death occur: <input type="checkbox"/> during pregnancy (including abortion and ectopic pregnancy) <input type="checkbox"/> within 42 days thereafter <input type="checkbox"/> between 43 days and 1 year thereafter</p> <p>13. Was the deceased dead on arrival at the hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>14. Was there a surgical procedure within 28 days of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>15. Date of surgery (yyyy/mm/dd)</p> <p>16. Condition necessitating surgery.</p>							
Autopsy Particulars							
17. Autopsy being held? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		18. Does the cause of death stated above take account of autopsy findings? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		19. May further information relating to the cause of death be available later? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
20. If accident, suicide, homicide or undetermined (specify):		21. Place of injury (e.g. home, farm, highway, etc.):		22. Date of injury (yyyy/mm/dd)			
23. How did injury occur? (describe circumstances)							
Certification							
By signing below, you certify that the information provided is correct to the best of your knowledge, according to instructions and requirements.							
24. Your signature (physician, coroner, RN(IE)) L.A. Smith				25. Date (yyyy/mm/dd) Jan 1, 2016			
26. Your name (last, first and middle names or single name) Smith, Linda Ann				27. Your title: <input type="checkbox"/> Physician <input type="checkbox"/> Coroner <input checked="" type="checkbox"/> RN(IE) Registration number 1234567			
28. Your address (street number and name, city, province, postal code) 321 Brown Street, Thunder Bay, ON P7K 1L8							
To be Completed by the Division Registrar							
By signing below, I am satisfied that the information in this Medical Certificate of Death and in the corresponding Statement of Death is correct and sufficient and I agree to register the death.							
Signature		Date (yyyy/mm/dd)		Registration number		Div. reg. code no.	
For the use of the Office of the Registrar General only							

- ✓ Use an original (current) medical certificate of death – form 16 (i.e., not a copy)
- ✓ Record information in a neat and legible format
- ✓ In Part I, report a sequence of events (one condition per line) with the most recent condition on line (a) followed by antecedent causes (if any) followed by the terminal disease (underlying cause) on the lowest line
- ✓ Specify a duration for each condition
- ✓ In Part II record any other significant conditions which contributed to the death; specify a duration for each condition in this section.
- ✓ Record information only in sections relevant to the case (e.g., no slashes or N/A, etc.)