STATE OF ILLINOIS
CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO.

LOCAL FILE NUMBER

STATE FILE NUMBER

(Based on the 2003 U.S. Standard Certificate)

Illinois Department of Public Health - Division of Vital Records

VR200 (Rev. 1/08)

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) | 2. SEX | 3. DATE OF DEATH (Month/Day/Year) (Spell Month)

4. COUNTY OF DEATH | 5a. AGE AT LAST BIRTHDAY (Years) | 5b. UNDER 1 YEAR (Months / Days) | 5c. UNDER 1 DAY (Hours / Minutes) | 6. DATE OF BIRTH (Month/Day/Year)

7a. CITY OR TOWN | 7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)

7c. PLACE OF DEATH (**Check only one:** see instructions)

IF DEATH OCCURRED IN A HOSPITAL
☐ Inpatient ☐ Emergency Room/Outpatient ☐ 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. BIRTHPLACE (City and State or Foreign Country) | 9. SOCIAL SECURITY NUMBER | 10. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Married but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown | 11. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage) | 12. EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No

13a. RESIDENCE (Street and Number) | 13b. APT. NO. | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? ☐ Yes ☐ No

13e. COUNTY | 13f. STATE | 13g. ZIP CODE | 14. FATHER'S NAME (First, Middle, Last) | 15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

16a. INFORMANT'S NAME | 16b. RELATIONSHIP | 16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code)

17. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Other (Specify): _____ | 18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) | 19. LOCATION - CITY, TOWN AND STATE | 20. DATE OF DISPOSITION (Month/Day/Year)

21a. FUNERAL HOME NAME | STREET AND NUMBER | CITY OR TOWN | STATE | ZIP

21b. FUNERAL DIRECTOR'S SIGNATURE | 21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER

22. LOCAL REGISTRAR'S SIGNATURE | 23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)

CAUSE OF DEATH (See instructions and examples)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

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):

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

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? ☐ Yes ☐ No

27. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

28. IF FEMALE:
☐ Not pregnant within past 12 months
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Pregnant at time of death
☐ Pregnant within one year of death but time unknown
☐ Unknown if pregnant within the past 12 months

29. MANNER OF DEATH
☐ Natural ☐ Suicide ☐ Could not be determined
☐ Accident ☐ Homicide ☐ *Pending Investigation*

30. DATE OF INJURY (Month/Day/Year) | 31. TIME OF INJURY ☐ A.M. ☐ P.M. | 32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area) | 33. INJURY AT WORK? ☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number | Apartment Number | City or Town | State | ZIP Code

35. DESCRIBE HOW INJURY OCCURRED:

36. IF TRANSPORTATION INJURY, SPECIFY:
☐ Driver/Operator ☐ Pedestrian
☐ Passenger ☐ Other (Specify) _____

37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON | 38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No | 39. DATE PRONOUNCED (Month/Day/Year) | 40. TIME OF DEATH ☐ A.M. ☐ P.M.

41. CERTIFIER (Check only one):
☐ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Physician in attendance at time of death only - 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.

42. NAME, ADDRESS AND ZIP CODE OF PERSON **COMPLETING CAUSE OF DEATH** (Item 24) | 43. PHYSICIAN'S LICENSE NUMBER

44. TITLE OF CERTIFIER | 45. DATE CERTIFIED (Month/Day/Year) | 46. SIGNATURE OF CERTIFIER

47. DECEDENT'S EDUCATION - Check the box that best describes the highest degree or level of school completed at the time of death.
☐ 8th grade or less
☐ 9th - 12th grade; no diploma
☐ High school graduate or GED completed
☐ Some college credit, but no degree
☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
☐ Unknown

48. DECEDENT OF HISPANIC ORIGIN? - Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify) _____

49. DECEDENT'S RACE - **Check one or more races** to indicate what the decedent considered himself or herself to be.
☐ White ☐ Black or African American
☐ American Indian or Alaskan Native (Name of the enrolled or principle tribe) _____
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Other Asian (Specify) _____
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Other Pacific Islander (Specify) _____
☐ Other (Specify) _____

50. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED).

51. BUSINESS/INDUSTRY (Enter type of business or industry, NOT COMPANY NAME)

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