DEPARTMENT OF HEALTH

Minnesota Documentation of Death

SFN

Deceased Name (First, Middle, Last, Suffix) | **Last Name Before First Marriage** | **Also Known As**

Date of Death MM DD YYYY

Sex ○ Male ○ Female ○ Unknown

Social Security Number - - ○ None ○ Unknown ○ Not Obtainable

Date of Birth ○ Unknown MM DD YYYY

Age (in years) | Under 1 Year: months, days | Under 1 Day: hours, minutes

Birth Country ○ Born in the United States ○ Not U.S. Specify ○ Unknown | State/Province | City/Town

Deceased's **Residence** Address ○ U.S. Address ○ Foreign country ○ Unknown | State/Province | County | City/Town | Street & Number, Zip Code | Inside City Limits? ○ Yes ○ No

Education (highest completed)
○ Unknown
○ 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., MD, DDS, DVM,

Ever In Armed Forces? ○ Yes ○ No ○ Unknown

Deceased's Usual Occupation

Kind of Business or Industry

Hispanic Origin
○ No, Not Spanish/Hispanic/Latino
○ Yes, Hispanic Origin Known
☐ Mexican, Mexican American, Chicano
☐ Puerto Rican
☐ Cuban
☐ Other, specify
○ Unknown if Spanish/Hispanic/Latino

Race ○ Unknown
☐ White
African African/American
☐ Black/African American
☐ Ethiopian
☐ Liberian
☐ Ghanaian
☐ Other African
Specify
☐ Kenyan
☐ Sudanese
☐ Nigerian
☐ Somali
☐ American Indian or Alaska Native
Name of the Enrolled or Principal Tribe
Asian
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Other Asian
Specify
☐ Korean
☐ Vietnamese
☐ Hmong
☐ Cambodian
☐ Laotian

Pacific Islander
☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander Specify
☐ Other Race Specify

Marital Status at time of Death ○ Married ○ Never Married ○ Married But Separated ○ Widowed ○ Divorced ○ Unknown ○ Not Obtainable

Spouse's Name (First, Middle, Last, Suffix) | Last name before first marriage

Father/ParentTwo Name (First, Middle, Last, Suffix)

Mother / Parent One Name (First, Middle, Suffix) | Last Name Before First Marriage

Informant's Name (First, Middle, Last or Institution) | Relationship to Deceased | Address(Street & Number, City, State, Zip)

Place of Death
Hospital
○ Inpatient
○ Emergency Room/Outpatient
○ Dead on Arrival

Other than a Hospital
○ Hospice
○ Nursing home/Long term care
○ Deceased's home
○ Other

County
Facility Name and Address (Street & Number, City, State, Zip)

Physician/ME Providing Cause of Death Information (First, Middle, Last) License # Title | Funeral Home/Other Institution, Estab. # | Funeral Director Name (First, Middle, Last)

Method of Disposition ○ Burial ○ Cremation ○ Donation ○ Entombment ○ Removal from State ○ Other (Specify)

Disposition Facility	State/Province	City/Town
Cemetery	State/Province	City/Town

The information on this form is correct to the best of my knowledge

Signature Date

Minnesota Department of Health
Office of Vital Records
PO Box 64499
St. Paul, MN 55164-0499
651-201-5970

DEPARTMENT OF HEALTH

Minnesota Cause of Death Worksheet

SFN

Deceased Name (First, Middle, Last, Suffix) | Also Known As

Physician/Medical Examiner providing this information | Title | License #

Date of Birth MM DD YYYY | Date of Death MM DD YYYY | Time of Death

Was the Medical Examiner Contacted? O Yes O No | Date last saw deceased:

Did INJURY or TRAUMA contribute to the cause of death? O Yes O No

If Yes, please explain:

Is there any reason to postpone final disposition? O Yes O No

If Yes, please explain:

Cause of Death

Part I Enter the chain of events-diseases, injuries, or complications that directly caused death. Do not enter terminal events such as cardiac arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause per line. Add additional lines if necessary.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (final disease or condition resulting in death)	a.	
Sequentially list conditions, if any, leading to the immediate cause. Enter the **UNDERLYING CAUSE** (disease or injury that initiated events resulting in death) **LAST**	Due to (or as a consequence of) 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

Was an autopsy performed? O Yes O No | Autopsy Results Available to complete the cause of death? O Yes O No

Did Tobacco use contribute to death?
- O Yes
- O No
- O Probably
- O Unknown

If Female
- O Not pregnant within past year
- O Pregnant at time of death
- O Not pregnant, but pregnant within 42 days of death
- O Not pregnant, but pregnant 43 days to 1 year before death
- O Unknown if pregnant within the past year

Manner of Death
- O Natural
- O Accident
- O Suicide
- O Homicide
- O Pending Investigation
- O Could not be determined

Complete Injury Information below if Manner of Death is not Natural

Date of Injury MM DD YYYY | Time of Injury ___ AM O PM O ___ Military | Injury at work? O Yes O No | If Transportation Injury, Specify (specify) O Driver/Operator O Passenger O Pedestrian O Other

Place of Injury (e.g. Deceased's home, construction site, restaurant, wooded area)

Location of Injury (Street & Number, Apt. #, City or Town, State, Zip Code)

Describe How Injury Occurred

Completed by Physician:

Print Name | Signature | Date

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