DEPARTMENT OF HEALTH

Request to Change Cause or Manner of Death

To request changes, you must be the physician, APRN, or PA who provided the cause of death, **OR**, a coroner/ME in the county where the death occurred. **Fill in the FROM and TO values ONLY for the fields you want to change.** Call 651-201-5970 for assistance.

Decedent information – REQUIRED to locate the death record		
Decedent's full name (first, middle, last, suffix)	Date of death (mm/dd/yyyy)	State file number (SFN)

CAUSE OF DEATH I

Other death info

CHANGE Date of death	**FROM**		**TO**	**CHANGE** Time of death	**FROM**		**TO**
CHANGE Medical Certifier	**FROM**		**TO**				
CHANGE Date last saw deceased	**FROM**		**TO**	**CHANGE** Was the ME contacted (Y or N)	**FROM**		**TO**
CHANGE Did injury/trauma contribute (Y or N)	**FROM**		**TO**				
CHANGE If Yes to "Did injury/trauma contribute", please explain	**FROM**		**TO**				

CHANGE this field	**FROM**	**TO**
COD Part 1 (A)		
Approximate Interval		
COD Part 1 (B)		
Approximate Interval		
COD Part 1 (C)		
Approximate Interval		
COD Part 1 (D)		
Approximate Interval		
Other significant conditions (COD Part 2)		

Manner of death

CHANGE this field	**FROM**	**TO**
Was an autopsy performed (Y or N)		
Autopsy findings available (Y or N)		
Was there a religious objection to autopsy (Y; N; or Unknown)		
Manner of death (Natural; Accident; Suicide: Homicide: Pending Investigation; Could not be determined)		
Did tobacco contribute (Y; N; Probably; Unknown)		
If female, pregnancy information: (**a**) *not* preg in last yr; (**b**) preg @ death; (**c**) preg w/in 42 days of dth - not @dth; (**d**) preg 43 days - 1 yr before dth; (**e**) Unknown		

CAUSE OF DEATH II - INJURY INFORMATION

CHANGE this field	**FROM**		**TO**	
Injury occurred (Yes, No, Unknown)				
Date of injury				
Time of injury	(HHmm)	a.m./p.m.	(HHmm)	a.m./p.m.
Place of injury				
Injury at work (yes; no; unknown)				
Country				
State				
County				
City				
Address				
Zip code				
Describe how injury occurred				
If transportation injury, specify (Driver/operator; passenger; pedestrian; other (specify); unknown; not applicable)				

REQUIRED – Medical certifier requesting changes to cause of manner of death			
Medical certifier's signature	Medical certifier's printed name	Date	Phone number (10-digit)

THERE IS NO FEE TO CHANGE CAUSE OF DEATH INFORMATION. Email form to health.amend@state.mn.us or fax to 866-416-1357.