



June 7, 2011  
FOR IMMEDIATE RELEASE

## Revised death certificate effective July 1

DES MOINES, IA – Iowa physicians are being advised that the Iowa Department of Public Health will be using a revised certificate of death, effective July 1, to conform with new legislation recently signed into law by Governor Terry Branstad.

The legislation, which was approved by the General Assembly earlier this year, allows physician assistants (PA) and advanced registered nurse practitioners (ARNP), in addition to medical physicians (MD) and osteopathic physicians (DO), to certify the cause of death. Revisions to the certificate are:

- **Box 26 (Name of person pronouncing death)** – Parentheses were added to remind the user that only the following professional titles may be listed – MD, DO, PA, ARNP, RN (registered nurse), LPN (licensed practical nurse).
- **Box 31b (If yes, medical examiner contacted)** – Revised from a yes/no option to a blank space for the medical examiner case number to be entered if “yes,” the medical examiner was contacted.
- **Box 34 (Autopsy findings available)** – The words “if yes” were added in the label.
- **Box 45 (Certifier)** – The first box now says “Certifying MD, DO, PA, ARNP” to conform with the new law and the second box now has “MD, DO” added after the words “medical examiner.”

The revised certificate (see sample below) and instructions are available at this website:  
<http://www.idph.state.ia.us/apl/deathreg.asp>

The Iowa Department of Public Health began using a new certificate on January 1, incorporating standards developed by the National Center for Health Statistics.

State law requires the certificate to be completed promptly so that families can close out the estate of the deceased person and begin to settle business and personal affairs.

## NON-NATURAL DEATHS

### 144.28 Medical Certification.

1. a. For the purposes of this [Iowa Code] section, “non-natural cause of death” means the death is a direct or indirect result of physical, chemical, thermal, or electrical trauma, or drug or alcohol intoxication or other poisoning.

b. Unless there is a non-natural cause of death, the medical certification shall be completed and signed by the physician, physician assistant,\* or advanced registered nurse practitioner\* in charge of the patient’s care for the illness or condition which resulted in death within seventy-two hours after receipt of the death certificate from the funeral director or individual who initially assumes custody of the body.

c. If there is a non-natural cause of death, the county or state medical examiner shall be notified and shall conduct an inquiry.

d. If the decedent was an infant or child and the cause of death is not known, the medical examiner’s inquiry shall be conducted and an autopsy performed as necessary to exclude a non-natural cause of death.

e. If upon inquiry into a death, the county or state medical examiner determines that a pre-existing natural disease or condition was the likely cause of death and that the death does not affect the public interest as described in [Iowa Code] section 331.802, subsection 3, the medical examiner may elect to defer to the physician, physician assistant,\* or advanced registered nurse practitioner\* in charge of the patient’s pre-existing condition the certification of the cause of death.

f. When an inquiry is required by the county or state medical examiner, the medical examiner shall investigate the cause and manner of death and shall complete and sign the medical certification within seventy-two hours after determination of the cause and manner of death.

2. The person completing the medical certification of cause of death shall attest to its accuracy either by signature or by an electronic process approved by rule.

### **NOTE:**

On the death certificate, the Medical Examiner should enter their case number in item #31b if the death falls within the jurisdiction of the Medical Examiner.

If the Medical Examiner is deferring certification back to the physician, physician assistant,\* or advanced registered nurse practitioner\* in charge of the patient’s care or condition that resulted in death, the ME should provide the physician, physician assistant,\* or advanced registered nurse practitioner\* with the case number to be entered in item #31b on the death certificate form.

\* Effective with July 1, 2011, death events pursuant to H.F. 393, 2011 legislative session.

## **DEATHS THAT FALL UNDER THE JURISDICTION OF A MEDICAL EXAMINER**

Deaths that have an impact on the “public’s interest” are routinely investigated by the County Medical Examiners under the guidance of the Iowa Office of the State Medical Examiner.

Deaths affecting the public’s interest include deaths that are:

Sudden, Unexpected, Violent, Suspicious, or Unattended

Deaths that come under the jurisdiction of the Medical Examiner’s Office are outlined in Iowa Code section 331.802(3) and generally include, but are not limited to:

1. Violent death, including homicide, suicide, or accidental death resulting from physical.
2. Death caused by mechanical, thermal, electrical, or radiation injury.
3. Death caused by criminal abortion, including self-induced, or by sexual abuse.
4. Death related to disease thought to be virulent or contagious that may constitute a public hazard.
5. Death that occurred unexpectedly or from an unexplained cause.
6. Death of a person confined in a prison, jail, or correctional institution.
7. Death of a person who was pre-diagnosed as a terminal or bedfast case who did not have a physician in attendance within the preceding thirty days; or death of a person who was admitted to and had received services from a hospice program as defined in Code section 135J.1, if a physician or registered nurse employed by the program was not in attendance within thirty days preceding death.
8. Death of a person if the body is not claimed by a person authorized to control the deceased person’s remains under section 144C5, or a friend.
9. Death of a person if the identity of the deceased is unknown or the body is unclaimed.
10. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.
11. Death of a person committed or admitted to a state mental health institute, a state resource center, the state training school, or the Iowa juvenile home.
12. Death of a person under the age of 55 who died suddenly when in apparent good health;
13. Death due to suspicious circumstances.
14. Death due to unknown or obscure causes.
15. Custody deaths.

STATE OF IOWA  
IOWA DEPARTMENT OF PUBLIC HEALTH  
**CERTIFICATE OF DEATH**

114-

BIRTH NUMBER

DECEDENT

PLACE

DISPOSITION

DATE

CAUSE OF DEATH

CERTIFIER

1. DECEDENT'S FULL NAME	FIRST		MIDDLE		LAST		SUFFIX, if any	
2. SEX	3a. AGE – LAST BIRTHDAY Years		3b. UNDER 1 YEAR Months Days	3c. UNDER 1 DAY Hours Minutes		4. DATE OF BIRTH (Month, Day, Year)		5. COUNTY OF DEATH
6. PLACE OF BIRTH (City & State, or Foreign Country)				7. SOCIAL SECURITY NUMBER		8. CITIZEN OF WHAT COUNTRY?		9. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No
10a. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown			10b. DECEDENT'S LAST NAME PRIOR TO ANY MARRIAGE (If ever married)		11. SURVIVING SPOUSE (Full name prior to any marriage)			
12a. RESIDENCE-STATE		12b. RESIDENCE-COUNTY		12c. RESIDENCE-CITY OR TOWN		12d. RESIDENCE-STREET & NUMBER, ZIP CODE		12e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. FATHER'S NAME			FIRST		MIDDLE		LAST	
14. MOTHER'S NAME PRIOR TO ANY MARRIAGE			FIRST		MIDDLE		LAST	
15a. INFORMANT'S NAME			15b. INFORMANT'S MAILING ADDRESS (Street & Number, City, State, Zip Code)				15c. RELATIONSHIP TO DECEDENT	
16. PLACE OF DEATH (Check only one)								
IF DEATH OCCURRED IN A HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Dead on Arrival			IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify) _____					
17a. FACILITY NAME (If not institution, give street and number)				17b. CITY, TOWN, OR LOCATION & ZIP CODE OF DEATH			17c. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DISPOSITION								
18. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) _____				19. PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place)				
20. LOCATION OF DISPOSITION (City or Town & State)			21. NAME AND COMPLETE ADDRESS OF FUNERAL HOME					
22a. FUNERAL DIRECTOR – Printed Name				22b. FUNERAL DIRECTOR'S Signature				23. LICENSE NUMBER
PRONOUNCEMENT, CERTIFICATION AND CAUSE OF DEATH								
ITEMS 24 – 28 REQUIRED TO BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH			24. DATE PRONOUNCED DEAD (Month, Day, Year) (Spell out month)			25. TIME PRONOUNCED DEAD TIME _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military		
26. NAME OF PERSON PRONOUNCING DEATH (If different than certifier) (Type or print legibly) (MD, DO, PA, ARNP, RN, LPN)				27. TITLE		28. LICENSE NUMBER		31a. MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No
29. ACTUAL OR PRESUMED DATE OF DEATH (Month, Day, Year) (Spell out month)				30. ACTUAL OR PRESUMED TIME OF DEATH TIME _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military				31b. If Yes, M.E. case number
<p style="text-align: center;"><b>CAUSE OF DEATH (See instructions and examples)</b></p> <p>32a. 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 stating the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →→→→→</p> <p style="text-align: right;">Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to the cause listed on line a. Enter only one condition on a line.</p> <p style="text-align: right;">Due to (or as a consequence of):</p> <p><b>UNDERLYING CAUSE</b> (disease or injury that initiated the events resulting in death) <b>LAST</b></p> <p style="text-align: right;">Due to (or as a consequence of):</p> <p style="text-align: right;">Due to (or as a consequence of):</p>								32b. Approximate interval between onset and death
32c. PART II. Enter other conditions contributing to death but not resulting in the underlying cause given in PART I.						33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
34. If yes, WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No						37. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined		
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		36. IF FEMALE: <input type="checkbox"/> Pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Pregnant at time 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				40. PLACE OF INJURY (e.g., home, farm, street, roadway, etc.)		
38. DATE OF INJURY (Month, Day, Year) (Spell out month)			39. TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM TIME _____ <input type="checkbox"/> Military		41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No			
42. LOCATION OF INJURY: (Complete physical address – Street & Number, Apt. #, City or Town, State, Zip Code)						43. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		
44. DESCRIBE HOW INJURY OCCURRED:								
45. CERTIFIER <input type="checkbox"/> Certifying MD, DO, PA, ARNP – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. (Check only one) <input type="checkbox"/> Medical Examiner (MD, DO) – On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, & place, and due to the cause(s) & manner stated.								
Signature _____						46. TITLE _____		47. DATE CERTIFIED (Month, Day, Year) _____
48. NAME & COMPLETE MAILING ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or print legibly)							49. LICENSE NUMBER	
50. FOR REGISTRAR ONLY – REGISTRAR SIGNATURE						50a. DATE RECEIVED BY REGISTRAR (Month, Day, Year)		