

# WISCONSIN DEATH CERTIFICATE WORKSHEET

DECEDENT	Decedent's Current Legal Name - <b>First</b> <span style="margin-left: 150px;"><b>Middle</b></span> <span style="margin-left: 150px;"><b>Last</b></span> <span style="float: right;"><b>Suffix</b></span>					
	If Alias Used: Alias Name - <b>First</b> <span style="margin-left: 150px;"><b>Middle</b></span> <span style="margin-left: 150px;"><b>Last</b></span> <span style="float: right;"><b>Suffix</b></span>					
	<b>Sex</b>	<b>Social Security Number</b>	Date Pronounced Dead	Time Pronounced Dead (0000-2359) <span style="float: right;">Pronouncer's Name &amp; Type</span>		
	Reportable to C/ME? <input type="checkbox"/> Yes <input type="checkbox"/> No State & County of Incident:		Hospice Responsible for Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospice Name		
	Hospital Death: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA from NH <input type="checkbox"/> DOA from Other <input type="checkbox"/> ER from NH <input type="checkbox"/> ER from Other		Other Place of Death <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence Care Apt (RCAC) <input type="checkbox"/> Decedent's Residence <input type="checkbox"/> Adult Family Home (AFH) <input type="checkbox"/> Hospice Facility <input type="checkbox"/> CBRF <input type="checkbox"/> Other			
	If Applicable, Facility Name:		<b>County of Death</b>	<b>City, Village, Township of Death</b> <input type="checkbox"/> <b>City</b> <input type="checkbox"/> <b>Village</b> <input type="checkbox"/> <b>Township</b>		
	<b>Street Address</b>			<b>Zip Code</b>		
	<b>Decedent's Birth Last Name</b>	<b>Date of Birth (MM/DD/YYYY)</b>	Age at Death <input type="checkbox"/> Years <input type="checkbox"/> Hours <input type="checkbox"/> Months <input type="checkbox"/> Days	<b>Country/State of Birth</b>		
	<b>Father's Birth Name - First</b> <span style="margin-left: 150px;"><b>Middle</b></span> <span style="margin-left: 150px;"><b>Last</b></span> <span style="float: right;"><b>Suffix</b></span>					
	<b>Mother's Birth Name - First</b> <span style="margin-left: 150px;"><b>Middle</b></span> <span style="margin-left: 150px;"><b>Last</b></span> <span style="float: right;"><b>Suffix</b></span>					
DECEDENT DEMOGRAPHICS	<b>Decedent's Residence Country/State</b>		<b>County of Residence</b>	<b>City, Village, Township of Residence</b> <input type="checkbox"/> <b>City</b> <input type="checkbox"/> <b>Village</b> <input type="checkbox"/> <b>Township</b>		
	<b>Decedent's Street Address</b>			<b>Zip Code</b>		
	<b>Decedent's Marital Status</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Annulled <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed		<b>Surviving Spouse's Birth Name (First, Middle, Last, Suffix)</b>			
	Wisconsin Domestic Partnership at Death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Surviving Partner's Birth Name (First, Middle, Last, Suffix)</b>			
	<b>Informant's Relationship to Decedent</b>		<b>Informant's Name (First, Middle, Last, Suffix)</b>			
	<b>Informant's Mailing Address (Street Address, City, State, Zip Code)</b>					
	<b>Decedent of Hispanic/Spanish/Latino Origin?</b> (Check all that apply) <input type="checkbox"/> Not Hispanic/Spanish/Latina(o) <input type="checkbox"/> Mexican/Mexican American/Chicana(o) <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Unknown <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic/Spanish/Latina(o) Specify:		<b>Race (Check all that apply)</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native Specify: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Laotian <input type="checkbox"/> Hmong <input type="checkbox"/> Other Asian Specify: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Charorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander Specify: <input type="checkbox"/> Other Specify: <input type="checkbox"/> Unknown			
<b>Decedent's Education</b> (Check the box that best describes the highest degree or level of school completed by the decedent.) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Unknown						
<b>Decedent's Usual Occupation (Do not use "Retired")</b>		<b>Kind of Business or Industry of Decedent</b>	<b>Was Decedent Ever in the Armed Forces?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>Was Decedent a Tribal Member?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Name of Tribe(s)</b>				
DISPOSITION	Method of Disposition <input type="checkbox"/> Other, Specify:		Place of Disposition	Country/State of Disposition	City, Village, Township of Disposition	
	<input type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Unknown		Funeral Home Name		FH License Number	Funeral Home Phone Number
	Funeral Home Mailing Address		Funeral Director's Full Name		FD License Number	

Decedent's Current Legal Name First Middle Last	Date Pronounced Dead
Social Security Number	

CERTIFIER	Certifier Type <input type="checkbox"/> Physician <input type="checkbox"/> Coroner/Medical Examiner	Certifier's Name (First Last, Title)	License Number
	Certifier's Mailing Address (Street, City, State, Zip Code)		
	Certifier's Phone Number	Certifier's Fax Number	
	Date of Death <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Time of Death (0000-2359) <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	

Cause of Death Information should only be completed by the Medical Certifier.			
Autopsy Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Tobacco Use Contribute to Death? (Statistical Use Only-will not appear on certificate) <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did Alcohol Use Contribute to Death? (Statistical Use Only-will not appear on certificate) <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Pregnancy Status (statistical use only - will not appear on certificate) <input type="checkbox"/> Not pregnant within the past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year prior to death		Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending	
Part I - Cause of Death Enter the chain of events-disease, injuries or complications-that directly caused the death. DO NOT enter terminal events such as cardiac arrest or respiratory arrest without showing the etiology. Immediate Cause (Final Disease or condition resulting in death) → a. _____ Due to (or as a consequence of) b. _____ Due to (or as a consequence of) c. _____ Due to (or as a consequence of) d. _____ (Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease that initiated the events resulting in death) LAST)			Interval Between Onset and Death
PART II - Other Significant Conditions Contributing to Death Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			

INJURY INFORMATION	Injury Information should only be completed by a Coroner, Medical Examiner, or their Deputies.			
	Date of Injury <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Time of Injury (0000-2359) <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Injury at Work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Place of Injury
	Country/State of Injury	County of Injury	City, Village, Township of Injury <input type="checkbox"/> City <input type="checkbox"/> Village <input type="checkbox"/> Township	
	Address of Injury			Zip Code
Describe How Injury Occurred				

It is important that information on this worksheet be complete and accurate. Understand that the provided information (unless otherwise noted) will appear on the certified copy of the death record. The information will be used by health and medical researchers to study and improve the health of Wisconsin's citizens. Any person who willfully and knowingly supplies false information in the preparation of a death certificate is guilty of a Class I felony [a fine of not more than \$10,000 or imprisonment of not more than 3 years and six months or both per Wisconsin Statute section 69.24(1)].

Certifier's Signature – I attest that the information I have provided is accurate to the best of my knowledge.	Date Signed
Funeral Director's Signature – I attest that the information I have provided is accurate to the best of my knowledge.	Date Signed