

STATE OF VERMONT DEPARTMENT OF HEALTH REQUEST TO CORRECT A DEATH CERTIFICATE

Please type or print legibly

It is requested that the death certificate for _____ who died on _____
First Name Last Name mm/dd/yyyy

In the town/city of _____ be corrected or completed with the following information.

MEDICAL CERTIFICATION (This section may only be corrected/completed by a physician.)

27. MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could Not Be Determined			
28. CAUSE PART I. PHYSICIAN: TYPE / LEGIBLY PRINT INFORMATION AS YOU WISH DEATH CERTIFICATE TO APPEAR			
			APPROXIMATE INTERVAL: ONSET TO 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. _____			_____
29. CAUSE PART II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I.			
30. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		31. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death	
32a. WAS MEDICAL EXAMINER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No	32b. M.E. CASE NUMBER	33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	34. WERE FINDINGS OF AUTOPSY AVAILABLE TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No
35. DATE OF INJURY (Month, Day, Year)	36. TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM	37. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)	38. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
39. LOCATION OF INJURY (Street and Number, City or Town, State)			
40. DESCRIBE HOW INJURY OCCURRED		41. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (specify) _____	
OTHER CORRECTIONS INCLUDING CHANGES TO DEMOGRAPHIC INFORMATION:			
Print Name of Person Requesting Change		Signature of Person Requesting Change	Date
Phone Number: () _____ - _____			

Please return completed and signed form to:
Vermont Department of Health – Vital Records
108 Cherry Street – P.O. Box 70
Burlington, VT 05402-0070
802-863-7275