



Certifying A Death in Vermont

This training module is designed to:

- Review the information needed to certify a death
- Show you how to use the Vermont Electronic Death Registration System (EDRS)
- Facilitate your enrollment as an EDRS user so you may access the application to certify deaths



Medical Certification Requirement and the EDRS

Getting Started

Who Should Certify

Logging onto the EDRS

Finding/Creating a Record in the EDRS

EDRS Screen 1: Name Known to Physician

EDRS Screen 2: Place of Death and Hospice

Key Terms for Death Certification

EDRS Screen 3: Manner and Cause of Death

Cause of Death Part 1

Cause of Death Part 2

EDRS Screen 4: Other Factors

EDRS Screen 5: Certification

EDRS Edits

Printing Documentation

Accessing Certified Records

Where to Get Help

Enrolling as an EDRS User



According to Vermont statute a death shall be certified by the physician, physician assistant, or advanced practice registered nurse, last in attendance of the patient. Documentation of the death must be provided to the funeral director or family within 24 hours of the event so that permits may be obtained prior to final disposition of the deceased.

It is your responsibility to provide as accurate information as possible, which often requires review of medical records.

Accurately certifying a death in a timely manner is crucial because the cause-of-death information provided by YOU, the certifier, is the data used by local, state, and national decision makers as the basis for determining policies and research funding.

More importantly, you are providing information to family and others (insurance agents, banks, lawyers, physicians, the SSA, and researchers) who use death certificate data for many purposes.



All deaths occurring within the State of Vermont must be certified using the Electronic Death Registration System (EDRS).

The Electronic Death Registration System (EDRS) is a web-based application with which physicians, physician assistants, advanced practice registered nurses, and funeral directors can submit all information required for the filing of a death certificate. Its users include Vermont funeral directors, physicians, the Office of the Chief Medical Examiner and the Vermont Department of Health Vital Records Office.

Registering a death using the EDRS involves completing two sections.

- Medical information is entered and “certified” by a physician, physician assistant or advanced practice registered nurse.
- Demographic information is entered and “signed” by a funeral director.

Once both portions of a record are complete, the record is registered and considered a death certificate. Certified copies of the death certificate are then available from the Town Clerk or from the Vital Records Office. All data is also immediately available to the Vermont Department of Health.

EDRS users may print final versions of the information they have certified for record keeping and to provide to those caring for the body.



The following procedures should be followed when you are asked to certify a death

1. **Evaluate if the death is reportable to the medical examiner.** Each state has specific laws relating to which cases are reportable to the Medical examiner or Coroner. In Vermont, these are described under [18 V.S.A. § 5205](#). Also see [reportable deaths](#) on the medical examiner's webpage.

Familiarity with local law is essential. If you are unclear if the death is reportable, it is wise to report it. There is no charge for doing so (**1-888-552-2952**). If the medical examiner accepts the case then they will certify the death.

If the medical examiner declines jurisdiction and asks you to certify the death, proceed to Step 2. Of course, before reporting a case one must know something of the circumstances of the death which may require contacting another physician or reviewing the medical record. (see #2).

2. **Evaluate if there is a more appropriate certifier.** You may be asked to certify the death of a patient about whom you have little or no personal knowledge. This can be a common scenario for emergency room physicians, hospitalists, and cross covering physicians.

In these cases, you should attempt to identify and contact the patient's personal physician or other doctor who may be more familiar with the case as he or she may be able to more accurately and completely certify the death. If there is no one more appropriate, proceed to Step 3.

3. **Certify the cause of death as accurately as possible.**



Before using the EDRS for the first time you must obtain a Username and Password from the Vermont Department of Health. At the end of this tutorial, you will be able to submit a request to obtain these.

Once you have your username and password, you can log on and use the system anywhere you have access to the Web.

To Log on to the EDRS: Go to the EDRS Project web page:

<https://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vital-records-reporting-edrs>

- EDRS is compatible with Firefox version 8 or higher and Edge.
- **You must allow pop-ups** from the EDRS web site in order to access the application. If this has not been done the screen will say “loading” but not progress or direct you immediately to a page that says Access Denied.
- **To fix this, please consult with your local IT** and have your web browser set to always allow pop-ups from this site or try a different web browser. This is a change you should only have to make once, but it may need to be repeated if your system is updated or you work on multiple computers.

TIP: The key information you will need to navigate the EDRS including tips for troubleshooting log on issues is also available in the **EDRS Quick Guide**. This document is always available on the EDRS web site at: <https://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vital-records-reporting-edrs>, but you may wish to print and save a copy as a reference for the first time you access the EDRS.

Getting Started: Finding or Creating A Record



Once you have logged on to the EDRS, select **Create/Update Medical Record** from the menu in blue on the left side of the screen to start the process of creating or updating a death record.

Vital Records Electronic Death Registration System

User: tberry Facility: Tim's Hospital

Vital Records

Welcome to the Electronic Death Registration System

You will be asked to enter the decedent's last name and year of death. You will be directed to **review the list of unregistered records** that match the information you entered.

Since it is possible that the funeral director has already started the record or that the record was started by another provider, it is important that you always review this list to avoid creating a duplicate record.

If you see the name of your patient, choose the **"Select"** button to the left of the name to open the record.

If the medical side has been started by another provider, you will only be able to open the record if that physician is associated with your medical facility. If you do not see a record matching your patient select **"Add New"** from the bottom of the list.

Search for a Record

Started EDRS Records
Please review this list and select the record you wish to update or complete. If no record has been started for the decedent select "Add New" from the bottom of the page.

Select	Last Name	First Name	Middle Name	Date of Birth	Date of Death	Demographic Assigned	Medical Assigned	Record
Select	Bon Jovi	John	Michael	1/4/1969	11/7/2007	<input checked="" type="checkbox"/>	<input type="checkbox"/>	INCOM
Select	Lauper	Cindi		11/7/2007	11/7/2007	<input checked="" type="checkbox"/>	<input type="checkbox"/>	INCOM
Select	ones	Tom		4/3/1960	11/8/2007	<input checked="" type="checkbox"/>	<input type="checkbox"/>	INCOM
Select	ZUZU		Test			<input type="checkbox"/>	<input checked="" type="checkbox"/>	INCOM
Select	zuzu	zuzu		10/10/2007	12/12/2007	<input checked="" type="checkbox"/>	<input type="checkbox"/>	INCOM
Select	Zzoom	Zzane		5/1/1920	4/24/2008	<input checked="" type="checkbox"/>	<input type="checkbox"/>	INCOM

Add New **Cancel**

EDRS Screen 1: Name Known to Physician



The **Name Known to Physician** is just that. The patient's name as you know it. For example, you may know the man as Al Newman. This is what you should enter. Alfred Edward Newman IV may actually be the deceased's full name. The patient's complete legal name will be entered by the funeral director and if the funeral director has already entered the name, you will not be able to edit it.

The **Date of Death** - This information may have been entered by the funeral director, but the physician has the final word, so, if this has been populated you can edit it.

Approximate Age Known To Physician is just that. The patient's date of birth may have been entered by the funeral director. The age entered by you will be available to the Medical Examiner or other physicians you ask to review the record. It is useful in assessing whether the cause of death makes sense.

IMPORTANT: Once you have addressed all items on a page **you must select "save" or "save this page"**. This is true of every page in the EDRS. If you do not save before moving to the next page your work will be lost.

Once the page is saved, you can move to the next page by selecting the link in the green box on the left hand side of the screen.

Name Known To Physician

First Name:

Middle Name:

*Last Name:

Suffix:

The decedent is an unknown person

Date of Birth: (if known)

*Date of Death:

Approximate Age:

To certify a death you must complete information on each of the following pages:

- Name Known to Physician
- Place of Death
- Manner and Cause of Death
- Other Factors
- Certification

To proceed, save this page and then select the next page from the list found in the green column on the left of this page. When you have completed information on all pages select "Certify" from the Certification page.

NOTE: You may complete pages in any order, but you must save before leaving a page or any new data will be lost.

TIP: You will notice that many of the EDRS screens include directions to help you navigate the application or address specific questions. If you are stuck, look for these.

EDRS Screen 2: Hospice Care and Place of Death



If a funeral director has already entered their portion of the record, this page may be populated.

If pre-existing information does not match the information you have, please contact the funeral director to discuss which information is correct. If no information has been entered, you must provide it.

Did Decedent Receive Hospice Care (in past 30 days)? - Since most hospice care in Vermont is not provided in a "Hospice Facility", funeral directors (and family members) often do not know whether the decedent was receiving this care.

Place of Death – It is important that you review these fields even if entered by a funeral director. For example, in the case of a hospital death, the funeral director or family member is unlikely to know whether the decedent was an "Inpatient" or "Outpatient", or whether he/she was in the "Intensive Care Unit" or "Dead on Arrival".

Place of Death

Did decedent receive hospice care in the past 30 days?

Yes No Unknown

Place of Death:

Hospital: Inpatient Hospice Facility
 Hospital: Emergency room/Outpatient Nursing home/Long term care facility
 Hospital: Intensive Care Unit Other
 Hospital: Dead on arrival Unknown
 Decedent's home

If Other, Specify:

(If not institution, give street and number)

Facility Name:

If Other, Specify:

City/Town:

State/Province:

Country:

Reminder: When all information is complete, select **Save this Page** before navigating to another page.

Definitions

Before moving on to the remaining sections, we will first define several key terms and concepts:

Manner of Death

Cause of Death (immediate and underlying)

Mechanism of Death (sometimes called Mode or Immediate Cause)



The **manner of death** describes the circumstances surrounding the death. In Vermont and in most of this country there are only 5 choices:

- Natural
- Accident
- Suicide
- Homicide
- Could Not Be Determined

“Pending Investigation” is only available to medical examiners.

All cases that are not due exclusively (100%) to natural disease **MUST**, by law, be reported to the Medical Examiner's Office (1-888-552-2952).

If an injury in any way contributes to the person's death, no matter how long ago that injury was sustained, the death is not considered natural.



Stated very simply, a **cause of death** is the disease or injury responsible for starting the lethal sequence of events which ultimately lead to death. A competent cause of death must be as etiologically specific as possible. Etiologically specific causes of death are the disease entities studied in basic pathology courses. Examples include:

- Atherosclerotic cardiovascular disease
- Chronic alcoholism
- Hypertensive cardiovascular disease
- Blunt trauma
- Multiple sclerosis
- Alzheimer's disease
- Breast carcinoma
- Parkinson's disease
- Prostate carcinoma
- Pulmonary emphysema
- Diabetes mellitus
- Hodgkin's disease
- Viral encephalitis*
- Bacterial meningitis*
- Pertussis (whooping cough)*
- Human immunodeficiency virus*

* Infectious diseases or suspected infectious diseases, which are a threat or potential threat to public health must be reported to the Health Department at 802-863-7240 or 1-800-640-4374 (within VT only). An epidemiologist is available 24/7 for diseases that require prompt public health follow-up.

Mechanism of Death (or Mode of Death)



The **mechanism of death** is the altered biochemistry or physiology whereby the cause exerts its lethal effects. Mechanisms are not specific and can **NEVER** replace or substitute for a cause of death.

Mechanisms can never stand alone on a death certificate and always need an underlying cause of death.

Always ask yourself what the mechanism is due to in order to find the underlying cause of death.

Examples of Mechanisms of Death

Bronchopneumonia
Coagulopathy
Acute myocardial infarct
Multi-organ failure
Cardiopulmonary arrest
Respiratory failure
Congestive heart failure
Intracerebral hemorrhage
Liver failure
Respiratory arrest
Asystole
and the list goes on.

Examples

Coagulopathy due to *Coumadin* treatment for **chronic atrial fibrillation**

Coagulopathy due to *Liver failure* due to *Hepatic Cirrhosis* due to **Chronic alcohol abuse**

Intracerebral hemorrhage due to rupture of **berry aneurysm**

Intracerebral hemorrhage due to middle cerebral artery infarct due to **atherosclerotic cardiovascular disease**

Congestive heart failure due to **Coronary artery atherosclerosis**

Congestive heart failure due to *pericardial adhesions* due to **viral pericarditis**

Congestive heart failure due to **calcific aortic valve stenosis**

In these examples the *mechanisms* are *italicized* and the **causes** are in **bold**.

EDRS Screen 3: Manner and Cause of Death



Manner and Cause of Death are reported in the EDRS using the page displayed on the right.

Instructions including the number to report cases to the Office of the Chief Medical Examiner are included on the screen.

Note that **abbreviations may not be used in stating the cause of death** as they may be misinterpreted.

The next section of this tutorial will provide in depth discussion of how to address the **Cause of Death Part 1** and **Part 2**.

Manner and Cause of Death

Manner of Death:

If this death occurred in a manner that is anything but "Natural" please call 1-888-552-2952 to refer this death to the Office of the Chief Medical Examiner.

- Natural Suicide Pending Investigation
 Accident Homicide Could not be determined

Cause of Death

Part 1:

Enter the chain of events – diseases, injuries, or complications – that directly caused the death. Begin with the immediate (final) cause on line a and sequentially list on lines b-d the conditions, if any, leading to the immediate cause. Enter the **UNDERLYING CAUSE** (etiologically specific disease or injury that initiated the events resulting in death) **LAST**. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without listing an underlying cause below it. DO NOT ABBREVIATE. Enter only one condition/cause on a line.

CAUSE OF DEATH:

Approx. Interval:

Immediate Cause:(Final disease or condition resulting in death.)

ONSET TO DEATH

a: Cardiac tamponade

hours

Due to (or as a consequence of):

b: Ruptures myocardial infarct

days

Due to (or as a consequence of):

c: Atherosclerotic coronary artery disease

years

Due to (or as a consequence of):

d:

Part 2:

Enter other significant conditions contributing to death that did not result in the underlying cause given in Part 1.

Hypertension, Obesity, Diabetes Mellitus Type II, Tobacco

Save this Page

Return to Edits

Cancel

Cause of Death Part 1 - Introduction



Part 1 of the Cause of Death is formatted so that sequential information is reported with **ONE CONDITION per line**, starting with the most recent condition and going backward in time.

CAUSE OF DEATH:	Approx. Interval
<i>Immediate Cause: (Final disease or condition resulting in death.)</i>	<i>ONSET TO DEATH</i>
a: Cardiac tamponade <i>Most recent condition</i>	hours
<i>Due to (or as a consequence of):</i>	
b: Ruptured myocardial infarct <i>Next oldest condition</i>	days
<i>Due to (or as a consequence of):</i>	
c: Atherosclerotic coronary artery disease <i>Oldest (original, initiating) condition</i>	years

In this scenario "Cardiac tamponade" and "Ruptured myocardial infarct" are non-specific mechanisms. Both can be caused by various pathologic processes.

However, in this case, **atherosclerotic coronary artery disease** is the underlying cause which initiated the events of infarct, rupture and subsequent tamponade, the immediate causes or mechanisms of death.

*A major goal in writing cause of death statements is to **report the underlying cause of death** as specific as possible.*



Example 1: Chronic Alcohol Abuse

In the example, "chronic alcohol abuse" is the underlying cause of death. "Upper gastrointestinal hemorrhage" is the immediate cause or mechanism of death. The other two conditions are intermediate steps which fall somewhere in the pathologic process between the underlying cause, which begins the lethal chain of events and the immediate cause or mechanism of death.

Part 1:

A. Upper gastrointestinal hemorrhage

Due to, or as a consequence of:

B. Ruptured esophageal varix

Due to, or as a consequence of:

C. Cirrhosis of the liver

Due to, or as a consequence of:

D. Chronic alcohol abuse

Example 2: Myxomatous Degeneration

In this example, myxomatous degeneration or the floppy mitral valve syndrome is the etiologically specific condition that started the lethal sequence of events. To date there is no known cause of mitral valve degeneration thus it is a "competent" underlying cause of death.

Part 1:

A. Cerebral infarct

Due to, or as a consequence of:

B. Thrombo-embolism to right internal carotid artery

Due to, or as a consequence of:

C. Bacterial endocarditis of mitral valve

Due to, or as a consequence of:

D. Floppy mitral valve syndrome



Example 3: Amyotrophic Lateral Sclerosis

In this example, “amyotrophic lateral sclerosis” is the underlying cause of death.

"Respiratory failure" was the final and fatal complication of the progressive neurologic disease and is the immediate cause or mechanism of death.

It is necessary to report amyotrophic lateral sclerosis as the underlying cause of death because there are a number of conditions that can cause respiratory failure. Other possibilities that can cause respiratory failure include:

- Pulmonary emphysema
- Flail chest from trauma *
- Pneumocystic carinii pneumonia complicating AIDS
- Congestive heart failure complicating coronary atherosclerosis.
- Anaphylaxis from food allergy *
- Bronchial asthma
- Legionnaires disease**
- Hantavirus**
- etc.

If only respiratory failure was reported it would be impossible for a user of the Cause of Death statement to know which underlying condition this patient had.

* Cases which need to be reported to the Medical Examiner

** Suspected and/or confirmed cases must be reported to the Health Department at 802-863-7240 or 1-800-640-4374 (within VT only and to the OCME (1-888-552-2952).

Part 1:

A. Respiratory failure

Due to, or as a consequence of:

B. Amyotrophic lateral sclerosis

Due to, or as a consequence of:

C.



Example 4: Challenges in Reporting the Immediate Cause

Sometimes it may not be possible to report an immediate cause of death.

Consider a 50 year old woman with metastatic breast cancer. After enduring years of treatment modalities (surgical, chemo and radiation) she dies quietly in bed at home. Her death was expected so she does not fall under the medical examiner's jurisdiction, and permission for a hospital autopsy could not be obtained.

In this scenario, insufficient information exists to cite an immediate cause or mechanism such as bronchopneumonia, hemorrhage of a brain metastasis or some other mechanism. In cases like this, Line A serves as both the underlying and immediate cause, a "single line" format.

Part 1:

A. [Metastatic breast carcinoma](#)

Due to, or as a consequence of:

B.

Due to, or as a consequence of:

C.

NOTE: When reporting a cancer in the EDRS you will receive a "soft edit" asking you to be sure you have included the site, cell type (invasive ductal) and whether the condition has metastasized, if this is known.

If you have already provided this information you simply select the option to "Verify" your statement when this message appears. Otherwise, you should provide the additional details.



It is acceptable to express uncertainty* and one can qualify a cause of death with words such as "probable" or "presumed."

Since all cause of death statements are opinions based on the available information and need only meet the test of being "more likely than not," these qualifiers are not usually necessary.

* If after reviewing a patient's records and history you have no idea what disease or injury caused this person to die, contact the Medical Examiner.

Part 1:

A. Acute myocardial infarction

Due to, or as a consequence of:

B. Probable coronary artery atherosclerosis

Due to, or as a consequence of:

C.

“TO THE BEST OF MY KNOWLEDGE, ON THE BASIS OF THE CASE HISTORY, EXAMINATION AND/OR INVESTIGATION, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO CAUSE(S) AND MANNER STATED.”

This is the statement you attest to every time you certify a death. It appears on the certifying screen of the EDRS.



Many patients may die of fatal nonspecific processes or complications of an underlying cause of death.

Consider an elderly patient who develops an upper gastrointestinal hemorrhage and dies prior to a full medical work up and there is no autopsy.

Of course, one should be reasonably certain that only natural causes were involved. This approach lets a death certificate user know that thought was given about the underlying cause of death and that it wasn't just omitted through oversight.

Using the same scenario but adding that the patient had symptoms and signs suggesting peptic ulcer disease or had past peptic ulcer disease, it would be preferable to certify the death as:

Part 1:

A. Upper gastrointestinal hemorrhage

Due to, or as a consequence of:

B. Undetermined natural causes

Due to, or as a consequence of:

C.

Part 1:

A. Upper gastrointestinal hemorrhage

Due to, or as a consequence of:

B. Probable peptic ulcer disease

Due to, or as a consequence of:

C.

Medical judgment and **common sense** are required for certifying the cause of death. Truthfulness, completeness, and reasonable accuracy should be the goal. *Convenience and expedience* should not play a role when certifying causes of death.

Cause of Death Part 1 – A Word About Intervals



The Cause of Death Part I contains a space for reporting the time interval between the onset of each condition and death.

Try to be as accurate as possible. Using generic intervals such as seconds, minutes, hours, days, weeks, months, years, and decades is acceptable. It is also acceptable to indicate these are “Approximate”.

It should be apparent that intervals get longer when reading from top to bottom.

The EDRS requires that you enter an interval for each line you use. If you can not provide a reasonable assessment of the interval enter “Unknown”.

Part 1: A. Intracerebral hemorrhage	Interval between onset and death Approx. 8 hours
<i>Due to, or as a consequence of:</i> B. Hypertensive cardiovascular disease	Interval between onset and death 10-15 years

Part 1: A. Failure to thrive	Interval between onset and death Approx. 2 months
<i>Due to, or as a consequence of:</i> B. Alzheimer's dementia	Interval between onset and death years

Part 1: A. Bronchopneumonia	Interval between onset and death Approx. 10 days
<i>Due to, or as a consequence of:</i> B. Pulmonary emphysema	Interval between onset and death 5 years
<i>Due to, or as a consequence of:</i> C. Tobacco use	Interval between onset and death 30 years



In all previous examples only a single underlying disease entity existed. In many patients several conditions (disease and/or injuries) exist simultaneously and are either inseparable or have added together to cause death.

Part 2 exists for citing "Other Significant Conditions."

This section is used to report conditions which co-existed or pre-existed and contributed to death but did not result in the underlying cause of death reported in Part 1.

Part 2:

Enter other significant conditions contributing to death that did not result in the underlying cause given in Part 1.

Diabetes Mellitus, type II

Save this Page

Return to Edits

Cause of Death Part 2 – Example



Acute Myocardial Infarct - The case below is a classic example of the intended use of Part 2.

Scenario: A 64 year old man who is obese (5'8", 260 lbs.), is a diabetic (type II) who smokes one pack of cigarettes per day and is being treated for hypertension calls EMS complaining of chest tightness, left arm pain and shortness of breath. During transportation he arrests and despite resuscitation protocols is pronounced dead in the ER.

Part 1:

A. Acute myocardial infarction

Due to, or as a consequence of:

B. Atherosclerotic coronary artery disease

Due to, or as a consequence of:

C.

Part 2: OTHER SIGNIFICANT CONDITIONS

Conditions contributing to death but not resulting in the underlying cause of death in Part 1.

Essential hypertension

Obesity

Diabetes mellitus type II

Tobacco

The clinical course is highly suggestive of myocardial ischemia. However, this obese man also had hypertension. Both conditions can contribute to cardiac hypertrophy which increases cardiac oxygen demand and may facilitate or exacerbate the effects of coronary atherosclerosis.

Since the hypertension and obesity coexisted and contributed to death but did not cause the coronary atherosclerosis, they are correctly listed in Part 2.

Listing diabetes and tobacco abuse in Part 2 is a matter of convention (general agreement). Since diabetes and tobacco have been shown to cause atherosclerosis, people can argue to place them in Part 1. However, in specific cases it may be difficult to show a cause and effect relation. Using this convention recognizes the contribution these "risk factors" have and ensures they are recorded in mortality statistics. (Vermont, like many states, has a separate question on the "Other Factors" page of the EDRS asking the physician if they believe tobacco contributed to death).

EDRS Screen 4: Other Factors



The following questions regarding specific aspects of the decedent's health and the event of the death all require your response.

Did Tobacco Use Contribute to Death? Select the choice which you believe best represents this person's history.

If Female [give pregnancy status]. This question was added to the 2003 U.S. Standard Certificate of Death to improve the measurement of maternal mortality.

Was ME Contacted? If you contacted the Office of the Chief Medical Examiner regarding the circumstances of the death answer "Yes" even if a Medical Examiner did not take over the case. Leave the **ME Case #** blank. This is a field that is only completed by the Office of the Chief Medical Examiner.

Was an Autopsy Performed? YES or NO

Were findings available prior to completion of cause of death? YES or NO. If no autopsy was done select "Not Applicable". If an autopsy was done but the results were not available prior to you completing the Cause of Death statement, check "No". If an autopsy was completed and results were available to you at the time of completing the death certificate, check "Yes".

Other Factors

Did tobacco use contribute to death?

Yes No Unknown Probably

If Female:

Indicate pregnancy status of decedent. Select Not Applicable ONLY if under age 5 or over age 75, OR if male.

Not applicable
 Not pregnant within the past year
 Not pregnant, but pregnant 43 days-1 yr. before
 Not pregnant, but pregnant within 42 days of death
 Pregnant at the time of death
 Unknown, if pregnant within the past year

Was Medical Examiner contacted?

Yes No Unknown

M.E. case number: -

Was an autopsy performed?

Yes No Unknown

Were findings of autopsy available to complete the cause of death?

Yes No Unknown Not Applicable

EDRS Screen 5: Certification – Dates & Times

Vital Records		Electronic Death Registration System		VERMONT DEPARTMENT OF HEALTH Logout	
User: tberry Facility: TLC Hospital					
Create/Update Medical Record		Certification			
View Record		Actual or Presumed Date of Death: 12 / 1 / 2009			
Print Informational Copy					
Fred Flintstone		Enter the time of death and time pronounced dead in military format. Separate the hours and minutes with a colon. Example: 09:00 for 9:00AM, 21:00 for 9:00PM			
Medical Certification Pages:		Actual or Presumed Time of Death: 21:00 <input checked="" type="checkbox"/> Approximate Time			
Name Known to Physician		Date pronounced dead: 12 / 1 / 2009			
Place of Death		Time Pronounced Dead: 21:05			
Manner and COD					
Other Factors					
Certification					

Actual or Presumed Date / Time of death - This is the date and time the patient died. Sometimes the exact time of death is not known and this should be indicated. For example: An elderly women with multiple medical problems is discovered dead in bed on routine morning rounds. The exact time of death is unknown. If an approximate time of death can be reasonably assessed you should enter the time, but also check the box labeled "Approximate Time" next to this field. If you can not provide a reasonable estimate, you can indicate the time is "unknown" by entering 99:99 as the time of death.

Date / Time Pronounced Dead - By consensus, the first "official" person informed of the death can pronounce, this can be the nurse or nurse supervisor alerted to the death. The date and time should be recorded and then entered into the EDRS by the person certifying the death (this does not need to be the same person). This field should never be left blank. "Not Pronounced" or "Unknown" is unacceptable and can not be entered into the EDRS. In the example above of a patient found dead on routine morning rounds, the time pronounced is the time the body was discovered.

In some instances time of death and time pronounced dead are the same. Consider a patient who arrested in the field or hospital. The time at which resuscitation efforts are stopped would be the time of death and the time pronounced dead.

EDRS Screen 5: Certification – Certifier Info.



The EDRS recognizes all users who have authority to certify a death and will pre-populate your name, license number and other contact information on the Certifier page.

You must enter the **Date Certified** and must indicate your **Title**.

Name of Other Attending Physician: If there is another physician (for example Primary Care Provider) who may be familiar with the case, you may name him or her.

Select **Certify** when you wish to submit the record as final.

Date Certified:	<input type="text" value="6"/> / <input type="text" value="6"/> / <input type="text" value="2010"/>		
Name of Certifier:	<input type="text" value="TestPhysician, Rose"/>		
First Name:	Rose		
Middle Name:			
Last Name:	TestPhysician		
Suffix:			
Title:			
License Number:	1234567890		
Address of Certifier:			
Street 1:	123 Doctor St.		
Street 2:			
City/Town:	Arlington		
State:	VT	Zip:	05250
Contact Phone Number:	(802)111-2222		
Title of Certifier:	<input type="radio"/> Medical Examiner <input type="radio"/> Pathologist <input checked="" type="radio"/> Physician <input type="radio"/> Physician Assistant <input type="radio"/> Advanced Practice Registered Nurse <input type="radio"/> Unknown		
Name of attending physician if other than Certifier:			
First Name:	<input type="text" value="Joe"/>		
Middle Name:	<input type="text" value="M"/>		
Last Name:	<input type="text" value="TestCertifier"/>		
Suffix:	<input type="text"/>		
<input type="button" value="Save this Page"/>		<input type="button" value="Certify"/>	



Once you select “Certify”, the EDRS reviews your submission and reports back to you any areas that appear to be incomplete or inconsistent. These are called “edits”.

The goals of edits are to improve the quality of reporting and provide guidance to you about what information is needed at the time you are actually completing the death record, thus reducing the need for follow-up calls. There are two types of edits you may encounter:

“**Hard**” edits alert you when required fields have been left blank or when data provided is not appropriate. All hard edits must be addressed before the certification of the record can be completed.

“**Soft**” edits occurs when you have provided data that appears to be out-of-range, inconsistent, or incomplete. You may revise your entry or “verify” that the information provided is accurate and complete to the best of your knowledge.

In both cases, clicking on **Revise** to the right of the edit message will bring you to the page containing the data that has triggered the edit.

NOTE: The EDRS edits will prevent you from making many common errors such as missing fields or typos in dates. However, providing immediate feedback on the cause of death via edits is more challenging. You will receive some guidance from the edits, but it is still important for you to understand what is expected in medical certification of a death. If the information you have provided appears incomplete or is not clear, you will still be contacted by the Office of the Chief Medical Examiner or Vital Records for more information.



Edit Case

Hard Edits:
*The following are edits for the entire record.
"Revise" will return you to the page corresponding
to the edit. All hard edits must be addressed
before certifying.*

Edit Message
The question if the decedent received hospice care is required. Please select
one of the given options. [Revise](#)

Clicking on **Revise** next to the Hard Edit in this case will bring you to the **Place of Death** page where the question “Did decedent receive hospice care in the past 30 days?” is located.

Once all necessary changes have been made, selecting the **Return to Edits** button at the bottom of the page will return you to the edits page to complete the certification process.

[Save this Page](#) [Return to Edits](#)
[Cancel](#)

Vermont Department of Health, EDRS Version 4.0.0.2010.03.08
Please forward questions or concerns to: EDRS@vdh.state.vt.us 1-800-439-5008



Soft Edits:

Soft edits can only be addressed when attempting to Sign or Certify a record. If you choose to verify the value you have entered as final rather than revise the item, check the box at left. Records with verified values can be completed by Signing or Certifying "With Exceptions".

Verify Edit Message

Use of the term 'Cancer' suggests that you may be reporting a cancer death. If this is the case and it is possible to do so, please provide the site, cell type and whether the condition has metastasized. If you are not reporting a cancer death or have already provided all available information, check the box at the left and then click 'Certify with Exceptions'.

Revise

The Soft Edit in this case is simply a reminder to provide detailed information when reporting cancer deaths. So, this may only require verification rather than a revision of the data.

If the scenario is one in which you need to amend the data, you would select **Revise** as in the hard edit example, and the system would bring you to the appropriate page. If you need to seek out additional information you also may log out of the EDRS and return to the record later when you are ready to complete certification. If this is the case, be sure to **save** before closing the application.

As noted in the message, you can **verify** your data is complete by checking the box to the left of the message and then selecting "**Certify With Exceptions**".

Verification of soft edits can only be saved when all hard edits have been addressed and you are ready to complete certification of the record.

Completing Certification



Edit Case

This record has passed all edits. Select 'Certify' to complete the Certification process.



When all edits have been passed you must select “**Certify**” or “**Certify With Exceptions**” (in the case of verified soft edits) one final time on the Edit Case screen as shown above. This includes cases where edits all passed right away.

A message will then notify you that the record will be locked once it's been certified, preventing further data entry in the medical side of the record. This is the final confirmation of your intent to certify and gives you an opportunity to Cancel and return to the current page.

Printing Documentation



After you certify a record you will have the option to print documentation for administrative purposes. These documents are valid to provide to a funeral director/family for use in obtaining necessary permits for disposition or for inclusion in medical records.

If the demographic information has not yet been signed in the EDRS by a funeral director you will be able to print a **PROD (Preliminary Report of Death)**. This document contains a report of the information you have certified along with a form on which the funeral director or family can complete the demographic information.

If the demographic side has been completed, the record will automatically be “registered” and your print option will be to print an **Administrative Copy** of the death certificate.

In either case, the document you are permitted to print is valid for administrative uses.

The screenshot shows a dialog box titled "Post Signing Options" with a light green header. The main content area is light gray and displays the name "Fred Flintstone" and the "Date of Death: 1/1/2010". At the bottom, there are three buttons: "Print Informational Copy" on the left, "Print PROD" on the right, and "Cancel" centered below the other two.

Reviewing or Printing a Record After it is Certified



Once the medical certification has been completed on a record it is considered final, and you will not be able to access it through the Create/Update Medical Information function. Instead, you should use the **View Record** function available on the main menu at the left of your screen just under the Create/Update function.

Vital Records **Electronic Death Registration System** VERMONT
DEPARTMENT OF HEALTH
User: tberry Facility: Tim's Hospital Logout

Create/Update Medical Record
View Record
Print Informational Copy

Vital Records
Welcome to the Electronic Death Registration System

From within the View Record function you will be able to:

- View both the demographic and medical sides of a record
- Print any appropriate documentation needed for records or to provide to a family or funeral director for up to 30 days from the date the record is registered
- Review a record in a read only mode both prior to and after certification

NOTE: Changes can only be made to a certified record by requesting a correction from the Department of Health Vital Records Office by submitting a [correction request form](#).

Where to Get Help



The Office of the Chief Medical Examiner (OCME) is available to assist in certifying deaths of your patients. For a consultation call 802-863-7320, M-F 8:00 - 4:00.

If you need to report a death or to inquire whether a death falls under medical examiner jurisdiction call 888-552-2952, 24 hours/7 days a week.

If you are experiencing difficulty logging onto or navigating the EDRS you will find most common issues are addressed in the **EDRS Quick Guide** available on line at:
<https://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vital-records-reporting-edrs>

If you are still unable to access the system or have forgotten your password you can also contact the Vital Records Office via email at EDRS@vermont.gov



More Information about Death Certification in Vermont is available on the VDH Website including:

Quick Guide to Certifying a Death

<https://www.healthvermont.gov/sites/default/files/documents/pdf/HSI-VR-QuickGuideForPhysiciansRev2023.pdf>

Visit the Office of the Chief Medical Examiner site to find information about autopsy, reportable cases, how to report cases, red flags and more.

<https://www.healthvermont.gov/systems/medical-examiner>



You have now completed the Certifying A Death In Vermont tutorial.

Thank you, for taking time to review this important information.

If you have not already enrolled as an EDRS user, you may do so now.

To enroll select the link below. This will bring you to a short assessment covering key points from this tutorial. Once you have completed the assessment, you will have the opportunity to accept the EDRS user agreement and request for a username and password.

[Click here to link to the EDRS assessment](#) and enroll as an EDRS user.

If you have any questions or would like additional support in using the EDRS please contact the Vital Records Office at EDRS@vermont.gov or (800) 439-5008.

Go back to the tutorial beginning.

