


STATE REGISTRAR NOTICE

Subject: Medical Certification of a Report of Death	Type: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Transitory	Number: 2020-10
Date Issued: April 8, 2020 Revised: September 28, 2021	Audience: All Death Reporting Stakeholders	By Direction of:  Audrey Marrocco State Registrar

Text shown in a red font indicates updated information since this State Registrar Notice was issued.

All deaths reported in Pennsylvania shall be determined in accordance with the Uniform Determination of Death Act of 1982.¹ Within four days, the report of death shall be filed with the Bureau of Health Statistics and Registries in accordance with the Vital Statistics Law of 1953² (VSL). The funeral director (or person in charge of interment) shall complete the personal and demographic portion of the report of death, while the medical certification shall be completed as described in this state registrar notice.

Medical Certification of Deaths

The medical certification of all reports of death³ shall be completed by a medical professional who attended the decedent during the last illness. A medical professional⁴ is defined as a physician, certified registered nurse practitioner, physician assistant, or dentist who is a staff member of a licensed healthcare facility⁵. If the decedent is a family member of the medical professional or the medical professional is physically unable to certify the case, then the case shall be referred to another medical professional at that facility.

The VSL authorizes a medical professional to refer a case⁶ to a county coroner⁷ or medical examiner **for medical certification** only in the following two scenarios⁸:

¹ 35 P.S. §§ 10201 – 10203.

² 35 P.S. § 450.501

³ A report of death is an electronic report submitted through the Electronic Death Registration System (EDRS) or a paper form titled “Certificate of Death” (H105.143).

⁴ A medical professional may also include a physician, certified registered nurse practitioner, physician assistant, or dentist who attended the decedent during the last illness and is affiliated with a medical facility owned and operated by the U.S. Department of Veterans Affairs.

⁵ A health care facility as defined in the Act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

⁶ Additional reporting may be requested by your county coroner or medical examiner. Contact your county coroner or medical examiner for specific instructions.

⁷ An elected or appointed coroner or an elected or appointed medical examiner as defined in Act of August 9, 1955 (P.L. 323, No.130).

⁸ 35 P.S. § 450.503.

- If another medical professional of the licensed healthcare facility is unavailable or unwilling to medically certify the death, or
- If the circumstances surrounding the death suggest that the death was sudden, violent, suspicious in nature, or was the result of other than natural causes.

The medical certification of a report of death shall also be completed by the county coroner or medical examiner from the county where the death occurred in the following scenarios⁹:

- The manner of death is accident, homicide, suicide, pending investigation, or could not be determined.
- The medical professional that attended the decedent during the last illness or a professional nurse¹⁰ who was involved in the direct care of the patient was not in attendance during the last illness of the decedent.
- A medical professional was not in attendance at time of delivery of a fetal death.

Cause of Death

The cause of death section of the report of death follows guidelines issued by the World Health Organization (WHO). If completed properly, the cause of death section provides an etiologic explanation of the order, type, and association of events resulting in death.

Medical professionals are to use their best medical judgment when completing the cause of death section. County coroners and medical examiners should use information obtained from their examination and/or investigation to complete this section of the report of death.

The cause of death section (shown in image below) consists of two parts: Part I is used to report the chain of events that led directly to the death and Part II is used to report other significant diseases, conditions, or injuries that contributed to death but which did not result in the underlying cause of death. For more in-depth instruction, see “[Instructions for Completing the Cause of death Section of the Death Certificate](#)” issued by the Center for Disease Control and Prevention (CDC).

⁹ 35 P.S. § 450.503.

¹⁰ Professional nurse licensed under the act of May 22, 1951 (P.L. 317, No. 69) known as “The Professional Nursing Law”.

Cause of Death

NCHS Recommendations for Entry of Cause of Death

Enter the chain of events- diseases, injuries, or complications- that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. DO NOT ENTER OLD AGE. Enter only one cause on a line. Add additional lines if necessary.

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

Cause of Death	Approximate Interval	Onset to Death
Immediate Cause (Final disease or condition resulting in death) PART I Line a FINAL CONDITION PRIOR TO DEATH *DO NOT REPORT A MECHANISM OF DEATH*	2 days	
Due to or as a consequence of Line b NEXT CONDITION CAUSED BY FORMER CONDITION	2 days	
Due to or as a consequence of Line c CONDITION DUE TO UNDERLYING CONDITION	2 days	
Due to or as a consequence of Line d UNDERLYING CONDITION THAT LED TO DEATH	1 week	
PART II Other significant conditions OTHER CONDITIONS CONTRIBUTING TO DEATH THAT ARE NOT REPORTED IN THE CHAIN OF EVENTS LISTED IN PART I, LINE A, B, C OR D ABOVE.		

For statistical and research purposes, it is important that the cause of death be reported as specifically and precisely as possible. This information is used for public health surveillance, outbreaks and public health emergencies. Every cause of death statement is coded and tabulated by the CDC according to the latest revision of the *International Classification of Diseases* (currently ICD-10).

Part I – Chain of Events

Enter the sequence of medical conditions that had the greatest impact on causing the death AND the time interval between the onset of each condition. The immediate cause of death is entered first with the underlying cause entered as the lowest line used in Part I. Do not abbreviate when entering cause of death information.

The mechanism of death or terminal event, such as cardiac or respiratory arrest, should not be reported as it is a statement not specifically related to the disease process, and merely attests to the fact of death. The mechanism of death or terminal event, therefore, provides no additional information on the cause of death.

Line A: Immediate Cause of Death

The immediate cause of death is the final disease, injury, condition, or complication directly causing death of the decedent. All reports of death must include an immediate cause of death. List only one condition as the immediate cause of death. The immediate cause may be the sole entry in the cause of death section if that condition is the only condition causing the death.

Lowest Line Used: Underlying Cause of Death

The underlying cause of death is the disease or injury that initiated the change of morbid events that led directly and inevitably to death. The underlying cause should be specific and precise, so that there is no ambiguity about the etiology of this cause.

The underlying cause of death should be entered on the lowest line used in Part I of the cause of death section. List sequentially all conditions that developed due to the underlying cause which lead to the immediate cause of death.

If the underlying cause has not been definitely diagnosed, the condition may be qualified as being “probable”, “presumed”, or “likely”. Once definitely diagnosed, the death record should be amended.

If the decedent has microscopic examinations or autopsy results pending at time the report is filed, include wording such as “pending test results” by the disease or condition being reported. Once the test results have been received, the medical certifier that originally signed the report of death shall submit a request to amend the death record based on this additional information.

If the coroner or medical examiner is unable to determine the immediate cause of death until postmortem examination results have been received, the cause of death may be reported as “pending” or “pending investigation” so that the report of death is filed within four days. Once the additional information has been received, the coroner or medical examiner shall submit a request to amend the death record based on the additional information.

Part II – Significant Conditions Contributing to Death

Enter all diseases or conditions contributing to death that were not reported in the chain of events in Part I and that did not result in the underlying cause of death. If two or more possible sequences resulted in death or if two conditions seem to have added together, report in Part I the one that in your opinion most likely caused the death. Then enter the other condition or disease in Part II.

Timely Reporting of Deaths

In accordance with the VSL, all deaths must be fully reported within 4 days of the death occurring¹¹. Full reporting requires that the funeral director (or person in charge of interment) sign the personal and demographic portion of the report of death, and that a medical professional, coroner or medical examiner has certified the medical portion of the report of death.

General Guidance and Training

The following resources are available for general guidance and training on cause of death reporting is available from the CDC as follows:

¹¹ 35 P.S. §450.501.

- Cause of Death mobile app available at <https://www.cdc.gov/nchs/nvss/mobile-app.htm>.
- Online training module titled “Improving Cause of Death Reporting” available at https://www.cdc.gov/nchs/nvss/improving_cause_of_death_reporting.htm. Continuing Medical Education (CME) and Continuing Nursing Education (CNE) credits are available to medical professionals that successfully complete this course.
- Instructions for Completing the Cause of death Section of the Death Certificate available at https://www.cdc.gov/nchs/data/dvs/blue_form.pdf
- Physicians’ Handbook on Medical Certification of Death (2003 Revision) available at https://www.cdc.gov/nchs/data/misc/hb_cod.pdf
- Medical Examiners’ and Coroners’ Handbook on Death Registration and Fetal Death Reporting (2003 Revision) available at https://www.cdc.gov/nchs/data/misc/hb_me.pdf.
- Funeral Director’s Handbook: Death Registration and Fetal Death Reporting (2019 Revision) available at <https://www.cdc.gov/nchs/data/nvss/handbook/2019-Funeral-Directors-Handbook-508.pdf>

Pennsylvania’s Electronic Death Registration System (EDRS)

In 2019, almost 92,000 or 70% of all deaths were reported through EDRS. EDRS improves the quality and timeliness of death data reporting which is critical for public health surveillance, outbreak detection, and public health emergency response.

For more information on EDRS including training materials and upcoming training webinars, visit the EDRS website at www.doh.pa.gov/edrs.

Contact Information for EDRS User Support and the Death Registry Unit:

By Phone: Vital Events Stakeholder Hotline at 800-323-9613

By Email: EDRS User Account Creation: RA-DHEDRSUSERACCT@pa.gov
 Death Registration and EDRS Support: RA-DHEDRS@pa.gov