Chronology and Death Certificate Extract Form

**Date of birth:** ___ / ___ / ___
First formal oral request for DWD (mm/dd/yr) ___ / ___ / ___
Second formal oral request for DWD (mm/dd/yr) ___ / ___ / ___
Written request from patient for DWD (mm/dd/yr) ___ / ___ / ___
Attending M.D. form signed (mm/dd/yr) ___ / ___ / ___
Consulting M.D. form signed (mm/dd/yr) ___ / ___ / ___
Prescription form completed (mm/dd/yr) ___ / ___ / ___
Psychiatric consultation form signed (mm/dd/yr) ___ / ___ / ___

**Date of death:** ___ / ___ / ___
Family Informed:  □ 1 Yes  □ 2 No  □ 8 NA  □ 9 NS
Attending DWD physician: # _____ _____ _____ _____

**Death Certificate Information**
Physician who signed death certificate: # _____ _____ _____ _____
Sex: □ ♂  □ 2 ♀
Decedent’s Age ______
County of Residence: □ 03 □ 20 □ 24 □ 26 □ 34 □ ____
Marital Status: □ 1 Married  □ 4 Legally Separated
□ 2 Widowed  □ 5 Divorced
□ 3 Never Married  □ 6 Unknown
Race: □ 1 White □ 4 Chinese □ 7 American Indian
□ 2 Japanese □ 5 Other Asian □ 8 Hispanic
□ 3 Vietnamese □ 6 Black □ 9 Unknown
Highest level of education: □ 1 8th grade or less
□ 2 9th-12th grade, no diploma
□ 3 High school graduate or GED
□ 4 Some college, no degree
□ 5 Associate degree
□ 6 Bachelor’s degree
□ 7 Master’s degree
□ 8 Doctorate, etc. □ 9 Unknown

Occupation: ______________________________
Underlying cause of death: ______________________________________
Death certificate/forms review done on ___ / ___ / ___ by ____ (initials)