

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12859



8 - OTHER

000001

CERTIFICATE OF DEATH

File Number

Date

ENTRIES SHOULD BE TYPEWRITTEN ONLY USE BLACK RIBBON.

DECEDENT

INSTRUCTIONS ON OTHER SIDE

PARENTS

INFORMANT

DISPOSITION

INSTRUCTIONS ON OTHER SIDE

CAUSE OF DEATH

CERTIFIER

1. DECEDENT'S NAME (First, Middle, Last)				2. SEX Male		3a. DATE OF DEATH (Month, Day, Year) April 22, 1998		3b. HOUR OF DEATH 5:25 PM	
4. SOCIAL SECURITY NUMBER		5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 24 HRS Hours: Minutes:	6. DATE OF BIRTH (Month, Day, Year)		7. BIRTHPLACE (City and State or Foreign Country)		
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)			9a. PLACE OF DEATH (Check only one; see instructions on other side) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
9b. FACILITY NAME (If not institution, give street and number)				9c. CITY, TOWN, OR LOCATION OF DEATH			9d. CITIZENS OF WHAT COUNTRY		
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)		11. SURVIVING SPOUSE (If wife, give maiden name)		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired)			12b. KIND OF BUSINESS/INDUSTRY 12c. <input type="checkbox"/> MANUFACTURER <input type="checkbox"/> WHOLESALE <input type="checkbox"/> RETAILER		
13a. RESIDENCE - STATE		13b. COUNTY		13c. CITY, TOWN, OR LOCATION			13d. STREET AND NUMBER		
13e. INSIDE CITY LIMITS? (Yes or No)		13f. ZIP CODE		14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify		15. RACE - American Indian, Black, White, etc (Specify)		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAME (First, Middle, Maiden Surname)				
19a. INFORMANT'S NAME			19b. RELATIONSHIP TO DECEDENTS		19c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. DATE OF DISPOSITION		20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)			20d. LOCATION - City or Town, State	
21a. SIGNATURE OF FUNERAL DIRECTOR				21b. LICENSE NUMBER (of Licensee)		22. NAME AND ADDRESS OF FACILITY			
23a. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) If Yes, Type Med Ex Name No				23b. DATE		24. IF DECEDENT WAS MARRIED WOMAN, ENTER MAIDEN NAME (First, Middle, Last)			
25. PART I: Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)		A. <u>Hyperkalemia</u> DUE TO (OR AS A CONSEQUENCE OF)							
		B. <u>Rhabdomyolysis</u> DUE TO (OR AS A CONSEQUENCE OF)							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		C. <u>Massive Hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF)							
		D. <u>Acute Hepatic Failure</u>							
PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						26a. WAS AN AUTOPSY PERFORMED? (Yes or no) No		26b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH (Yes or no) No	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c. INJURY AT WORK?	23d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town State)			
29. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 16, 1998 to April 22, 1998 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 22, 1998 and that death occurred from the causes and on the date and hour stated above									
30a. SIGNATURE [Signature] MD						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		30b. DATE SIGNED April 22, 1998	
30c. PHYSICIAN'S NAME (Type)									
31. WAS THE DECEDENT PREGNANT IN THE PAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		REMARKS * IF UNDER 4 YEARS, ENTER PLACE OF BIRTH - HOSPITAL OR ADDRESS IF NOT IN HOSPITAL				Authority For Cremation Granted By Medical Examiner Date			

Memorandum to ARMS # 12859

Date: 16 Aug 99

From: Medical Officer, Clinical Research and Review Staff, Office of Special Nutritionals, HFS-452

Subject: Medical Records Placed in Permanent Storage.

The following types and amounts of records (more than 20 pages total) were placed in permanent storage on this date because they were not considered essential for interpretation of this adverse event.

Approx Pages	Type of Records
	Nursing notes
	Dietitian notes
	Respiratory therapy/occupational therapy/physical therapy notes
	Clergy notes
5	Medication records
	Physician's orders
131	Vital signs, fluids, input/output records & nursing
	Ventilator records
4	Hospital administrative records (e.g., insurance information, living will, etc)

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