ARKANSAS DEPARTMENT OF HEALTH
Vital Records

For Office Use Only

Vol._______ Page _________

Year __________

Supplemental Report of Cause of Death

Name of Deceased			
Date of Death	County of Death	Sex	Race

I hereby certify that the cause of death of the decedent was as given below and the original certificate of death should be amended accordingly.

Note: If this form is used as authorization to amend a cause of death previously reported on a death certificate, please check here. ☐

Reason for amendment: ☐ Autopsy ☐ Other Specify ____

3a. DATE OF DEATH (Mo/Day/Yr)	3b. TIME OF DEATH ☐ AM ☐ PM

18a. DATE PRONOUNCED DEAD (Mo/Day/Yr)	18b. TIME PRONOUNCED DEAD ☐ AM ☐ PM	18c. NAME AND TITLE OF PERSON PRONOUNCING DEATH (PRINT / TYPE)	19. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH

20. PART I. 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. Enter only one cause on a line.

APPROXIMATE INTERVAL: Onset to Death

IMMEDIATE CAUSE

(Final disease or condition resulting in death) → a. ______________________________

Due to (or as a consequence of)

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.

b. ______________________________

Due to (or as a consequence of)

c. ______________________________

Due to (or as a consequence of)

d. ______________________________

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

21a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

21b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

22. MANNER OF DEATH ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined

23. DID TOBACCO USE CONTRIBUTE TO DEATH?
☐ Yes ☐ Probably
☐ No ☐ Unknown

24. IF FEMALE:
☐ Not pregnant within past year
☐ Pregnant at time of death
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Unknown if pregnant within last year

25a. DATE OF INJURY (Mo/Day/Yr)	25b. TIME OF INJURY ☐ AM ☐ PM	25c. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)	25d. INJURY AT WORK? ☐ Yes ☐ No

25e. LOCATION OF INJURY: (Number, Street, Apartment No., City, State, Zip Code)

25f. DESCRIBE HOW INJURY OCCURRED:

25g. IF TRANSPORTATION INJURY, SPECIFY.
☐ Driver / Operator
☐ Passenger
☐ Pedestrian
☐ Other (Specify)_________

Name of Certifier (Print or Type)	Title	License #
Signature of Certifier	Date	

Certifier's Address	City	State	Zip Code

Notary Public Seal

Subscribed and sworn to before me

This ______ day of ________________, __________

My Commission Expires _______________________

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Signature of Notary Public