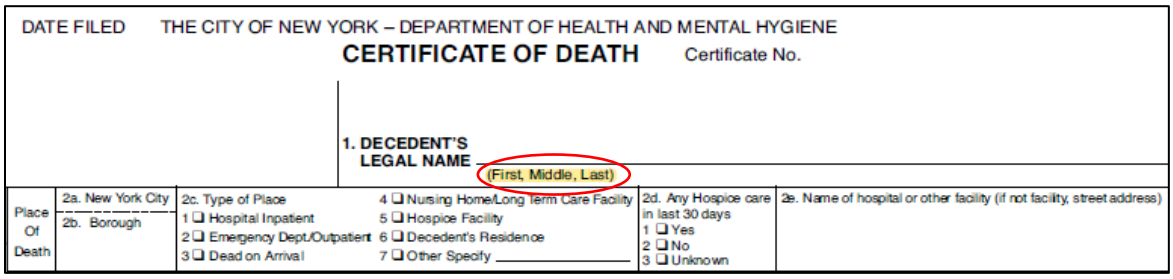
NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
Commissioner

Guidance on Changes to the New York City Department of Health and Mental Hygiene's Certificate of Death (VR15)

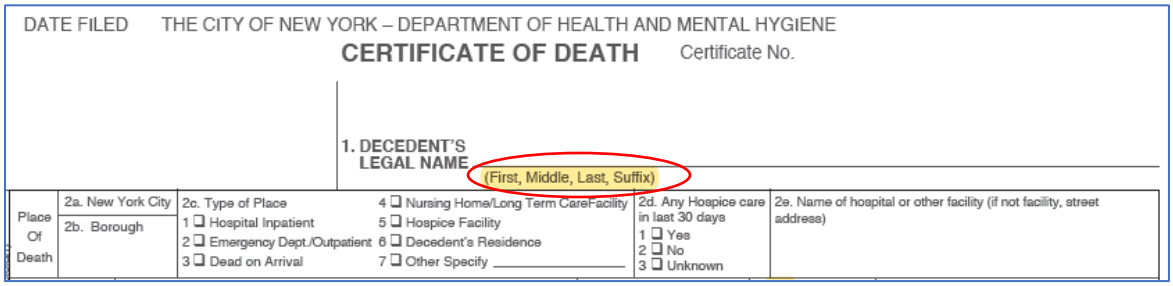
The below guidance pertains to changes to New York City Vital Record forms that will be in effect January 2, 2020. Question numbers correspond to the box numbers on the certificates. Before and after images are included to show the changes that were made.

1. **Question 1**: Suffix added to Name of Decedent
    a. **Original**: (First, Middle, Last)
    b. **New**: (First, Middle, Last, Suffix)
    c. **Purpose**: To match the birth certificate (VR6S)

Current Death certificate


DATE FILED THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH Certificate No.
1. DECEDENT'S LEGAL NAME (First, Middle, Last)
Place Of Death | 2a. New York City 2b. Borough | 2c. Type of Place 1 Hospital Inpatient 2 Emergency Dept./Outpatient 3 Dead on Arrival 4 Nursing Home/Long Term Care Facility 5 Hospice Facility 6 Decedent's Residence 7 Other Specify | 2d. Any Hospice care in last 30 days 1 Yes 2 No 3 Unknown | 2e. Name of hospital or other facility (if not facility, street address)

Updated Death certificate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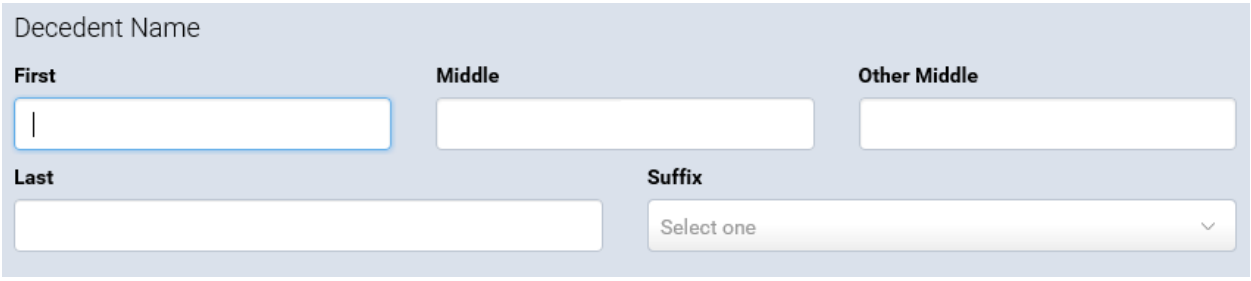
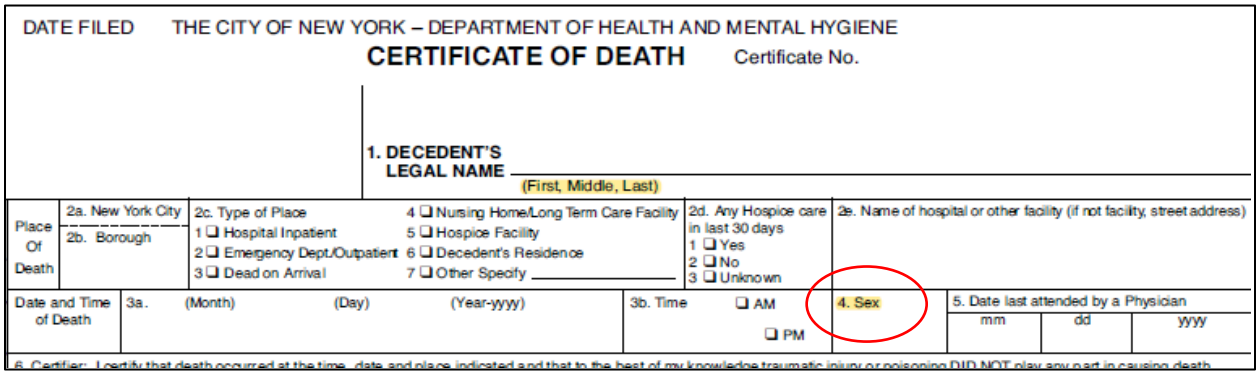
Current eVital screen, no changes made to eVital


Decedent Name
First | Middle | Other Middle
Last | Suffix
Select one

2. **Question 4**: Adding option of Gender X for decedent sex to capture gender identity
    a. **Original**: Male or Female
    b. **New**: Male, Female, or X
    c. Purpose: To provide option of a gender marker for persons who do not identify exclusively as female or male

Current Death certificate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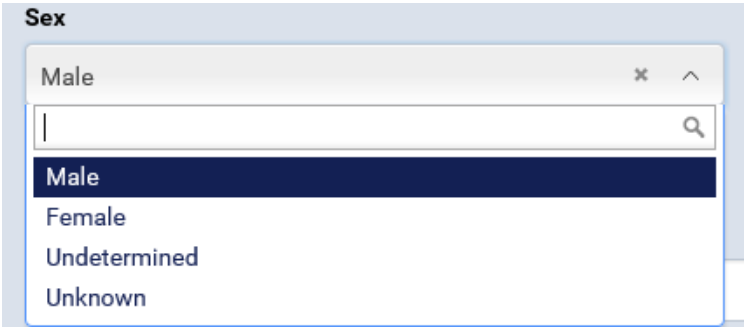
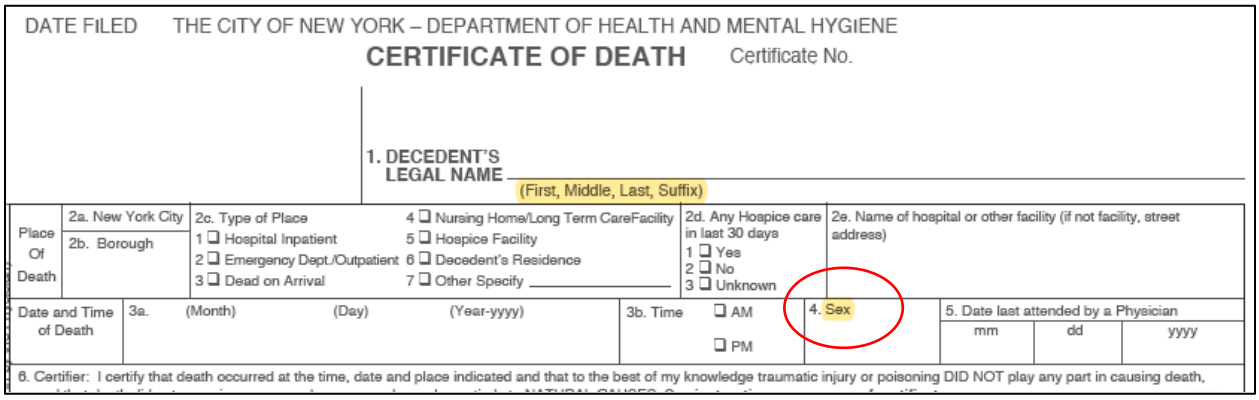
Date and Time of Death | 3a. (Month) (Day) (Year-yyyy) | 3b. Time ❑ AM ❑ PM | 4. Sex | 5. Date last attended by a Physician mm dd yyyy
6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death

Current eVital screen



Updated Death certificate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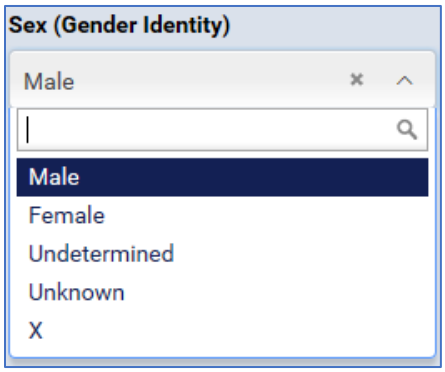
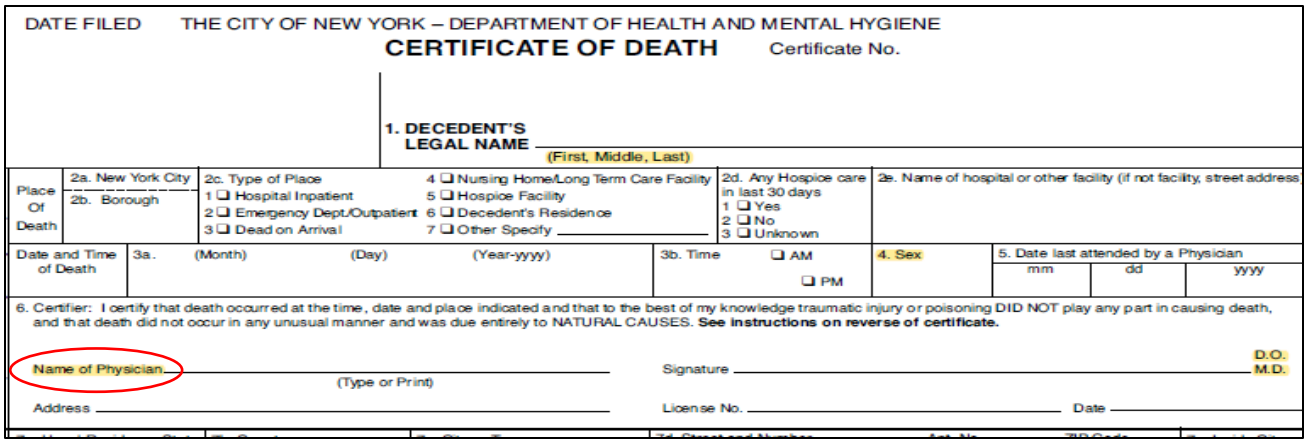
Date and Time of Death | 3a. (Month) (Day) (Year-yyyy) | 3b. Time ❑ AM ❑ PM | 4. Sex | 5. Date last attended by a Physician mm dd yyyy
6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death,

New eVital screen



3. **Question 6**: Change label for name of certifier
    a. **Original**: Name of physician
    b. **New**: Name of medical certifier
    c. **Purpose**: To be more accurate per New York City Health Code 205.05

Current Death certificate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1. DECEDENT'S LEGAL NAME (First, Middle, Last)

Place Of Death | 2a. New York City | 2b. Borough | 2c. Type of Place 1 ❑ Hospital Inpatient 2 ❑ Emergency Dept./Outpatient 3 ❑ Dead on Arrival 4 ❑ Nursing Home/Long Term Care Facility 5 ❑ Hospice Facility 6 ❑ Decedent's Residence 7 ❑ Other Specify | 2d. Any Hospice care in last 30 days 1 ❑ Yes 2 ❑ No 3 ❑ Unknown | 2e. Name of hospital or other facility (if not facility, street address)

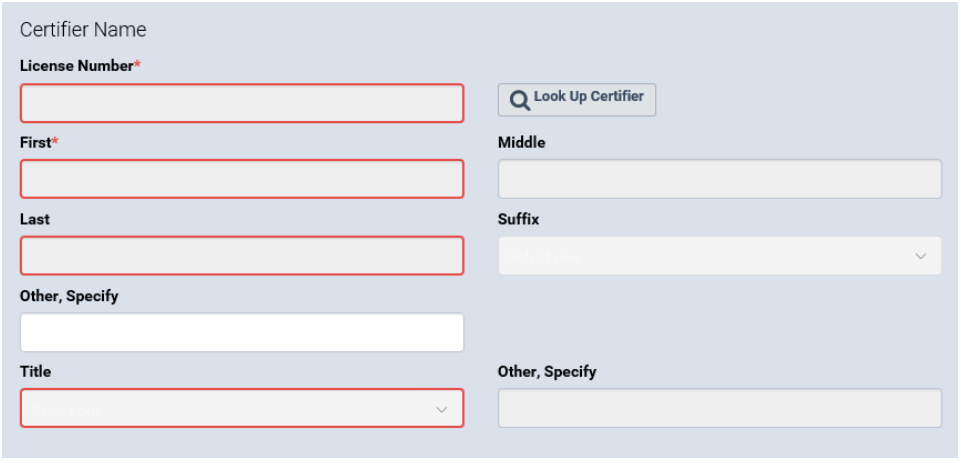
Date and Time of Death | 3a. (Month) (Day) (Year-yyyy) | 3b. Time ❑ AM ❑ PM | 4. Sex | 5. Date last attended by a Physician mm dd yyyy

6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death, and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. **See instructions on reverse of certificate.**

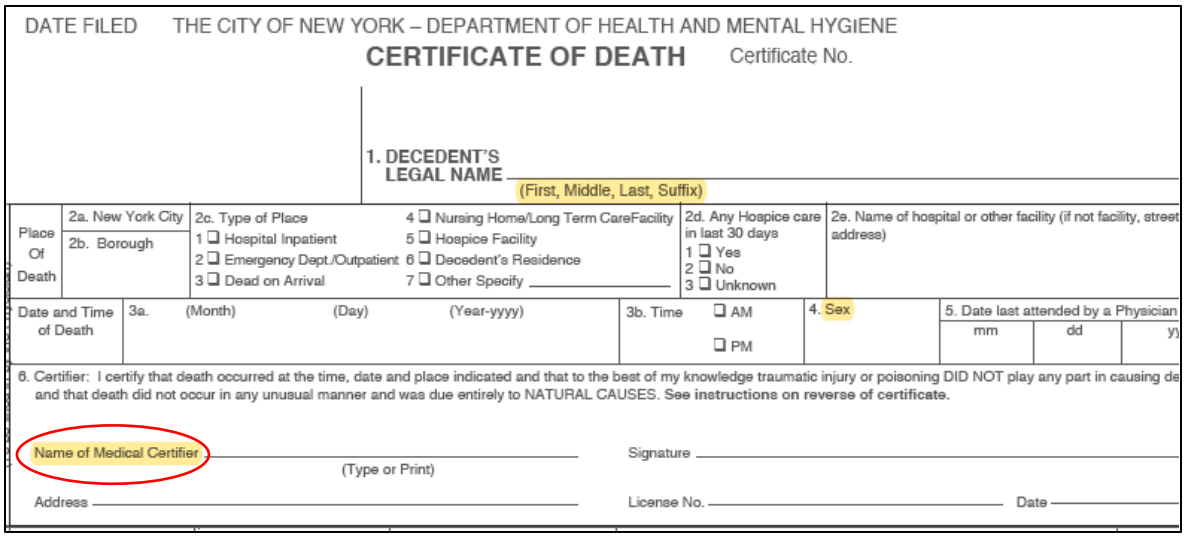
Name of Physician (Type or Print) Signature D.O. M.D.

Address License No. Date

Current eVital screen, no changes made to eVital



Updated Death certificate



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CERTIFICATE OF DEATH Certificate No.

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Place Of Death — 2a. New York City / 2b. Borough — 2c. Type of Place: 1 ❑ Hospital Inpatient; 2 ❑ Emergency Dept./Outpatient; 3 ❑ Dead on Arrival; 4 ❑ Nursing Home/Long Term CareFacility; 5 ❑ Hospice Facility; 6 ❑ Decedent's Residence; 7 ❑ Other Specify ____ — 2d. Any Hospice care in last 30 days: 1 ❑ Yes 2 ❑ No 3 ❑ Unknown — 2e. Name of hospital or other facility (if not facility, street address)

Date and Time of Death — 3a. (Month) (Day) (Year-yyyy) — 3b. Time ❑ AM ❑ PM — 4. Sex — 5. Date last attended by a Physician mm dd y

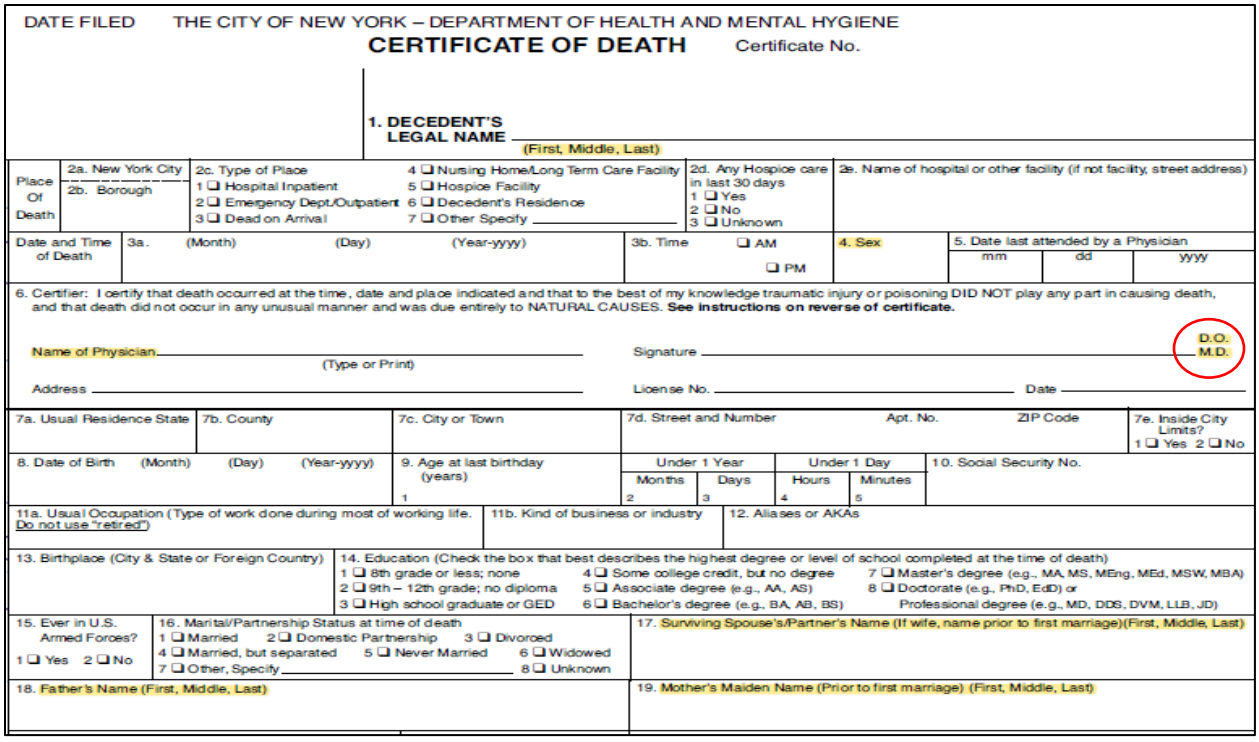
6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing de and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. See instructions on reverse of certificate.

Name of Medical Certifier (Type or Print) Signature

Address License No. Date

4. **Question 6 and after Question 30**: Add additional options for medical certifier
    a. **Original**: MD or DO
    b. **New**: MD, DO, NP, RPA
    c. **Purpose**: To be more accurate per New York City Health Code 205.05

Current Death certificate



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Date and Time of Death — 3a. (Month) (Day) (Year-yyyy) — 3b. Time ❑ AM ❑ PM — 4. Sex — 5. Date last attended by a Physician mm dd yyyy

6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death, and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. **See instructions on reverse of certificate.**

Name of Physician (Type or Print) Signature D.O. M.D.

Address License No. Date

7a. Usual Residence State — 7b. County — 7c. City or Town — 7d. Street and Number Apt. No. ZIP Code — 7e. Inside City Limits? 1 ❑ Yes 2 ❑ No

8. Date of Birth (Month) (Day) (Year-yyyy) — 9. Age at last birthday (years) — Under 1 Year: Months 2, Days 3 — Under 1 Day: Hours 4, Minutes 5 — 10. Social Security No.

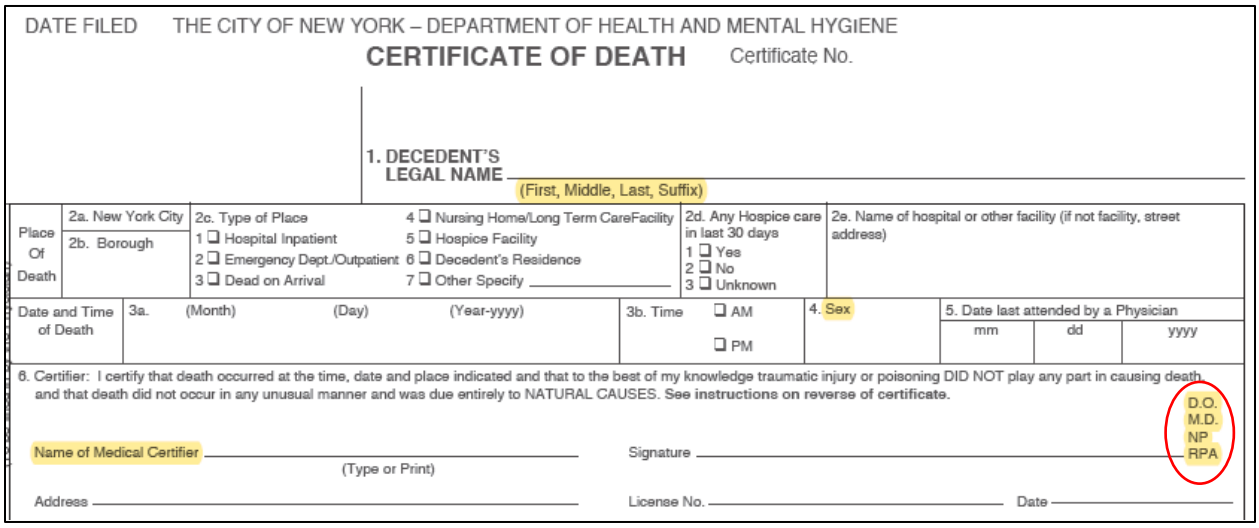
11a. Usual Occupation (Type of work done during most of working life. Do not use "retired") — 11b. Kind of business or industry — 12. Aliases or AKAs

13. Birthplace (City & State or Foreign Country) — 14. Education (Check the box that best describes the highest degree or level of school completed at the time of death): 1 ❑ 8th grade or less; none; 2 ❑ 9th – 12th grade; no diploma; 3 ❑ High school graduate or GED; 4 ❑ Some college credit, but no degree; 5 ❑ Associate degree (e.g., AA, AS); 6 ❑ Bachelor's degree (e.g., BA, AB, BS); 7 ❑ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA); 8 ❑ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

15. Ever in U.S. Armed Forces? 1 ❑ Yes 2 ❑ No — 16. Marital/Partnership Status at time of death: 1 ❑ Married; 2 ❑ Domestic Partnership; 3 ❑ Divorced; 4 ❑ Married, but separated; 5 ❑ Never Married; 6 ❑ Widowed; 7 ❑ Other, Specify ____; 8 ❑ Unknown — 17. Surviving Spouse's/Partner's Name (If wife, name prior to first marriage)(First, Middle, Last)

18. Father's Name (First, Middle, Last) — 19. Mother's Maiden Name (Prior to first marriage) (First, Middle, Last)

Updated Death certificate



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2c. Type of Place: 1 ❑ Hospital Inpatient; 2 ❑ Emergency Dept./Outpatient; 3 ❑ Dead on Arrival; 4 ❑ Nursing Home/Long Term CareFacility; 5 ❑ Hospice Facility; 6 ❑ Decedent's Residence; 7 ❑ Other Specify

2d. Any Hospice care in last 30 days: 1 ❑ Yes; 2 ❑ No; 3 ❑ Unknown

2e. Name of hospital or other facility (if not facility, street address)

Date and Time of Death — 3a. (Month) (Day) (Year-yyyy)

3b. Time ❑ AM ❑ PM

4. Sex

5. Date last attended by a Physician: mm dd yyyy

6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death, and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. See instructions on reverse of certificate.

D.O. M.D. NP RPA

Name of Medical Certifier (Type or Print)

Signature

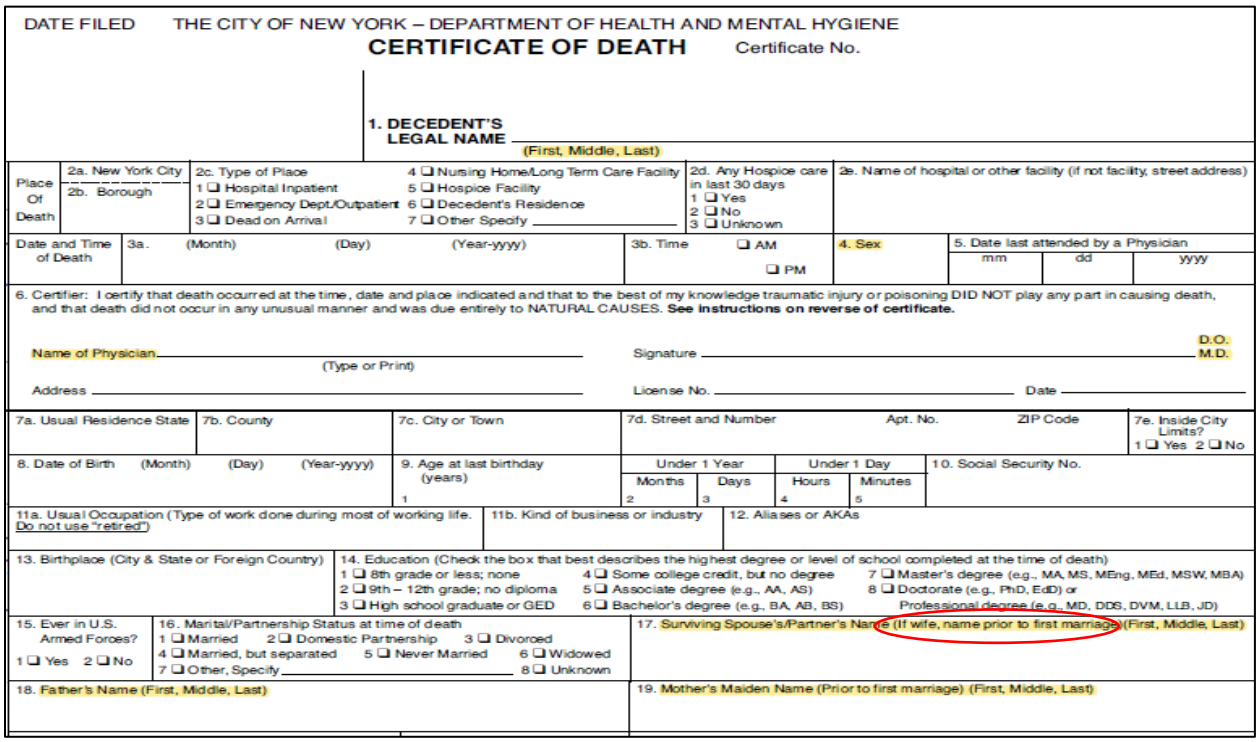
Address

License No.

Date

5. **Question 17**: Remove "if wife" from surviving spouse's name
    a. **Original**: Surviving Spouse's/Partner's Name (if wife, name prior to first marriage) (First, Middle, Last)
    b. **New**: Surviving Spouse's/Partner's Name (prior to first marriage) (First, Middle, Last)
    c. **Purpose**: To make language gender neutral

Current Death certificate



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CERTIFICATE OF DEATH Certificate No.

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2c. Type of Place: 1 ❑ Hospital Inpatient; 2 ❑ Emergency Dept./Outpatient; 3 ❑ Dead on Arrival; 4 ❑ Nursing Home/Long Term Care Facility; 5 ❑ Hospice Facility; 6 ❑ Decedent's Residence; 7 ❑ Other Specify

2d. Any Hospice care in last 30 days: 1 ❑ Yes; 2 ❑ No; 3 ❑ Unknown

2e. Name of hospital or other facility (if not facility, street address)

Date and Time of Death — 3a. (Month) (Day) (Year-yyyy)

3b. Time ❑ AM ❑ PM

4. Sex

5. Date last attended by a Physician: mm dd yyyy

6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death, and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. **See instructions on reverse of certificate.**

Name of Physician (Type or Print)

D.O. M.D.

Signature

Address

License No.

Date

7a. Usual Residence State | 7b. County | 7c. City or Town | 7d. Street and Number | Apt. No. | ZIP Code | 7e. Inside City Limits? 1 ❑ Yes 2 ❑ No

8. Date of Birth (Month) (Day) (Year-yyyy)

9. Age at last birthday (years) 1

Under 1 Year: Months 2 | Days 3

Under 1 Day: Hours 4 | Minutes 5

10. Social Security No.

11a. Usual Occupation (Type of work done during most of working life. Do not use "retired")

11b. Kind of business or industry

12. Aliases or AKAs

13. Birthplace (City & State or Foreign Country)

14. Education (Check the box that best describes the highest degree or level of school completed at the time of death)
1 ❑ 8th grade or less; none
2 ❑ 9th – 12th grade; no diploma
3 ❑ High school graduate or GED
4 ❑ Some college credit, but no degree
5 ❑ Associate degree (e.g., AA, AS)
6 ❑ Bachelor's degree (e.g., BA, AB, BS)
7 ❑ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
8 ❑ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

15. Ever in U.S. Armed Forces? 1 ❑ Yes 2 ❑ No

16. Marital/Partnership Status at time of death
1 ❑ Married
2 ❑ Domestic Partnership
3 ❑ Divorced
4 ❑ Married, but separated
5 ❑ Never Married
6 ❑ Widowed
7 ❑ Other, Specify
8 ❑ Unknown

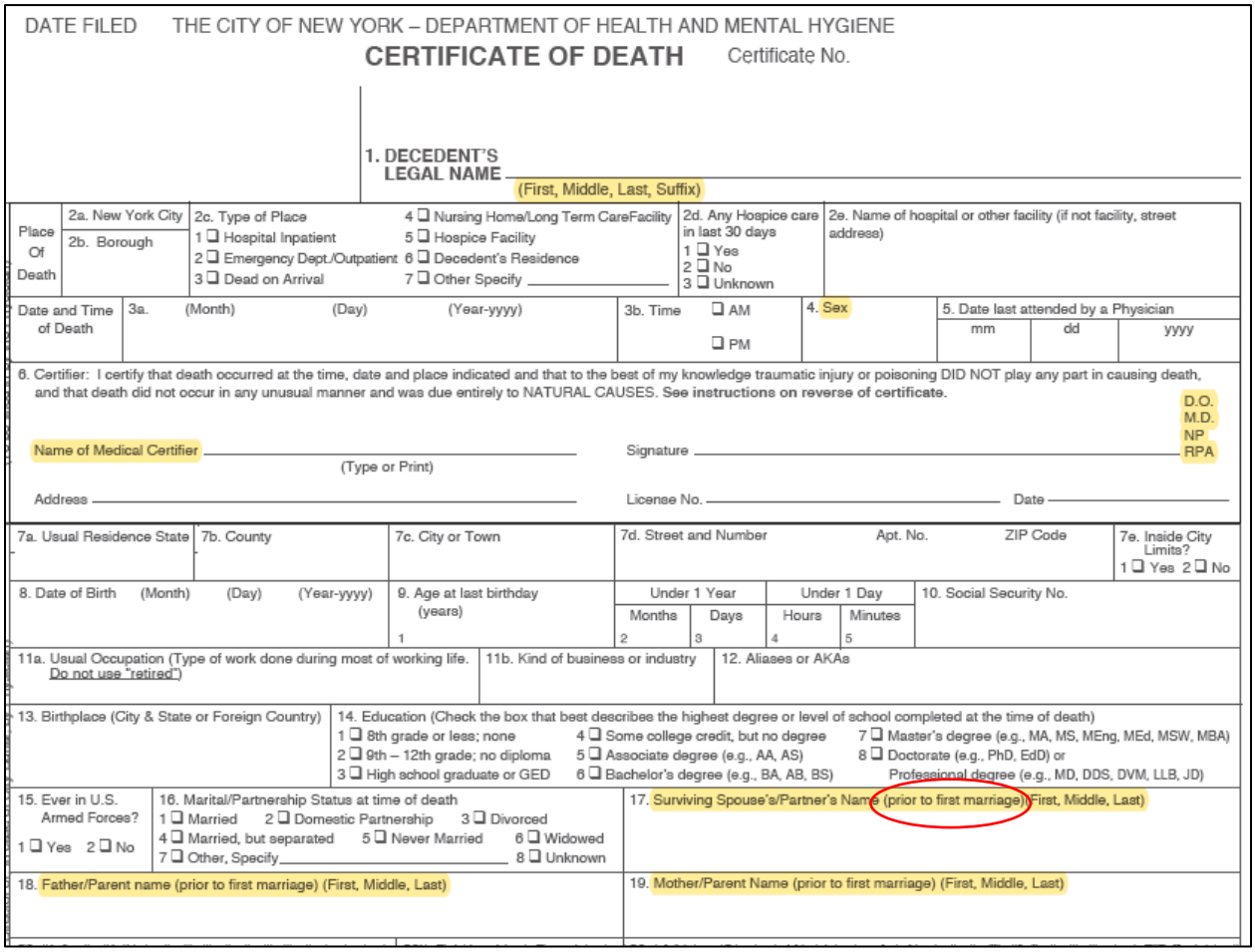
17. Surviving Spouse's/Partner's Name (If wife, name prior to first marriage) (First, Middle, Last)

18. Father's Name (First, Middle, Last)

19. Mother's Maiden Name (Prior to first marriage) (First, Middle, Last)

Current eVital screen (Family Members Page)

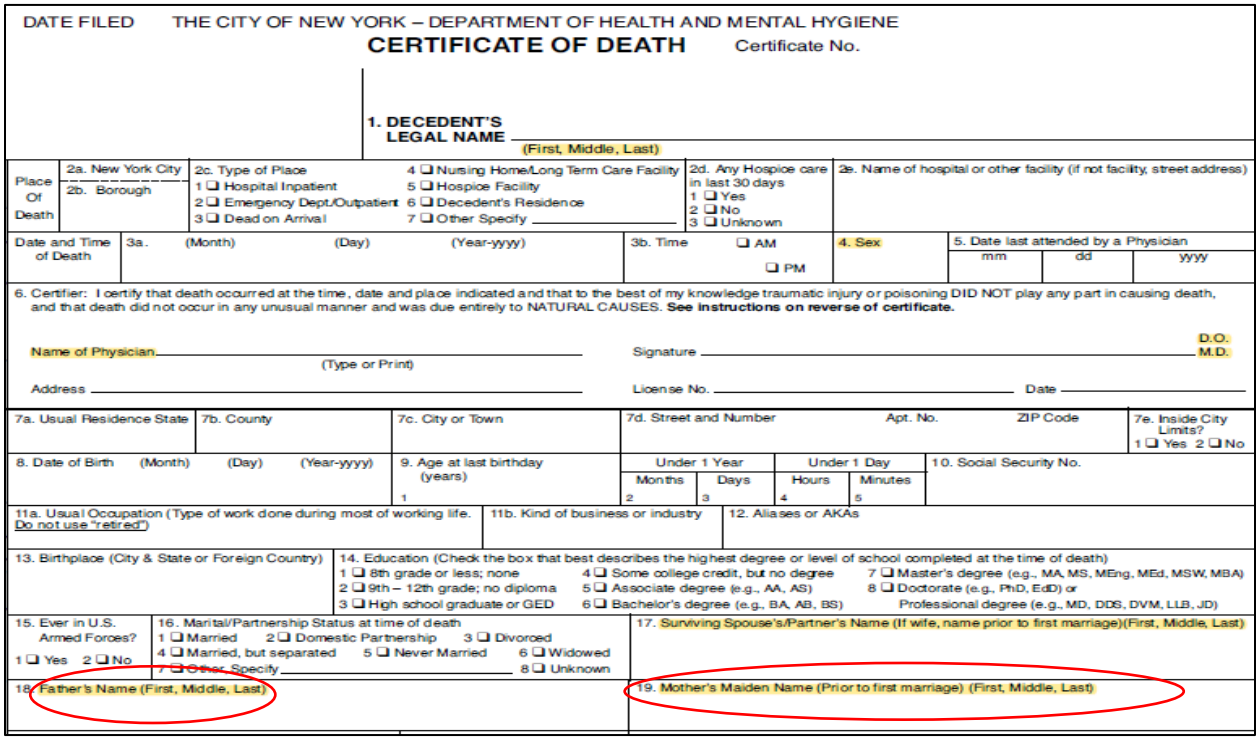
Updated Death certificate



New eVital screen (Family Members Page)

6. **Question 18 and 19**: Add 'Parent' to labeling
    a. **Original**: Father's Name (First, Middle, Last); Mother's Maiden Name (Prior to first marriage) (First, Middle, Last)
    b. **New**: Father/Parent Name (Prior to first marriage) (First, Middle, Last); Mother/Parent Name (Prior to first marriage) (First, Middle, Last)
    c. **Purpose**: To make language gender neutral

Current Death certificate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Date and Time of Death: 3a. (Month) (Day) (Year-yyyy); 3b. Time ❑ AM ❑ PM; 4. Sex; 5. Date last attended by a Physician mm dd yyyy

6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death, and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. **See instructions on reverse of certificate.**

Name of Physician (Type or Print) Signature D.O. M.D.

Address License No. Date

7a. Usual Residence State; 7b. County; 7c. City or Town; 7d. Street and Number Apt. No. ZIP Code; 7e. Inside City Limits? 1 ❑ Yes 2 ❑ No

8. Date of Birth (Month) (Day) (Year-yyyy); 9. Age at last birthday (years) 1; Under 1 Year Months 2 Days 3; Under 1 Day Hours 4 Minutes 5; 10. Social Security No.

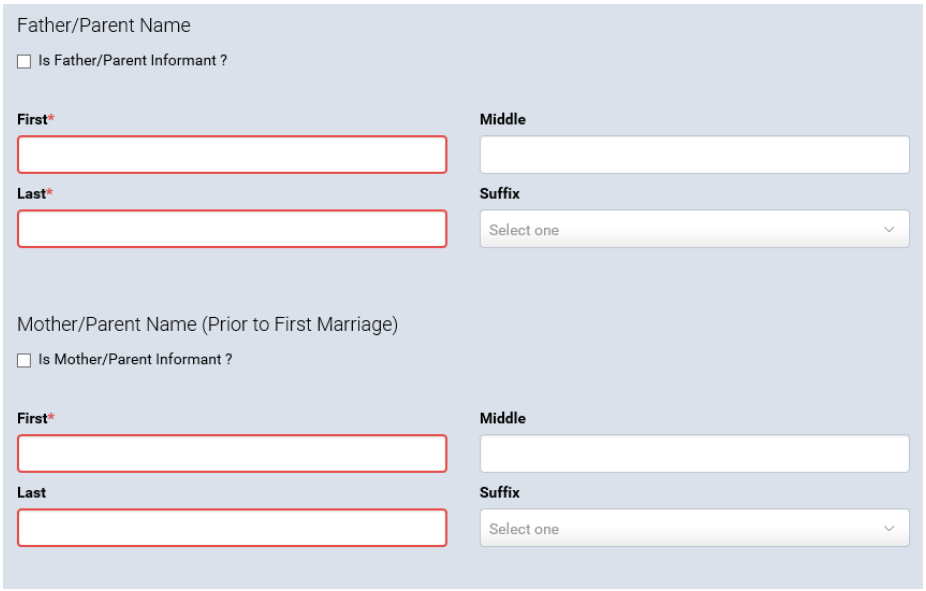
11a. Usual Occupation (Type of work done during most of working life. Do not use "retired"); 11b. Kind of business or industry; 12. Aliases or AKAs

13. Birthplace (City & State or Foreign Country); 14. Education (Check the box that best describes the highest degree or level of school completed at the time of death) 1 ❑ 8th grade or less; none 2 ❑ 9th – 12th grade; no diploma 3 ❑ High school graduate or GED 4 ❑ Some college credit, but no degree 5 ❑ Associate degree (e.g., AA, AS) 6 ❑ Bachelor's degree (e.g., BA, AB, BS) 7 ❑ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) 8 ❑ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

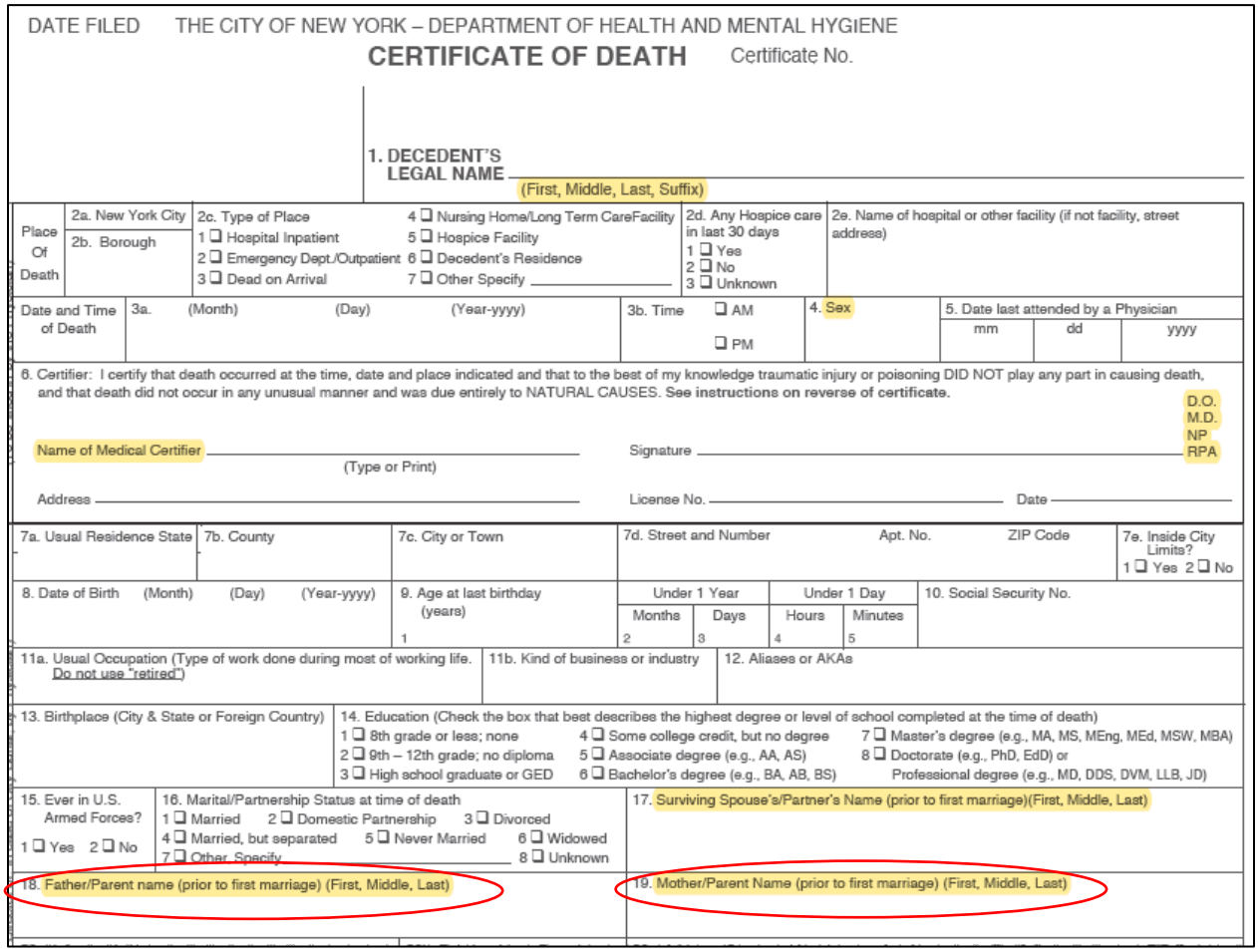
15. Ever in U.S. Armed Forces? 1 ❑ Yes 2 ❑ No; 16. Marital/Partnership Status at time of death 1 ❑ Married 2 ❑ Domestic Partnership 3 ❑ Divorced 4 ❑ Married, but separated 5 ❑ Never Married 6 ❑ Widowed 7 ❑ Other, Specify 8 ❑ Unknown; 17. Surviving Spouse's/Partner's Name (If wife, name prior to first marriage)(First, Middle, Last)

18. Father's Name (First, Middle, Last); 19. Mother's Maiden Name (Prior to first marriage) (First, Middle, Last)

Current eVital screen, no changes made to eVital

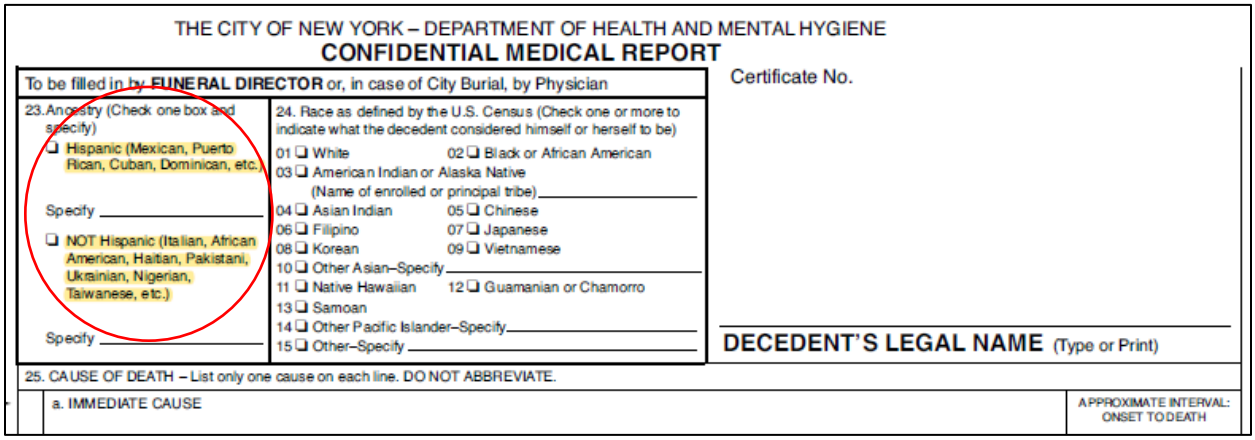


Updated Death certificate



7. **Question 23**: Adding Latino to ancestry label
    1. **Original**: Hispanic
    2. **New**: Hispanic/Latino
    3. **Purpose**: To be more inclusive and match the US Standard Death Certificate

Current Death certificate


THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CONFIDENTIAL MEDICAL REPORT

To be filled in by **FUNERAL DIRECTOR** or, in case of City Burial, by Physician

Certificate No.

23. Ancestry (Check one box and specify)
- ❑ Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.)

Specify _____

- ❑ NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.)

Specify _____

24. Race as defined by the U.S. Census (Check one or more to indicate what the decedent considered himself or herself to be)

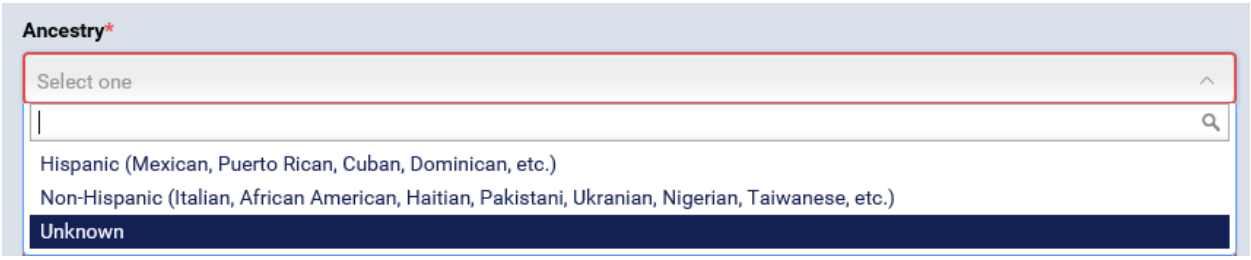
01 ❑ White 02 ❑ Black or African American
03 ❑ American Indian or Alaska Native (Name of enrolled or principal tribe) _____
04 ❑ Asian Indian 05 ❑ Chinese
06 ❑ Filipino 07 ❑ Japanese
08 ❑ Korean 09 ❑ Vietnamese
10 ❑ Other Asian–Specify _____
11 ❑ Native Hawaiian 12 ❑ Guamanian or Chamorro
13 ❑ Samoan
14 ❑ Other Pacific Islander–Specify _____
15 ❑ Other–Specify _____

DECEDENT'S LEGAL NAME (Type or Print)

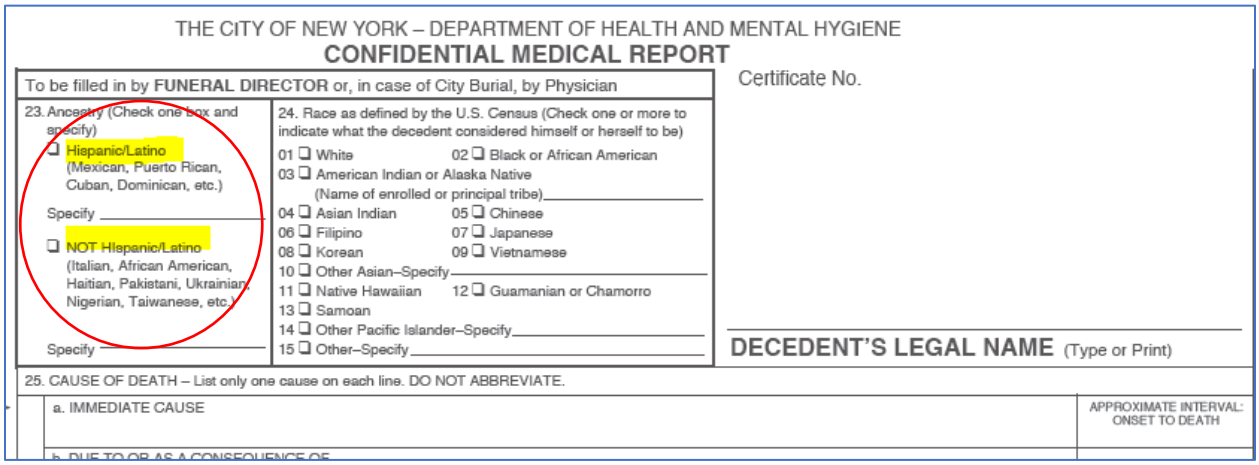
25. CAUSE OF DEATH – List only one cause on each line. DO NOT ABBREVIATE.

a. IMMEDIATE CAUSE — APPROXIMATE INTERVAL: ONSET TO DEATH

Current eVital screen



Updated Death certificate


THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CONFIDENTIAL MEDICAL REPORT

To be filled in by **FUNERAL DIRECTOR** or, in case of City Burial, by Physician

Certificate No.

23. Ancestry (Check one box and specify)
- ❑ Hispanic/Latino (Mexican, Puerto Rican, Cuban, Dominican, etc.)

Specify _____

- ❑ NOT Hispanic/Latino (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.)

Specify _____

24. Race as defined by the U.S. Census (Check one or more to indicate what the decedent considered himself or herself to be)

01 ❑ White 02 ❑ Black or African American
03 ❑ American Indian or Alaska Native (Name of enrolled or principal tribe) _____
04 ❑ Asian Indian 05 ❑ Chinese
06 ❑ Filipino 07 ❑ Japanese
08 ❑ Korean 09 ❑ Vietnamese
10 ❑ Other Asian–Specify _____
11 ❑ Native Hawaiian 12 ❑ Guamanian or Chamorro
13 ❑ Samoan
14 ❑ Other Pacific Islander–Specify _____
15 ❑ Other–Specify _____

DECEDENT'S LEGAL NAME (Type or Print)

25. CAUSE OF DEATH – List only one cause on each line. DO NOT ABBREVIATE.

a. IMMEDIATE CAUSE — APPROXIMATE INTERVAL: ONSET TO DEATH

b. DUE TO OR AS A CONSEQUENCE OF

New eVital screen