Doctors will inevitably need to fill in a death certificate, but newly qualified doctors might not know what is expected. This article is intended as an aid to completing death certificates.

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What is a death certificate?
A death certificate is a legal document issued by the attending physician, and at times by coroners, which states the date, location, and cause of death.¹

Why do we need a death certificate?Doctors in charge of a patient are legally required to notify any deaths to the registrar of births, deaths, and marriages.¹ The death certificate enables the family of the deceased to register the death and proceed with funeral arrangements.² It forms a record, providing information about illnesses that could run in the family, which could be important for the health of subsequent generations.³

Who can issue death certificates?The doctor who was caring for the patient before death is legally obligated to issue the death certificate.² The issuing doctor must be aware of the patients’ medical conditions, and outcomes of investigations and treatment. In situations that more than one doctor has cared for the patient, the ultimate responsibility lies with the consultant in charge.

Guidance on completion

- Cause of death should be stated as per the physician’s best knowledge and belief, which does not need to be flawless.
- In section Ia (box 1), mention the immediate terminal event that led to death, and in Ib, and Ic list the underlying conditions, which might in certain cases be chronic, leading to death. Thus, the diseases mentioned in Ib, and Ic should have directly caused all the conditions in Ia.
• In section II state all the diseases, injuries, and conditions that contributed to death but were not part of Ia, Ib, and Ic.

If death is due to widespread metastatic cancer from an unknown primary, you should clearly state that the primary site is unknown. If more than one possible cause could have led to death (section Ia), and you are uncertain about which of them is the most likely cause of death, all these possible causes must be listed in the certificate (box 2).

**When to refer to the coroner?**

Advice should be sought from a coroner when the death might warrant a post-mortem examination including:

- Accident;
- Violence;
- Neglect (by self or others);
- Industrial disease;
- Death occurring during surgery or before full recovery from anaesthesia;
- Death due to unknown reason;
- If the patient has not been seen by a doctor for 14 days prior to death;

If you have any doubts about the cause of death or difficulty in filling up the death certificate, help and advice should be sought from the consultant or coroner.

**What to write, and what to avoid**

1. Avoid stating “old age” as a cause of death, especially if the patient is younger than 70 years of age. It can be mentioned as a cause of death only if:
   - You have personally cared for the deceased over a long period (years, or many months);
   - You have observed a gradual decline in your patient’s general health and functioning;
   - You are not aware of any identifiable disease or injury that contributed to the death;
   - You are certain that there is no reason that the death should be reported to the coroner.

For cases in which “old age” is attributed as the cause of death, any other possible causes should also be stated.

2. If organ failure is stated as the cause of death, the underlying disease leading to organ failure should also be mentioned.

3. Avoid the term “natural causes”.

4. Avoid ambiguous terms such as “terminal illness”, “cardiac arrest,” or “shock”.

5. Avoid abbreviations, for example MI for myocardial infarction.

6. Avoid the term cerebrovascular accident. Instead use the terms “cerebral infarction” or “cerebral haemorrhage”.

I have no conflict of interest.

**References**