EDRS Remote Attestation
Sample Workflows

Electronic Death Registration Systems (EDRS) use computer generated faxes to request physicians' certification of medical data. Signed attestations from the physicians are automatically computer processed to notify the EDRS of the certification.

Each state has tailored the workflow to meet their specific goals and mesh with their environment. This document shows several workflows that are in use by different states. There are also different options for what the forms themselves look like. Some states include a cover page with instructions, others send just the single page that needs to be reviewed and signed.

The following diagrams show several workflow options.

Data Entry	**Highlights**
Funeral home	Medical data is handwritten by the physician, transcribed by the Funeral Director, and then faxed to the physician who certifies the data and signs the attestation form. Sample documents with fictitious content for this workflow process are included.
State staff	Medical data is handwritten by the physician and faxed to the state, where the data is entered and approved as accurate and complete. The entered data is faxed to the physician who certifies the data and signs the attestation form. Sample documents with fictitious content for this workflow process are included.
Physician's office	Medical data is entered by staff at the physician's office and faxed to the physician who certifies the data and signs the attestation form.
Manual	All data is gathered manually, typically by the Funeral Director, and faxed to the state (or optionally brought to a local office) where the data is entered and approved as accurate and complete. The entered data is faxed to the physician who certifies the data and signs the attestation form.

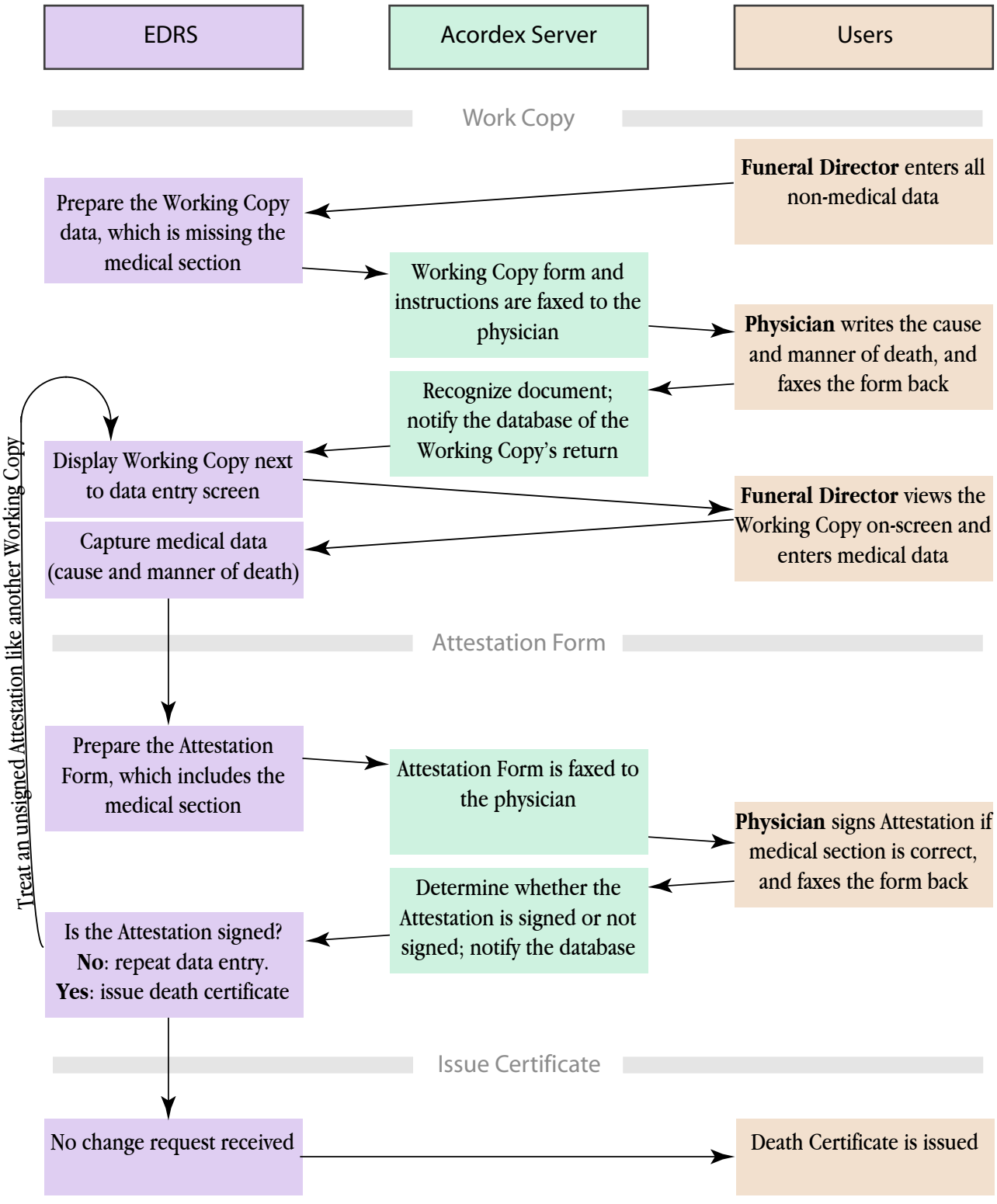
Please contact Acordex for further information:

Acordex Imaging Systems
37 Walker Rd., 1st Floor
North Andover, MA 01845

http://acordex.com

978-975-8000

Fax Attestation Workflow — Funeral Director Option



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Division of Vital Records
Electronic Death Registration System (EDRS)

WORK COPY

Fax Cover Sheet

RE: TRACKING NO: 692273	Date & Time Sent: May21, 2008 8:19 AM
Pages: 2	
TO CERTIFYING PHYSICIAN:	S. L. Marr, MD
OFFICE PHONE NO:	217-555-3412
FROM FUNERAL HOME:	Derricks FH
OFFICE PHONE NO:	217-555-8759
FAX NO:	217-555-8758

Thank you for participating in the Illinois EDRS Fax Attestation Process.
Please follow the steps below to complete the cause of death certification:

• Attached is a WORK COPY of the medical portion of the death record for your patient named in item 1.

• Verify the decedent's Name, Date and Place of death (items 1, 3, 4, 7a, 7b, 7c).

• Starting with item 24, complete the medical portion of the record.

• Fax the completed WORK COPY to the Funeral Home at 1-217-557-7104

•The funeral director will input the information provided from the WORK COPY into the EDRS

•The system will send you a completed ATTESTATION COPY for review and signature.

•If there are any questions or this was faxed to you in error, contact the funeral home listed on this cover sheet.

TRACKING NO: 692273 ILLINOIS CERTIFICATE OF DEATH

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month/Day/Year) (Spell Month)
KRIS K KROSS	MALE	MAY 21, 2008

4. COUNTY OF DEATH	5a. AGE AT LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR Months	5b. UNDER 1 YEAR Days	5c. UNDER 1 DAY Hours	5c. UNDER 1 DAY Minutes	6. DATE OF BIRTH (Month/Day/Year)
ALEXANDER	98					FEBRUARY 2, 1910

7a. CITY OR TOWN	7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)
EAST CAPE GIRARDEAU	

7c. PLACE OF DEATH **(Check only one:** see instructions)

IF DEATH OCCURRED IN A HOSPITAL
☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL
☐ Hospice Facility ☐ Nursing Home/Long-term care facility ☐ Decedent's Home ☒ Other (Specify): SCENE

WORK COPY

Please complete the Cause of Death Section below starting with Item 24. When completed, fax to the Funeral Director at (217) 557-7128.

21a. FUNERAL HOME NAME	STREET AND NUMBER	CITY OR TOWN	STATE	ZIP
DERRICKS FH	222 SOUTH MAIN	EAST CAPE GIRARDE/	ILLINOIS	62957

21b. FUNERAL DIRECTOR'S SIGNATURE	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER
RICK R RORY	034010450
22. LOCAL REGISTRAR'S SIGNATURE	**23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)**
JAMES J JOKER	

CAUSE OF DEATH (See Instructions and examples)

24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

APPROXIMATE INTERVAL BETWEEN ONSET AND 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. b. _____ Due to (or as a consequence of):

Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST c. _____ Due to (or as a consequence of):

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

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH ☐ Yes ☐ No

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

28. IF FEMALE:
☐ Not pregnant within past 12 months
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Pregnant at time of death
☐ Pregnant within one year of death but time unknown
☐ Unknown if pregnant within the past 12 months

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

30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY ☐ A.M. ☐ P.M.	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK? ☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number Apartment Number City or Town **State** **ZIP Code**

35. DESCRIBE HOW INJURY OCCURRED:	36. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☒ No	39. DATE PRONOUNCED (Month/Day/Year)	40. TIME OF DEATH 02:00 ☐ A.M. ☒ P.M.

41. CERTIFIER (Check only one):
☒ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated.
☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

42. NAME, ADDRESS AND ZIP CODE OF PERSON **COMPLETING CAUSE OF DEATH (Item 24)**	43. PHYSICIAN'S LICENSE NUMBER
MARR, SPLD	

44. TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	PHYSICIAN'S SIGNATURE NOT NEEDED AT THIS TIME
PHYSICIAN IN CHARGE		

0001078909

46. SIGNATURE OF CERTIFIER

TRACKING NO: 692273 **ILLINOIS CERTIFICATE OF DEATH**

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month/Day/Year) (Spell Month)
KRIS K KROSS	MALE	MAY 21, 2008

4. COUNTY OF DEATH	5a. AGE AT LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR: Months	Days	5c. UNDER 1 DAY: Hours	Minutes	6. DATE OF BIRTH (Month/Day/Year)
ALEXANDER	98					FEBRUARY 2, 1910

7a. CITY OR TOWN	7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)
EAST CAPE GIRARDEAU	

7c. PLACE OF DEATH (Check only one: see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice Facility ☐ Nursing Home/Long-term care facility ☐ Decedent's Home ☒ Other (Specify): SCENE

WORK COPY

Please complete the Cause of Death Section below starting with Item 24. When completed, fax to the Funeral Director at (217) 557-7128.

21a. FUNERAL HOME NAME	STREET AND NUMBER	CITY OR TOWN	STATE	ZIP
DERRICKS FH	222 SOUTH MAIN	EAST CAPE GIRARDE/	ILLINOIS	62957

21b. FUNERAL DIRECTOR'S SIGNATURE	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER
RICK R RORY	034010450

22. LOCAL REGISTRAR'S SIGNATURE	23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)
JAMES J JOKER	

CAUSE OF DEATH (See instructions and examples)

24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (final disease or condition resulting in death)	a. Cardiac arrest (or as a consequence of):	2 min
Sequentially list conditions, if any, leading to the cause listed on line a.	b. rabies virus Due to (or as a consequence of):	3 days
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c. fox bite Due to (or as a consequence of):	4 days

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

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH ☐ Yes ☐ No

27. DID TOBACCO USE CONTRIBUTE TO DEATH	28. IF FEMALE	29. MANNER OF DEATH
☐ Yes ☐ Probably ☐ No ☐ Unknown	☐ Not pregnant within past 12 months ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Pregnant within one year of death but time unknown ☐ Unknown if pregnant within the past 12 months	☐ Natural ☐ Suicide ☐ Could not be determined ☐ Accident ☐ Homicide ☐ *Pending Investigation*

30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY ☐ A.M. ☐ P.M.	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK? ☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number	Apartment Number	City or Town	State	ZIP Code

35. DESCRIBE HOW INJURY OCCURRED	36. IF TRANSPORTATION INJURY, SPECIFY:
	☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☒ No	39. DATE PRONOUNCED (Month/Day/Year)	40. TIME OF DEATH
			02 30 ☐ A.M. ☒ P.M.

41. CERTIFIER (Check only one):

☒ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.

☐ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated.

☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

42. NAME, ADDRESS AND ZIP CODE OF PERSON **COMPLETING CAUSE OF DEATH (Item 24)**	43. PHYSICIAN'S LICENSE NUMBER
MARR, SPLD	

44. TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	**PHYSICIAN'S SIGNATURE NOT NEEDED AT THIS TIME**
PHYSICIAN IN CHARGE		

0001076909

46. SIGNATURE OF CERTIFIER

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Division of Vital Records
Electronic Death Registration System (EDRS)

ATTESTATION COPY

Fax Cover Sheet

RE: TRACKING NO: 692291	**Date & Time Sent:** May 22, 2008 1:32pm
Pages: 2 (Including this one)	
TO CERTIFYING PHYSICIAN:	S. L. Marr, MD
OFFICE PHONE NO:	217-555-3412
FROM FUNERAL HOME:	Derricks Funeral Home
OFFICE PHONE NO:	217-555-8759
FAX NO:	217-555-8758

Thank you for participating in the Illinois EDRS Fax Attestation Process.
Please follow the steps below to complete the cause of death certification:

- Verify the decedent's Name, Date and Place of Death (items 1, 3, 4, 7a, 7b, 7c).

- Review the Attestation Copy and **attest that the information is correct by affixing your signature in item 46.**

- Fax the signed Attestaton Copy to the Funeral Home at 1-217-557-7104

- If any information is incorrect:
  - **DO NOT SIGN**
  - Make corrections where needed
  - Fax to the Funeral Home at 1-217-557-7104
  - A corrected Attestation Copy will be faxed to you.

- If there are any questions or this was faxed to you in error, contact the funeral home listed on this cover sheet.

TRACKING NO: 692291 ILLINOIS CERTIFICATE OF DEATH

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month/Day/Year) (Spell Month)
KRIS K KROSS	MALE	MAY 21, 2008

4. COUNTY OF DEATH	5a. AGE AT LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR Months	5b. UNDER 1 YEAR Days	5c. UNDER 1 DAY Hours	5c. UNDER 1 DAY Minutes	6. DATE OF BIRTH (Month/Day/Year)
ALEXANDER	98					FEBRUARY 2, 1910

7a. CITY OR TOWN	7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)
EAST CAPE GIRARDEAU	

7c. PLACE OF DEATH **(Check only one:** see instructions)

IF DEATH OCCURRED IN A HOSPITAL
☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL
☐ Hospice Facility ☐ Nursing Home/Long-term care facility ☐ Decedent's Home ☒ Other (Specify): SCENE

ATTESTATION COPY

Please verify the Cause of Death section below. If correct, sign in the box at the bottom right hand corner of this form

21a. FUNERAL HOME NAME	STREET AND NUMBER	CITY OR TOWN	STATE	ZIP
DERRICKS FH	222 SOUTH MAIN	EAST CAPE GIRARDEA	ILLINOIS	62957

21b. FUNERAL DIRECTOR'S SIGNATURE	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER
RICK R RORY	034010450
22. LOCAL REGISTRAR'S SIGNATURE	23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)
JAMES J JOKER	

CAUSE OF DEATH (See Instructions and examples)

24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (final disease or condition resulting in death)	a.	Cardiac arrest	2 minutes
		Due to (or as a consequence of):	
Sequentially list conditions, If any, leading to the cause listed on line a.	b.	Rabies viral infection	3 days
		Due to (or as a consequence of):	
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c.	Fox bite	4 days
		Due to (or as a consequence of):	

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

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH ☐ Yes ☐ No

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

28. IF FEMALE:
☐ Not pregnant within past 12 months
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Pregnant at time of death
☐ Pregnant within one year of death but time unknown
☐ Unknown if pregnant within the past 12 months

29. MANNER OF DEATH
☒ Natural ☐ Suicide ☐ Could not be determined
☐ Accident ☐ Homicide ☐ *Pending Investigation*

30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY ☐ A.M. ☐ P.M.	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK? ☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number | Apartment Number | City or Town | State | ZIP Code

35. DESCRIBE HOW INJURY OCCURRED:

36. IF TRANSPORTATION INJURY, SPECIFY:
☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☒ No	39. DATE PRONOUNCED (Month/Day/Year)	40. TIME OF DEATH 02:00 ☐ A.M. ☒ P.M.

41. CERTIFIER (Check only one):
☐ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☒ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated.
☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

42. NAME, ADDRESS AND ZIP CODE OF PERSON **COMPLETING CAUSE OF DEATH (Item 24)**	43. PHYSICIAN'S LICENSE NUMBER
MARR, S.L. MD	

44. TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	**DO NOT WRITE OUTSIDE THE HEAVY LINE IN THE BOX BELOW.**
PHYSICIAN IN ATTENDANCE		

0001078619

46. SIGNATURE OF CERTIFIER

TRACKING NO: 692291 **ILLINOIS CERTIFICATE OF DEATH**

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month/Day/Year) (Spell Month)
KRIS K KROSS	MALE	MAY 21, 2008

4. COUNTY OF DEATH	5a. AGE AT LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR Months	Days	5c. UNDER 1 DAY Hours	Minutes	6. DATE OF BIRTH (Month/Day/Year)
ALEXANDER	98					FEBRUARY 2, 1910

7a. CITY OR TOWN	7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)
EAST CAPE GIRARDEAU	

7c. PLACE OF DEATH (Check only one; see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice Facility ☐ Nursing Home/Long-term care facility ☐ Decedent's Home ☒ Other (Specify) SCENE

ATTESTATION COPY

Please verify the Cause of Death section below. If correct, sign in the box at the bottom right hand corner of this form

21a. FUNERAL HOME NAME	STREET AND NUMBER	CITY OR TOWN	STATE	ZIP
DERRICKS FH	222 SOUTH MAIN	EAST CAPE GIRARDE/	ILLINOIS	62957

21b. FUNERAL DIRECTOR'S SIGNATURE	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER
RICK R RORY	034010450
22. LOCAL REGISTRAR'S SIGNATURE	23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year)
JAMES J JOKER	

CAUSE OF DEATH (See instructions and examples)

24. 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 etiology. If the decedent had a dementia related disease, Parkinsons Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death)	a. Cardiac arrest	2 minutes
Sequentially list conditions, if any, leading to the cause listed on line a.	b. Rabies viral infection — Due to (or as a consequence of):	3 days
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c. Fox bite — Due to (or as a consequence of):	4 days

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

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH ☐ Yes ☐ No

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

28. IF FEMALE: ☐ Not pregnant within past 12 months ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Pregnant within one year of death but time unknown ☐ Unknown if pregnant within the past 12 months

29. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined ☐ *Pending Investigation*

30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY ☐ A.M. ☐ P.M.	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK? ☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number	Apartment Number	City or Town	State	ZIP Code

35. DESCRIBE HOW INJURY OCCURRED.	36. IF TRANSPORTATION INJURY, SPECIFY. ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

37. I (DID) (DID NOT) ATTEND THE DECEDENT (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☒ No	39. DATE PRONOUNCED (Month/Day/Year)	40. TIME OF DEATH 02:30 ☐ A.M. ☒ P.M.

41. CERTIFIER (Check only one)

☐ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.

☒ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated.

☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

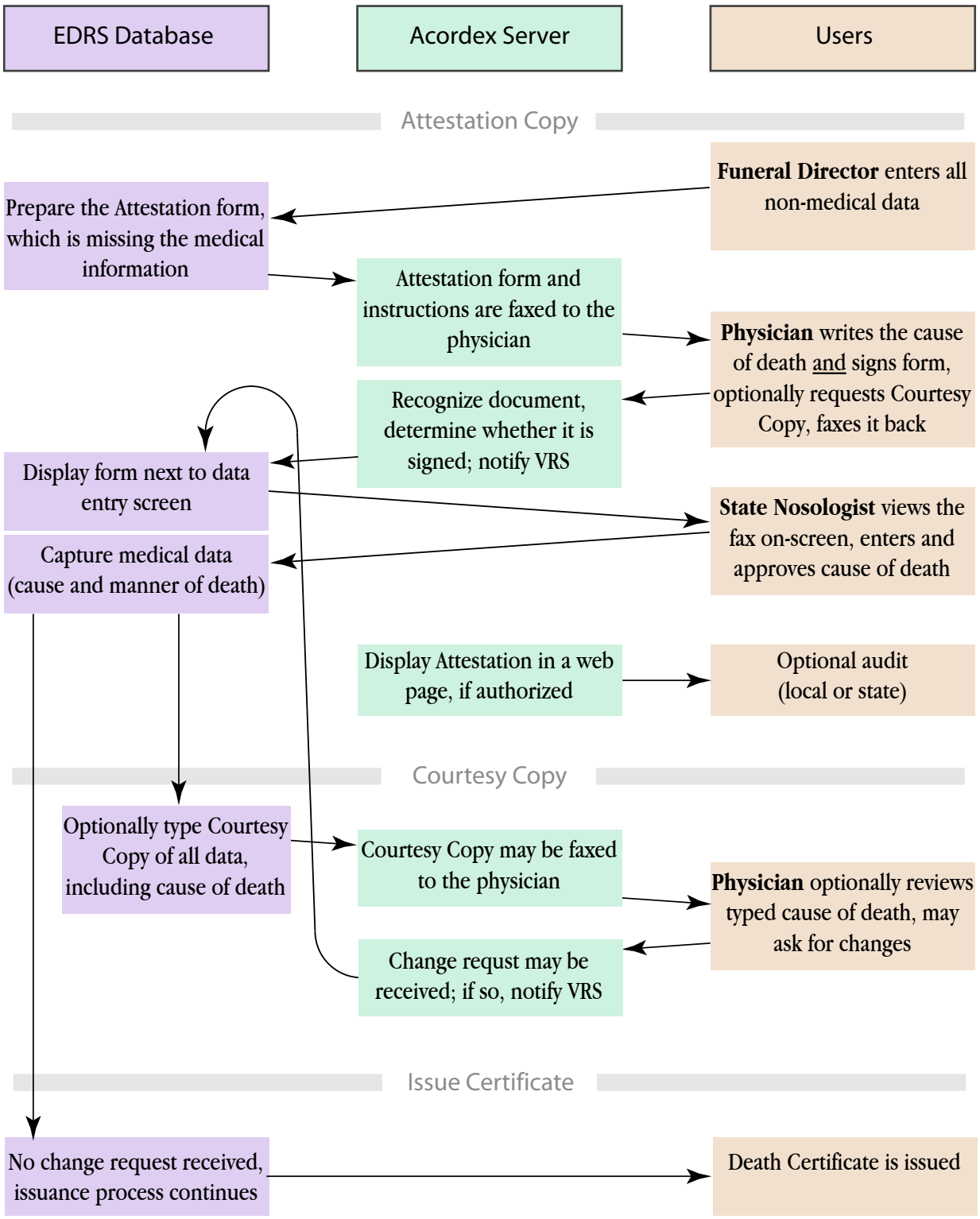
42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24)	43. PHYSICIAN'S LICENSE NUMBER
MARR, S. L. MD	123456

44. TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	DO NOT WRITE OUTSIDE THE HEAVY LINE IN THE BOX BELOW.
PHYSICIAN IN ATTENDANCE	5/20/2008	

0001078917

46. SIGNATURE OF CERTIFIER

Fax Attestation Workflow — State Nosologist Option



ILLINOIS CERTIFICATE OF DEATH
Fax Attestation

Medical Examiner's Case No:

Confidential and Time Sensitive Information

Tracking Number: 11392846	**Date and Time Sent:** 05/30/2012 12:00:11 PM	**Pages:** 1
Recipient: LANCE WALLMAN	**Recipient's Phone Number:**	
Sender: LEAK AND SONS	**Sender's Phone Number:** (773) 846-6567	

To certify the cause of death, complete the applicable sections below and sign in the bottom right hand corner.
Once completed and signed, fax it back to **(217)557-7104**.
For information about completing the cause of death online, email us at **dph.ivrs@illinois.gov**

A Courtesy Copy will be faxed to you after the record is completed by the Funeral Director.

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month/Day/Year)
JOHN DOE	MALE	MAY 22, 2012

4. COUNTY OF DEATH	5a. AGE AT LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR Months	5b. UNDER 1 YEAR Days	5c. UNDER 1 DAY Hours	5c. UNDER 1 DAY Minutes	6. DATE OF BIRTH (Month/Day/Year)
KANE	66					MAY 31, 1945

7a. CITY OR TOWN	7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)
AURORA	PROVENA MERCY CENTER

21a. FUNERAL HOME NAME	STREET AND NUMBER	CITY OR TOWN	STATE	ZIP
LEAK AND SONS	7838 SOUTH COTTAGE GROVE	CHICAGO	ILLINOIS	60619

21b. FUNERAL DIRECTOR'S SIGNATURE	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER
LEAK SR, SPENCER	031007489

CAUSE OF DEATH (See Instructions and examples)

24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

			APPROXIMATE INTERVAL BETWEEN ONSET AND 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.	b.	Due to (or as a consequence of):	
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c.	Due to (or as a consequence of):	

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

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH ☐ Yes ☐ No

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

28. IF FEMALE: ☐ Not pregnant within past 12 months ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Pregnant within one year of death but time unknown ☐ Unknown if pregnant within the past 12 months

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

30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK?
	☐ A.M. ☐ P.M.		☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number | Apartment Number | City or Town | State | ZIP Code

35. DESCRIBE HOW INJURY OCCURRED:

36. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify) _____

37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	38. WAS MEDICAL EXAMINER OR CORONER CONTACTED?	39. DATE PRONOUNCED (Month/Day/Year)	40. TIME OF DEATH
	☐ Yes ☐ No		10:17 ☒ A.M. ☐ P.M.

41. CERTIFIER (Check only one):

☒ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated.
☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

42. NAME, ADDRESS AND ZIP CODE OF PERSON **COMPLETING CAUSE OF DEATH (Item 24)**	43. PHYSICIAN'S LICENSE NUMBER
LANCE WALLACE, 20939 S CICERO, MATTESON, ILLINOIS, 60443	036085478

44. TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	
PHYSICIAN IN CHARGE		**Sign in the Box Below** ↓

ILLINOIS CERTIFICATE OF DEATH
Fax Attestation

Medical Examiner's Case No:

Confidential and Time Sensitive Information

Tracking Number: 11392846	**Date and Time Sent:** 05/30/2012 12:00:11 PM	**Pages:** 1
Recipient: LANCE WALLMAN	**Recipient's Phone Number:**	
Sender: LEAK AND SONS	**Sender's Phone Number:** (773) 846-6567	

To certify the cause of death, complete the applicable sections below and sign in the bottom right hand corner.
Once completed and signed, fax it back to **(217)557-7104.**
For information about completing the cause of death online, email us at dph.ivrs@illinois.gov

A Courtesy Copy will be faxed to you after the record is completed by the Funeral Director.

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month/Day/Year)
JOHN DOE	MALE	MAY 22, 2012

4. COUNTY OF DEATH	5a. AGE AT LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR Months	Days	5c. UNDER 1 DAY Hours	Minutes	6. DATE OF BIRTH (Month/Day/Year)
KANE	66					MAY 31, 1945

7a. CITY OR TOWN	7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)
AURORA	PROVENA MERCY CENTER

21a. FUNERAL HOME NAME	STREET AND NUMBER	CITY OR TOWN	STATE	ZIP
LEAK AND SONS	7838 SOUTH COTTAGE GROVE	CHICAGO	ILLINOIS	60619

21b. FUNERAL DIRECTOR'S SIGNATURE	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER
LEAK SR, SPENCER	031007489

CAUSE OF DEATH (See instructions and examples)

24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (final disease or condition resulting in death)	a.	Myocardial Infarction	30 minutes
Sequentially list conditions, if any, leading to the cause listed on line a.	b.	Due to (or as a consequence of): Cardiomyopathy	2 Months
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c.	Due to (or as a consequence of): Paroxysmal atrial fibrillation	2 Months
		Due to (or as a consequence of):	

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

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No
26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH ☐ Yes ☐ No

27. DID TOBACCO USE CONTRIBUTE TO DEATH ☐ Yes ☐ Probably ☒ No ☐ Unknown

28. IF FEMALE ☐ Not pregnant within past 12 months ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Pregnant within one year of death but time unknown ☐ Unknown if pregnant within the past 12 months

29. MANNER OF DEATH ☐ Natural ☐ Suicide ☐ Could not be determined ☐ Accident ☐ Homicide ☐ *Pending investigation*

30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY ☐ A.M. ☐ P.M.	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK? ☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number	Apartment Number	City or Town	State	ZIP Code

35. DESCRIBE HOW INJURY OCCURRED:	36. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☒ Yes ☐ No	39. DATE PRONOUNCED (Month/Day/Year)	40. TIME OF DEATH 10:17 ☒ A.M. ☐ P.M.
5/17/12			

41. CERTIFIER (Check only one):
☒ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated.
☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24)	43. PHYSICIAN'S LICENSE NUMBER
LANCE WALLACE, 20939 S CICERO, MATTESON, ILLINOIS, 60443	036085478

44. TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	Sign in the Box Below
PHYSICIAN IN CHARGE	5/31/12	Lance Wallace M.D.

0046550316

ILLINOIS CERTIFICATE OF DEATH
Fax Attestation

Medical Examiner's Case No:

COURTESY COPY OF DEATH RECORD
CONFIDENTIAL INFORMATION

Tracking Number: 11392846	**Date and Time Sent:** 05/31/2012 11:08:31 AM	**Pages:** 1
Recipient: LANCE WALLMAN	**Recipient's Phone Number:**	
Sender: LEAK AND SONS	**Sender's Phone Number:** (773) 846-6567	

THIS IS A COURTESY COPY - DO NOT FAX THIS COPY BACK

UNLESS any of the information in the cause of death section is incorrect. If corrections are needed, please make the changes on this copy, sign in the signature box below at the bottom of this form and fax it to (217) 557-7104.

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month/Day/Year)
JOHN DOE	MALE	MAY 22, 2012

4. COUNTY OF DEATH	5a. AGE AT LAST BIRTHDAY (Years)	5b. UNDER 1 YEAR Months	5b. UNDER 1 YEAR Days	5c. UNDER 1 DAY Hours	5c. UNDER 1 DAY Minutes	6. DATE OF BIRTH (Month/Day/Year)
KANE	66					MAY 31, 1945

7a. CITY OR TOWN	7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)
AURORA	PROVENA MERCY CENTER

21a. FUNERAL HOME NAME	STREET AND NUMBER	CITY OR TOWN	STATE	ZIP
LEAK AND SONS	7838 SOUTH COTTAGE GROVE	CHICAGO	ILLINOIS	60619

21b. FUNERAL DIRECTOR'S SIGNATURE	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER
LEAK SR, SPENCER	031007489

CAUSE OF DEATH (See Instructions and examples)

24. 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (final disease or condition resulting in death)	a.	MYOCARDIAL INFARCTION	30 **MINUTES**
		Due to (or as a consequence of):	
Sequentially list conditions, If any, leading to the cause listed on line a.	b.	CARDIOMYOPATHY	6 **MONTHS**
		Due to (or as a consequence of):	
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c.	PAROXYSMAL ATRIAL FIBRILLATION	4 **MONTHS**
		Due to (or as a consequence of):	

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

CHRONIC MYELOGENOUS LEUKEMIA

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH ☐ Yes ☐ No

27. DID TOBACCO USE CONTRIBUTE TO DEATH ☐ Yes ☐ Probably ☒ No ☐ Unknown

28. IF FEMALE: ☐ Not pregnant within past 12 months ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Pregnant within one year of death but time unknown ☐ Unknown if pregnant within the past 12 months

29. MANNER OF DEATH ☒ Natural ☐ Suicide ☐ Could not be determined ☐ Accident ☐ Homicide ☐ *Pending Investigation*

30. DATE OF INJURY (Month/Day/Year)	31. TIME OF INJURY	32. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	33. INJURY AT WORK?
	☐ A.M. ☐ P.M.		☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number	Apartment Number	City or Town	State	ZIP Code

35. DESCRIBE HOW INJURY OCCURRED:	36. IF TRANSPORTATION INJURY, SPECIFY:
	☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

37. I **(DID)** (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON	38. WAS MEDICAL EXAMINER OR CORONER CONTACTED?	39. DATE PRONOUNCED (Month/Day/Year)	40. TIME OF DEATH
MAY 17, 2012	☒ Yes ☐ No		10:17 ☒ A.M. ☐ P.M.

41. CERTIFIER (Check only one):

☒ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.

☐ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to cause(s) and manner stated.

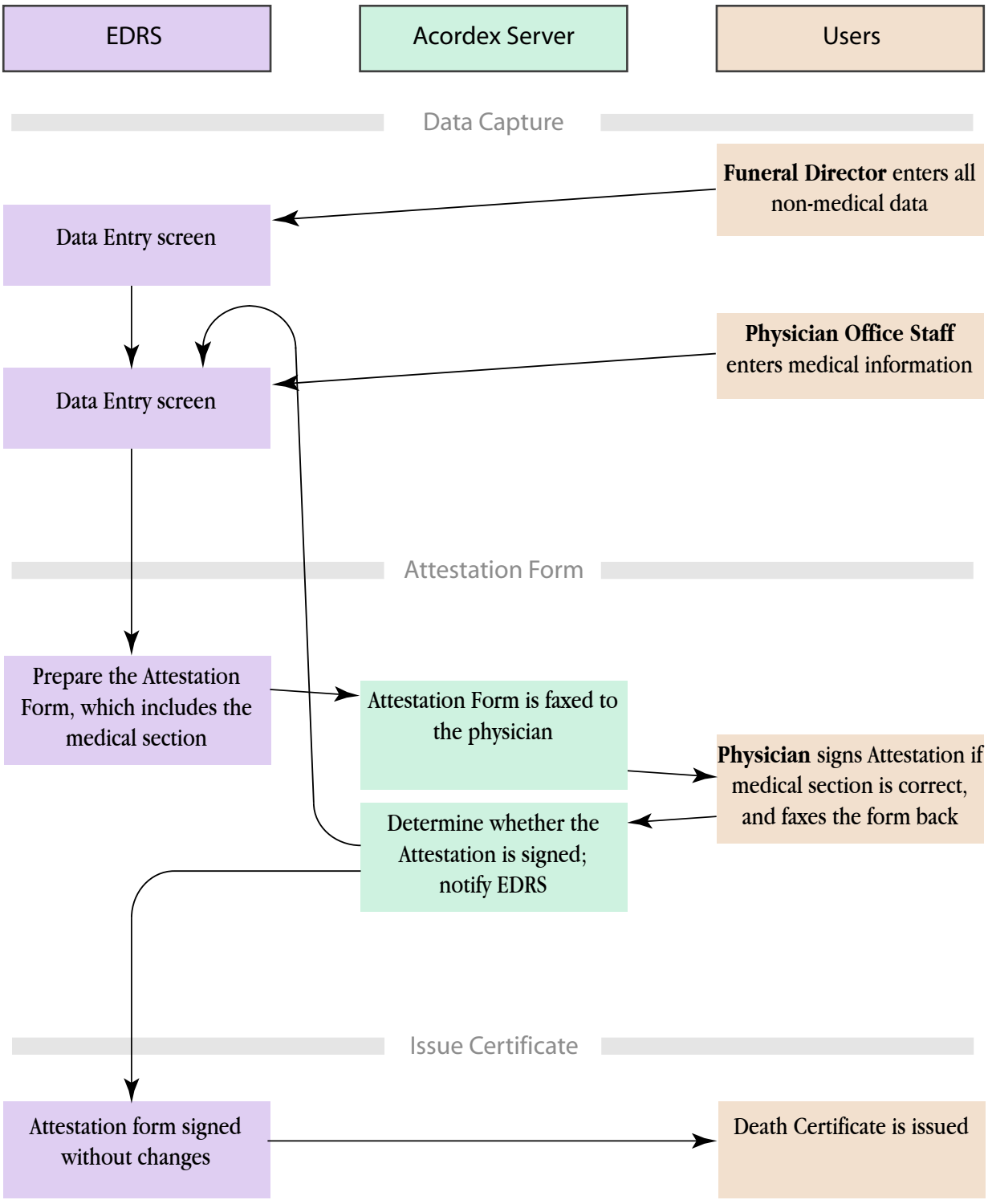
☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

42. NAME, ADDRESS AND ZIP CODE OF PERSON **COMPLETING CAUSE OF DEATH (Item 24)**	43. PHYSICIAN'S LICENSE NUMBER
LANCE WALLACE, 20939 S CICERO, MATTESON, ILLINOIS, 60443	036085478

44. TITLE OF CERTIFIER	45. DATE CERTIFIED (Month/Day/Year)	
PHYSICIAN IN CHARGE	MAY 31, 2012	**Sign in the Box Below** ↓

0046625113

Fax Attestation Workflow — Physician Office Option



Fax Attestation Workflow — Manual Paper Option