

You must use the Stillbirth Registration Form 8 when registering stillbirths. This form must be completed by the attending physician, coroner, or designated person before a burial permit can be issued. Please PRINT clearly in blue or black ink as it is a permanent legal record.

 Hospital code number

INFORMATION ABOUT THE DECEASED							
1. Name of deceased (last, first, middle) PICKERING, MAUREEN				2. Date of death [month - by name, day, year (in full)] MAR 28 / 2014			
3. Sex (M or F) F	4. Age 78	5. If under 1yr. Months Days	6. If under 1 day Hours Minutes	7. Gestation age	8. Birth weight		
9. Place of death (name of facility or location) CLNH							
				<input type="checkbox"/> hospital <input checked="" type="checkbox"/> nursing home <input type="checkbox"/> residence <input type="checkbox"/> other (specify)			
10. City, town, village or township WOODSTOCK				Regional municipality, county or district OXFORD			

CAUSE OF DEATH		
CAUSE OF DEATH	11. Part I	Approximate interval between onset & death
	Immediate cause of death (a) CVA <i>due to, or as a consequence of</i>	one week
	Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last (b) _____ (c) _____ (d) _____	
	Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above Alzheimer Hypertension	6 years 30 years
12. If deceased was a female, did the death occur: <input type="checkbox"/> during pregnancy (including abortion and ectopic pregnancy) <input type="checkbox"/> within 42 days thereafter <input type="checkbox"/> between 43 days and 1 year thereafter		
13. Was the deceased dead on arrival at the hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
14. Was there a surgical procedure within 28 days of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
15. Date of surgery (mm/dd/yyyy)		
16. Reason for surgery and operative findings		
Autopsy particulars	17. Autopsy being held? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	18. Does the cause of death stated above take account of autopsy findings? <input type="checkbox"/> Yes <input type="checkbox"/> No
	19. May further information relating to the cause of death be available later? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Accidental or violent death (if applicable)	20. If accident, suicide, homicide or undetermined (specify)	
	21. Place of injury (e.g. home, farm, highway, etc.)	
	22. Date of injury (mm/dd/yyyy)	
23. How did injury occur? (describe circumstances)		

CERTIFICATION	
By signing below, you certify that the information on this form is correct to the best of your knowledge.	
24. Your signature (physician, coroner, RN(EC) other) X <i>Richard</i>	25. Date (mm/dd/yyyy) MAR 28 / 2014
26. Your name (last, first, middle) RICHARD	27. Your title: <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Coroner <input type="checkbox"/> RN(EC) <input type="checkbox"/> other (specify)

TO BE COMPLETED BY THE DIVISION REGISTRAR			
By signing below, I am satisfied that the information in this Medical certificate of death and the Statement of death is correct and sufficient and I agree to register the death.			
Signature X	Date (mm/dd/yyyy)	Registration number	Div. reg. code no.

For the use of the Office of the Registrar General only

Personal information contained in this form is collected under the authority of the Vital Statistics Act, R.S.O. 1990, c.v.4 and will be used to register and record the births, still-births, deaths, marriages, additions or change of name, corrections or amendments, provide certified copies, extracts, certificates, search notices, photocopies and for statistical, research, medical, law enforcement, adoption and adoption disclosure purposes. Questions about this collection should be directed to the Deputy Registrar General at PO Box 4600, Thunder Bay ON P7B 6L8. Telephone 1 800 461-2156 or 416 325-8305.

CARESSANT CARE WOODSTOCK

81 Fyfe Ave., Woodstock, ON, N4S 8Y2, 519-539-6461

Residents Death Form

TO BE COMPLETED BY ATTENDING PHYSICIAN:

I, Dr. REDDICK pronounce MAUREEN PICKERING to be dead.

The apparent cause of his/her death is CUA

The body may be released to the Mortician and the remaining medications for the deceased destroyed.

Signature: [Signature] Time: 10 30 Date: Mar 28/2014

TO BE COMPLETED BY THE REGISTERED NURSE ON DUTY:

The attending physician was notified of the residents' apparent death at 0925 hr. The attending Physician pronounced the resident dead at 1035 hr.

Complete ONLINE Institutional Patient Death Record. PRINT before submitting the Online form. The Submission Confirmation Number is: 43149259. Write this # on printed form.

The Coroner was notified (see ONLINE Institutional Patient Death Record for guidelines) of the residents death DR GEORGE at 0930 by KAREN ROUTLEDGE on MAR 28 (date).

The residents' family, D.T. were notified by KAREN ROUTLEDGE at 0920 hr.

The body was released to OSTRANDER Funeral Home, (address) TILLSBURG at _____ hr.

The following articles accompanied the body:

1 pearl/silver ring RRF.

Signature of Nurse releasing the body to Mortician: [Signature]

Morticians' signature for receipt of the body plus accompanying articles: _____

Provide the attending Physician with the following information about the deceased:

Full name of deceased, Age, DOB, Sex, Date of admission, Diagnoses. These can be photocopied from Admission page. Provide any relevant clinical information, clinical findings from several days prior to the residents' death.



Office of the
Chief Coroner

Institutional Patient Death Record

For use by facilities to which the *Long-Term Care Homes Act 2007* applies, for the mandatory report required when a resident dies in the facility or off the premises and in the care of a Long-Term Care Home staff member.

Where a resident dies on the premises of a long-term care home, to which the *Long-Term Care Homes Act, 2007* applies, or off the premises and in the care of a Long-Term Care Home staff member, the *Coroners Act* requires that the death be immediately reported to a coroner. Online submission of this form is required.

Instructions:

- Please complete this form immediately after a resident dies in the circumstances noted above.
- After answering the 8 questions below:
 - If all answers to the 8 questions below are "No", submit the completed form. No call to Provincial Dispatch is required.
 - If there are one or more "Yes" answers, please call Provincial Dispatch **IMMEDIATELY** to report the death, and record the name of the coroner assigned in the field below, then submit the form.

Please direct any inquiries to:

Office of the Chief Coroner
occ.inquiries@ontario.ca

Coroner Dispatch Telephone: 416 314-4100 / 1 855 299-4100

Deceased Last Name Pickering		Deceased First Name Maureen	
<input type="checkbox"/> Male	<input checked="" type="checkbox"/> Female	Age 78	Time of Death 2014/03/28 09:15

Institution Name Caressant Care Woodstock Nursing Home			
Institution Address			
Unit No.	Street No. 81	Street Name Fyfe Ave	PO Box
City/Town Woodstock		Province ON	Postal Code N4S 8Y2

- Accidental Death? Yes No
(An accident is an event that caused unintended injuries that begin the process leading to death. The time interval between the injury and death may be minutes to years. For example, a hip fracture is a common injury that begins the process that leads to death in the elderly. If there is a possible connection between a fracture or an injury and the events leading to death, the death should be reported to a coroner.)
 - Suicide? Yes No
(Death due to an external factor initiated by the deceased.)
 - Homicide? Yes No
(Death due to an external factor initiated by someone other than the deceased.)
- *If there is a possibility of suicide or homicide, telephone both the police and the coroner, remove any other residents and seal the room until they arrive.
- Undetermined? Yes No
(The manner of death is unclear. There is some reason to think that the death may not be due to natural causes, but it is not clearly an accident, a suicide or a homicide.)
 - Is the death both sudden and unexpected? Yes No
(i.e. The death was not reasonably foreseeable.)
 - Has the family or any of the care providers raised concerns about the care provided to the deceased? Yes No
 - Has there been a recent increase in the number of deaths in your Long-Term Care Home? Yes No
 - Has there been a recent increase in the number of transfers to hospital? Yes No

Last Name of Person completing this form Roulledge		First Name Karen	
Title Registered Nurse		Telephone No. (incl. area code) (519) 539-6461	
Signature SUBMITTED ONLINE BY Karen Roulledge		Date Completed (yyyy/mm/dd) 2014/03/28	
Last Name of Local Coroner (if a local coroner was called)		Telephone No. (incl. area code)	