The Medical Certificate of Cause of Death: Accurate completion

Adam Griffin, Katherine Robinson, Gary Hall, Michaela Kelly

IN PART 2 of the Medical Certificate of Cause of Death series, which commenced with an editorial and part 1 in the April 2026 issue of *Australian Journal of General Practice*,[1,2] we describe the format of the death certificate and best practice in completion of a Medical Certificate of Cause of Death (hereafter 'death certificate'). Although there are jurisdictional differences in legislation in Australian states, compliance with local requirements is guaranteed by completing every section of the form.

Format of the death certificate

The format of the death certificate is determined by law, based on the World Health Organization (WHO) internationally accepted format.[3]

Cause of death is written as a causative chain: each antecedent cause describing a logical and chronological step explaining the death. The 'other significant conditions' are not directly causative but strongly linked to the cause of death. For example, deaths from ischaemic heart disease may include a list of relevant cardiac risk factors.

Doctor's details and basis for completion

After completing your details, you must identify how you formed your opinion. Usually, you would have treated the person in life or may only have the medical records to form an opinion. The latter is only sufficient to complete a certificate in Queensland and New South Wales. Other Australian jurisdictions require that you have treated the person in life or examined them in death.

Unique identifying information

You must fill in the decedent's name, date of birth, gender and physical address. The accuracy of the person's name is important for legal processes: full names where possible, with correct spelling and identifying aliases where known.

Date and time of death

The exact date and time of death should be entered. If unknown, the best estimate or a limited range of dates should be provided.

Relevance of place of death

The place of death must be considered as certain facilities (refer to part 1 of the series)[2] must always report deaths to the coroner. For example, in Queensland, deaths within nursing home facilities are not immediately reportable. Some supported accommodation (Level 3 facilities under *Residential Services Act 2002* (Qld) and National Disability Insurance Scheme–funded accommodation) must report all deaths. Deaths in declared mental health facilities are reportable.

Recent surgical procedures

You may be asked to note surgical procedures within a particular time frame (usually 6 weeks). This is for statistical reference and not necessarily indicating a reportable death. Any perceived association between healthcare provision and the death requires engagement with the coroner before authorising the certificate.

Cremation risk

You must ascertain whether the patient has a device or completed recent treatment that may represent a cremation risk (Table 1). For example, traditional pacemaker batteries explode when superheated and

Table 1. Cremation risk: Devices

Device	Comments
Pacemakers	Must be removed prior to cremation
Intracardiac pacemakers	These have been cremated safely, but crematoria will have local policy
Deep brain stimulators	Must be removed prior to cremation
Spinal stimulators	Must be removed prior to cremation

© The Royal Australian College of General Practitioners 2026

must be removed by morticians prior to cremation.[4] Newer, intracardiac pacemakers are challenging to remove, and you need to consult local policy. Similarly, deep brain stimulators and spinal stimulators must be removed prior to cremation.

Recent radiation-based therapy, particularly the placement of radioactive devices to manage malignancy, pose cremation risk (Table 2). Prior to cremation, these must be deemed safe by the medical team that implanted them.

Joint replacements, cardiac valves and portacaths do not represent a cremation risk.

Certifying information

You must provide your full name, title and contact number and the date you completed the certificate. The continuum of care for the deceased individual continues beyond death. An independent doctor reviewing the decedent prior to cremation may contact you to exclude reportable deaths.

Coding the cause of death

The diagnoses recorded on the death certificate are coded against the International Classification of Diseases (ICD). This allows recording, analysis, interpretation and comparison of mortality and morbidity data.[3] The ICD reflects the language preferred for completion of the death certificate but includes illnesses that are not causes of death.[5,6]

Writing the cause of death

Part 1 of the certificate (and subparts a, b, c and d) concerns the cause of death. Part 2 concerns other significant conditions. Known significant diseases or risk factors will make an opinion straightforward. A clearly documented cause of death, with a causative chain from 1(a) downward, is required, such that anyone reading can follow the chronological sequence. Acronyms must not be used.

Never use a ‘mode’ of dying as the cause of death. This is advised on the certificate, usually italicised. Examples of ‘modes’ of dying include organ failure and cardiorespiratory arrest. These are conditions occurring in all individuals within the moments of dying. They must be ascribed causes to distinguish how they developed in the deceased person. Although many would consider ‘heart failure’ a condition to be managed, the cause of the heart ‘failure’ needs to be described, for example, ischæmic heart disease, viral myocarditis, valvular heart disease, congenital heart disease, etc. Accuracy means causes can be incorporated into datasets and influence prevention strategies.

You must advise the duration of illness as accurately as possible, particularly for conditions associated with cognitive impairment. A ‘blank’ duration of illness may call into doubt the probity of legal documents previously completed by the deceased if their capacity is questioned. If you do not know the duration of illness and cannot ascertain this, then document as follows: at least since [insert date you took over care].

Cause of death (Part 1 of the form)

Immediate cause: should be listed first at line 1(a) and is the final disease, injury or complication directly causing the death.

Underlying causes: are the conditions or events that led to this outcome. These are recorded sequentially from the most immediate cause, working backward to the originating condition (lines 1b, 1c, etc). The cause of death should then read as a causative chain of events, with the duration of illness or diagnosis running in reverse chronological order (refer to Box 1). Simply listing all of the patient’s medical conditions is unhelpful.

Other significant conditions (Part 2 of the form)

This section is for any other diseases that contributed to the death but not within the direct sequence of events leading to death. Only pertinent information relating to the cause of death is required, not unrelated aspects of the patient’s medical history. Deaths associated with cardiovascular disease could incorporate cardiovascular risk factors. Conditions that lead to systemic stress, immunosuppression or acceleration of the primary cause of death should also be recorded. A duration of illness is required.

An investigative approach

Challenges arise in the sudden death of the otherwise well patient or one who has declined investigation of their illness. The approach below is a guide to assist.

The manner of death

If, on the basis of your knowledge of your patient’s health, you are unsurprised to learn of their death, the manner may readily be considered ‘natural’.

Table 2. Examples of cremation risk: Radiation therapy and radioactive implants

Radiation therapy	
Solutions	**Comments**
Strontium-89	Injections are often used in the management of malignant bones disease (eg prostate cancer). Cremation represents a risk, and additional precautions need to be taken, particularly safe handling of cremains.
Iodine-131	Used to treat hyperthyroidism and thyroid carcinoma, available in solution and capsules. Cremation risk is highest in the first few days after treatment.
Sealed sources/Implants	**Comments**
Iodine-125	Permanently implanted to treat malignancy, these radioactive seeds are deemed safe to cremate more than a year after implantation. Earlier than this would require removal prior to cremation.
Further information	
Local information can be sought from the treatment team in hospitals (who have legislated safety requirements regarding release of deceased individuals) and radiation safety officers contactable in your state.	

© The Royal Australian College of General Practitioners 2026

Box 1. Completion of Part 1 and 2 – Example 1

PART I		CAUSE OF DEATH	Approximate interval between onset and death
Disease or condition directly leading to death	A	*Klebsiella sp. Pneumonia*	*Days*
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	B	*Immobility*	*Weeks*
	C	*Dementia (Lewy-body)*	*6 years*
	D		
	E		
PART II Other significant conditions contributing to the death but not related to the disease or condition causing it.		*Chronic obstructive pulmonary disease, cigarette smoking*	*40 years, 20 years*

Template reproduced from Australian Bureau of Statistics (ABS). Principles of death certification. ABS, 2024. Available at www.abs.gov.au/statistics/detailed-methodology-information/cause-death-certification-guide/australia/principles-death-certification, with permission from the ABS.

Box 2. Completion of Part 1 and 2 – Example 2

Scenario

Mr. Y is a man aged 67 years who has been your patient for the past 5 years. He has hypertension, which is treated with two agents; diabetes treated with metformin; and recently ceased cigarette smoking. You are called by police, who have found him deceased in his home, where he lives alone. They assure you there are no suspicious circumstances, with the house appearing secure and no evidence he has taken excess medication or had a traumatic event such as a fall. You indicate you need some time to consider and contact Mr. Y's daughter. She is relieved to hear from you, and you explain that Mr. Y's death appears nonsuspicious and that cause of death is likely a sudden cardiac event given his risk factors. She raises no other concerns, and you proceed to complete the certificate as noted below.

PART I		CAUSE OF DEATH	Approximate interval between onset and death
Disease or condition directly leading to death	A	*Sudden cardiac death*	*Immediate*
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	B	*Coronary artery disease*	*Years*
	C	*Hypertension and diabetes (medically managed)*	*Years*
	D		
	E		
PART II Other significant conditions contributing to the death but not related to the disease or condition causing it.		*Cigarette smoking (recently ceased)*	*Years*

Template reproduced from Australian Bureau of Statistics (ABS). Principles of death certification. ABS, 2024. Available at www.abs.gov.au/statistics/detailed-methodology-information/cause-death-certification-guide/australia/principles-death-certification, with permission from the ABS.

If symptoms are less clear, consider the patient's risk factors for significant diseases. Despite risk modification, management reduces, not eliminates, risks. For example, a patient with diabetes has a higher cardiovascular disease risk than the general population,[7] and atrial fibrillation may cause embolism despite anticoagulation.

Any suspicion of accident, suicide or homicide requires legal referral. If police have called you, and no information regarding misadventure exists, natural causes are more likely. Elderly individuals who die peacefully in their sleep with no significant symptoms on retiring likely succumb to sudden unheralded events such as myocardial infarction, stroke or arrhythmia.

Where significant pathology is known with insufficient evidence to define a probable cause, documenting underlying pathology is appropriate, for example 'coronary atherosclerosis' where myocardial infarction cannot be conclusively established (eg refer to Box 2).

'Probable' cause of death

Legislation in Queensland requires identifying the 'probable cause of death'. 'Balance of probabilities' is defined in case law as that which is 'more likely than not', which is the level of proof in coronial jurisdictions. The test should not be higher: even after extensive forensic autopsy and investigation, the cause of death may remain undetermined.

Discussion with other doctors and consideration of medical records

Other sources of information may assist, for example, colleagues, non-GP specialists who may have provided care and paramedics in attendance are valuable resources. Knowing that paramedics recorded a 'shockable rhythm' supports an arrhythmia as a cause of death secondary to coronary atherosclerosis.

My Health Record cannot be used when considering the cause of death. This federal repository of clinical information is controlled by the patient for the purpose of delivering healthcare to the patient. A deceased person cannot access healthcare, prohibiting doctors accessing the file.[8] Unfortunately, this potentially valuable source of clinical data is 'off limits' in consideration of cause of death.

© The Royal Australian College of General Practitioners 2026

Talking to the family

Many GPs care for whole families, and the deceased's relatives may be known to you. If determining the cause of death is challenging, it is respectful to engage with family members. This can assist with grief management and avoids surprise when the death certificate arrives. Avoid a consultative approach, state with clear intention what you plan to write, and listen carefully to any concerns or new information they may raise.

If the family believes there was a failure in care, adopt an independent mindset and consider whether the death should be reported to the coroner. The family may contact the coroner or report concerns about healthcare quality to the local authority. In most cases, the family appreciate the communication and involvement in this important medical process.

Review for accuracy and completeness

Ensure you have completed the form in full. All sections require checks or entries. Ensure patient names are spelt correctly and dates are recorded accurately. It is important to note that you cannot claim a fee for completion of a death certificate.

In part 3 of the Medical Certificate of Cause of Death series, we will consider special situations and considerations.[9]

Key points

- My Health Record cannot be used when considering cause of death.
- If you require more information or clarification of the circumstances of the death to feel comfortable completing a certificate, always contact the attending police and/or ambulance service.
- The cause of death should be as specific as possible. For malignancy, describe the known histopathological diagnosis and metastatic nature or otherwise of the disease.
- Do not list a mode of death as the cause of death unless it is followed by an underlying cause(s) as explanation.
- Do not use vague terms such as 'natural causes' or 'old age' without additional information.
- After constructing the causative chain, read through to ensure it is logically ordered.
- Avoid listing numerous conditions on a single line. On the rare occasion that two conditions contribute equally, they may be listed on the same line, but a duration must be provided for each.

Authors

Adam Griffin MBBS, MForensMed, FACLM, Senior Partner and Forensic Physician, Lucid Legal Medicine, Brisbane, Qld

Katherine Robinson MBBS, MSc, MForensMed, FACLM, Senior Partner and Forensic Physician, Lucid Legal Medicine, Brisbane, Qld

Gary Hall MBBS, MForensMed, FACLM, Senior Partner and Senior Forensic Physician, Lucid Legal Medicine, Brisbane, Qld

Michaela Kelly BMedSc, MBBS, FRACGP, GCHEd, MClinEd, AICGG, Associate Professor, General Practice Clinical Unit, The University of Queensland, Brisbane, Qld

Competing interests: AG and KR receive honoraria for teaching in medicolegal medicine from the Australasian College of Legal medicine. GH and MK have no competing interests.

Funding: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript.

Correspondence to:
m.kelly4@uq.edu.au

References

1. Griffin A, Robinson K, Hall G, Kelly M. Our duty of care extends beyond death. Aust J Gen Pract 2026;55(4):167–68.
2. Griffin A, Robinson K, Hall G, Kelly M. The Medical Certificate of Cause of Death: Introduction and the decision to complete. Aust J Gen Pract 2026;55(4):233–37.
3. World Health Organization (WHO). ICD-11 Reference Guide: The international form of Medical Certificate of Cause of Death. WHO, 2022. Available at https://icdcdn.who.int/icd11referenceguide/en/html/index.html#data-source-the-international-form-of-medical-certificate-of-cause-of-death-mccd [Accessed 17 September 2025].
4. Maher T, Kong N, Spray R, et al. Safety and behavior of implantable electronic devices during cremation. Heart Rhythm 2025;22(4):1073–79. doi: 10.1016/j.hrthm.2024.08.031.
5. World Health Organization (WHO). International statistical classification of diseases and related health problems (ICD). WHO, 2022. Available at www.who.int/standards/classifications/classification-of-diseases [Accessed 17 September 2025].
6. World Health Organization (WHO). ICD-11 for Mortality and Morbidity Statistics. WHO, 2025. Available at https://icd.who.int/browse/2025-01/mms/en [Accessed 17 September 2025].
7. de Jong M, Woodward M, Peters SAE. Diabetes, glycated hemoglobin, and the risk of myocardial infarction in women and men: A prospective cohort study of the UK Biobank. Diabetes Care 2020;43(9):2050–59. doi: 10.2337/dc19-2363.
8. Commonwealth of Australia. My Health Records Act 2012, No. 63. Commonwealth of Australia, 2012.
9. Griffin A, Robinson K, Hall G, Kelly M, in press. The Medical Certificate of Cause of Death: Special situations and considerations. Aust J Gen Pract.

correspondence **ajgp@racgp.org.au**

© The Royal Australian College of General Practitioners 2026