Medical certification of cause of death (MCCOD): Rapid assessment tool

This form contains a set of simple questions for checking common errors to assess the cause of death certification practices. The assessors of the death certificates are required to go through the eight questions and verify whether there are any of the mentioned errors in the certificate completed by the certifier.

For further assistance in the use of this tool, please refer to: '*Assessing the quality of death certificates: Guidance for the rapid tool*' (the University of Melbourne) available at https://crvsgateway.info/

General Instructions

Age at death	Age of the deceased at death. Remember to include units (hours, days, months, years). Insert 'not recorded' if unknown.
Sex of the deceased	Male or female. Insert 'not recorded' if unknown.
Country	Relates to the country where the death was certified.
Hospital/health area	Name of hospital (or health facility) where the certificate was completed.
Place of death	For example, hospital, other health facility, home, or other. Insert 'not recorded' if unknown.
Certifier	For example, hospital or community physician, or other. Insert 'not recorded' if unknown.
Trained certifier	(Optional) Yes or no. Insert 'unknown' if the training status of the certifier is unknown.
Date of certification	Write the date the certificate was completed (DD/MM/YYYY). Insert 'not recorded' if unknown or blank.
Error types	Detailed instructions on how to assess the quality of the death certificate against each error type are provided in the document 'Assessing the quality of death certificates: Guidance for the rapid tool'.

MCCOD rapid assessment tool

General details about the deceased

Age at death:	
Sex of the deceased:	

Death certificate details

Country:	
Hospital/health area:	
Place of death:	
Certifier:	
Trained certifier:	
Date of certification:	

A correctly filled-in death certificate has none of the following errors

Did the certificate have:

Error type	Yes	No	Not assessed due to illegible handwriting
1. Multiple causes of death recorded in any of the lines of part 1			
2. Missing time interval from onset to death in any of the lines			
3. Abbreviations used in the entries in any of the lines			
4. Illegible hand writing in any of the lines			
5. Incorrect or clinically improbably chain of events leading to death in part 1			
6. Impossible underlying cause entered in the lowest used line of part 1*			
7. (a) Was the death due to an accident, violence, poisoning or other external cause?			
7. (b) For deaths due to external causes, i.e. accident/violence/ poisoning, were the circumstances missing? (details of the accident or violence including intent and activity [e.g. pedestrian knocked down by a car, assaulted with a knife] and place of occurrence)			
8. (a) Was the death due to a neoplasm?			
8. (b) For deaths due to neoplasms, additional details were missing (site, morphology, behavior)			

* Impossible underlying causes:
 a. Symptoms or signs (e.g. fever, backache, headache, enlarged liver etc.)
 b. Intermediate causes (e.g. septicaemia, secondary hypertension, pneumonitis, pathological fracture)
 c. Modes of dying (e.g. cardiac arrest, respiratory arrest, organ failure)
 d. Unspecified causes within a larger death category (e.g. cardiovascular disease, congenital anomaly etc.)

If two or more causes are reported in the lowest used line, and each condition is separated by a space, comma or a similar punctuation, consider the first condition as underlying. If two or more causes are reported on the lowest used line and the conditions are reported as 'due to', 'secondary to', 'as a consequence of' or a term having similar meaning, consider the last condition as underlying.

The program partners on this initiative include: The University of Melbourne, Australia; CDC Foundation, USA; Vital Strategies, USA; Johns Hopkins Bloomberg School of Public Health, USA; World Health Organization, Switzerland.

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