

# mRNA INJECTIONS & CANCER Part 2.1

**Is there a statistical correlation on a specific timeline between U.S. mRNA injection rates and cancer rates?**



**Bridging the data with the ICD-10 Coding Manual**



# **mRNA INJECTIONS & CANCER**

**CDC, WHO, ICD-10 Annex**

# mRNA INJECTIONS & CANCER

**CDC, WHO, ICD-10 Annex**

**The following is a detailed analysis of how the CDC is in complete alignment with the WHO, which is a direct proxy for China, relative to ICD-10 coding and COVID-19 and mRNA injection causation/correlation.**

**This is old work derived from the journalistic side of Edify Research & Consulting found at Political Moonshine [[www.politicalmoonshine.com](http://www.politicalmoonshine.com)]**

## mRNA INJECTIONS & CANCER

### Analysis

**The following analysis dates back to early October 2021 and it details one primary data harvesting and data obfuscation mechanism: THE ICD-10 CODING MANUAL**

**This analysis is critical because it represents the hierarchical diagnostic sequencing process that permits the federally funded and incentivized COVID-19 diagnosis to supersede all other diagnoses.**

**This analysis is critical because it represents the mechanism by which the criminal enterprise is obfuscating and suppressing cancer rates data.**

**Dr. Paul Alexander's findings respective to The Ethical Skeptic's data comport with our findings.**

**The following graphics are highly complex and can be consumed within the explanatory articles by accessing these links:**

**[It All Starts With a Code...](#)**

**[It All Starts With a Code: Part 2 – The ICDM-10 Coding Manual Mapped for COVID-19](#)**

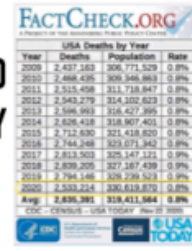


# ENTERPRISE FRAUD

1. The **PROBLEMATIC DATA POINT** of accurate mortality data causes a spiral of problems/solutions problematic to the construct.

## THE PROBLEMATIC DATA POINT

2020 MORTALITY



2. The construct features a **CLOSED LOOP PROPAGATION** system with redundant control mechanisms [like the data drivers.]

## CLOSED LOOP PROPAGATION



3. The construct design layers, compartmentalizes and disaggregates culpability so that **FEDERALISM ENFORCES** [state, county, local] it beginning with gubernatorial mandates predicated on federal guidelines.

## FEDERALISM ENFORCES



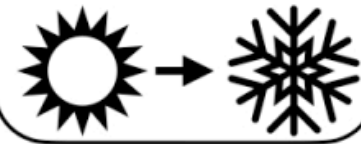
4. The construct has an apple:apples **COMORBIDITY HARVESTING** feature of seasonally available data reservoirs [flu/pneumo] to propagate as COVID-19.

## COMORBIDITY HARVESTING



5. Comorbidity harvesting necessitates a **SEASONAL DRAG-THROUGH** capacity to circumvent seasonal die-offs and bridge the construct from annual peak flu to annual peak flu.

## SEASONAL DRAG-THROUGH



6. The **DATA DRIVERS & DRAG-THROUGH** requirements are met with 1-NVSS diagnostic guidance, 2-PCR diagnostic testing and 3-ICD-10 coding [“variants” factor in.]

## DATA DRIVERS & DRAG-THROUGH



7. Comorbidity harvesting is conflicted by accurate mortality data requiring harvested sole-cause COVID-19 mortality data to undergo annual **BULK DATA REVISIONS** for reconciliation.

## BULK DATA REVISIONS

Before Revision	24 Aug 20 Revision	PROBLEMATIC BULK DATA REVISIONS	Before Revision	12 May 21 Revision
0%	94%	Invalid Data	0%	95%
100%	6%	Valid Data	100%	5%
0	2.6	Average Underlying	0	4.0

8. **POISONOUS MANDATES** [federalism] occur because they are predicated by enterprise fraud. Fraud vitiates everything [Throckmorton, USSC.]

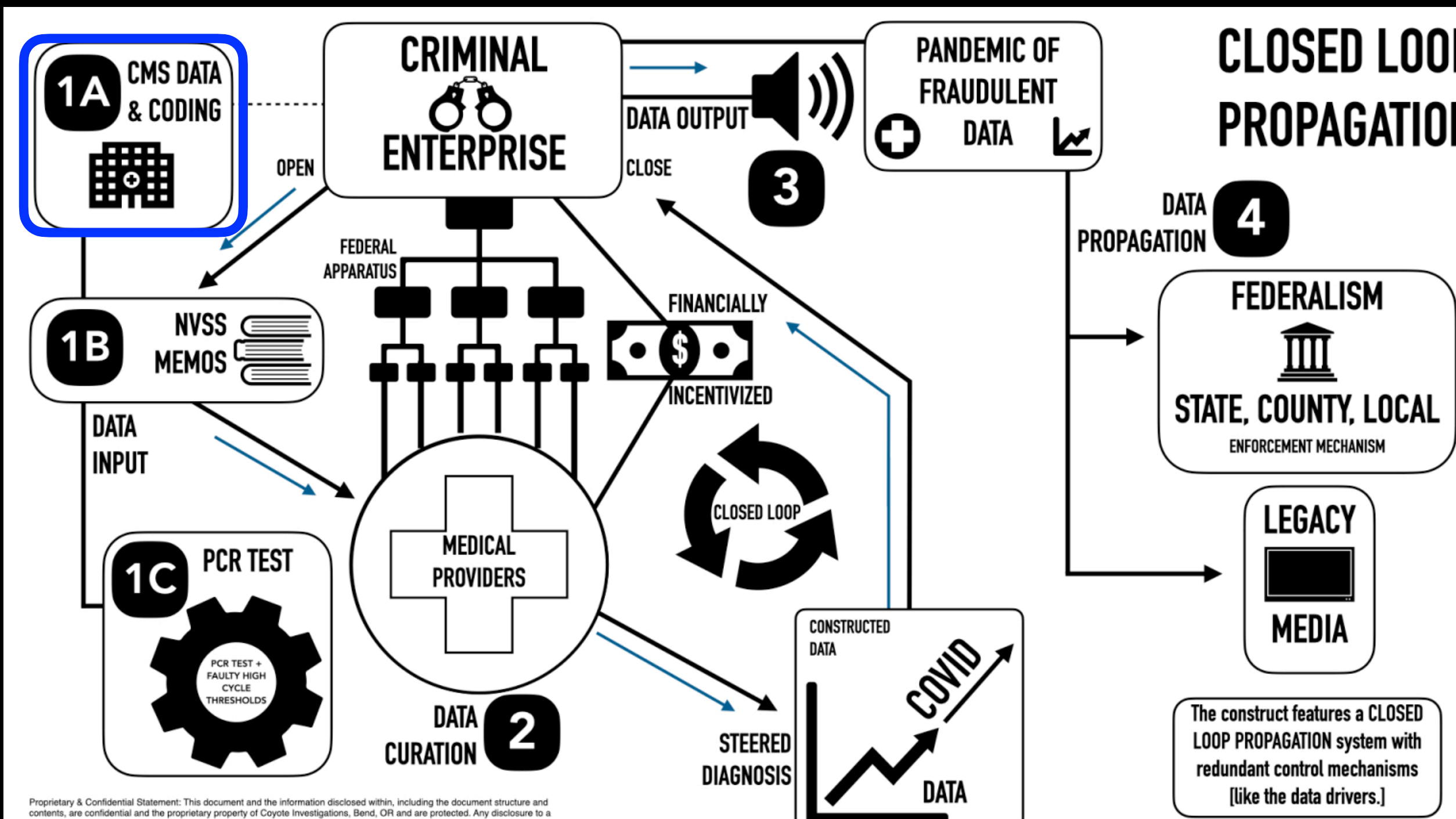
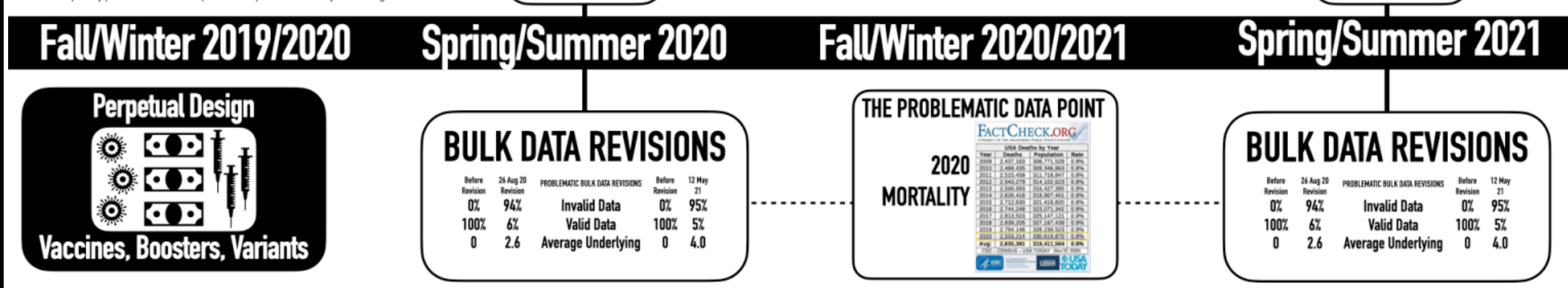
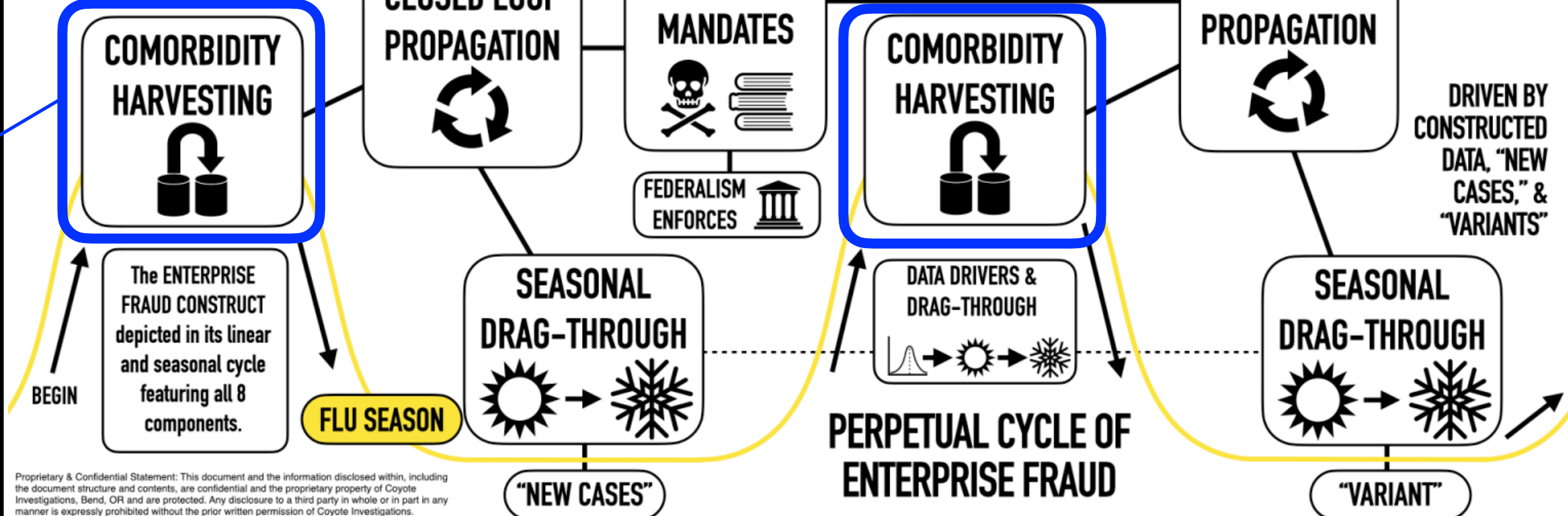
## POISONOUS MANDATES



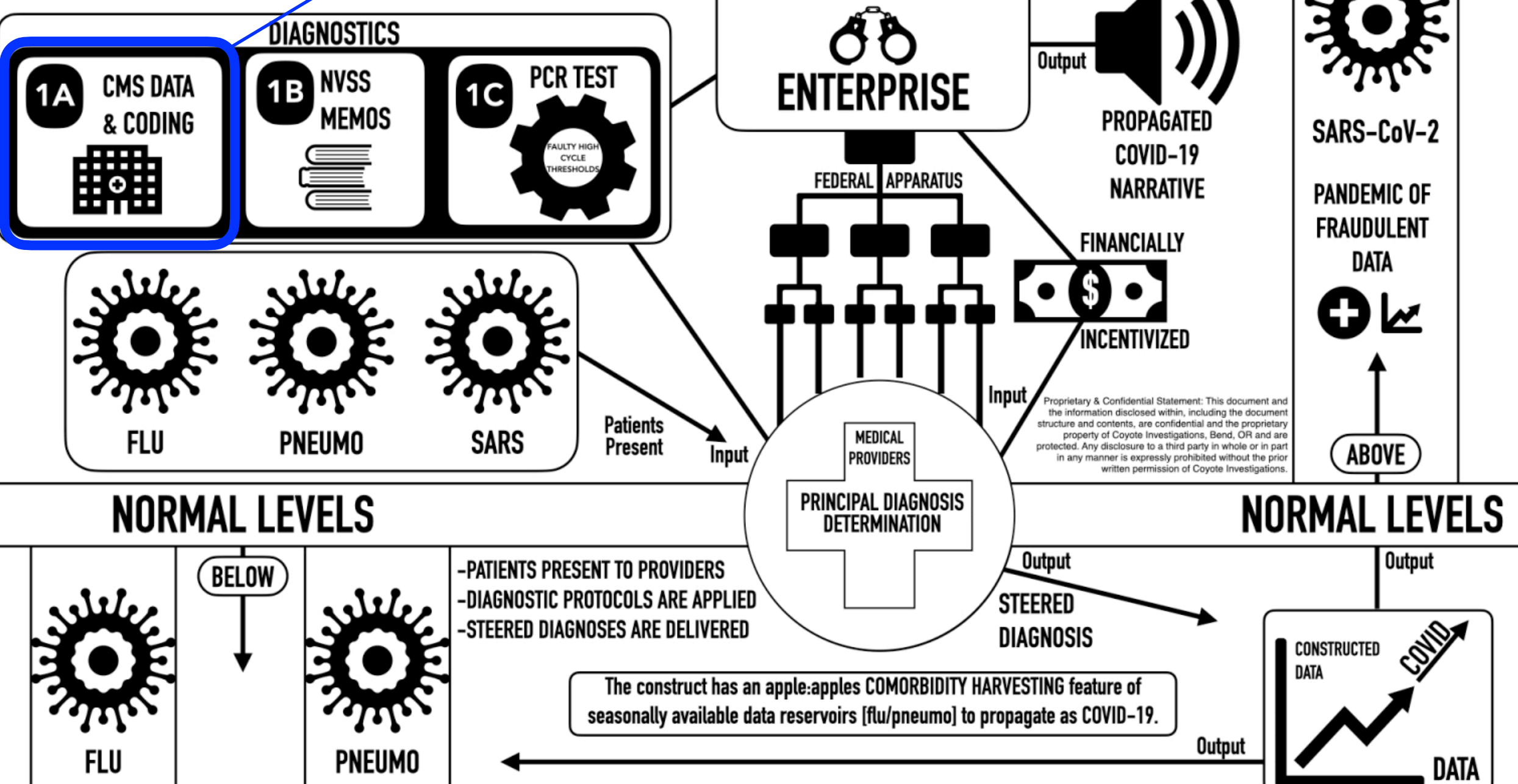
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# 8 CONCEPTS FOR RICO

# THE CONSTRUCT



# COMORBIDITY HARVESTING



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**mRNA INJECTIONS & CANCER**  
**Analysis**

**The following analysis and images may be consumed with this explanatory article:**

**[It All Starts With a Code...](#)**

**mRNA INJECTIONS & CANCER**

**4 / Analysis**

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# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

As we attempt to better understand the CDC's complex and intricate COVID-19 data sets, it's important to review some basic context about them noting **existing** positions that question the apparent compartmentalization of COVID-19 data in 37 "selected hospitals" that remain unidentified and receive competitive discretionary funding [in exchange for their data?].



## Data Sources

Information about COVID-19 cases comes from the following three key sources:



### Aggregate Count Data

**Description:** Aggregate count data provide case and death totals, reported through 60 U.S.-affiliated jurisdictions: the state and county level. Aggregate counts can be compiled quickly, and they are the most current. (Read on for more about reporting jurisdictions.)

**Source:** CDC collects this information through a robust process that includes a review of jurisdictional websites. Public health jurisdictions also report and validate data as part of the process.

**Where to find it:** CDC shares aggregate counts in [COVID Data Tracker](#).

## "ABOUT CDC COVID-19 DATA"

**RICO: LAYERED, INCONSISTENT, BACKEND REVISIONS, REDUNDANCY, COMPARTMENTALIZED, DISAGGREGATED, DUPLICATION, SETS & SUBSETS**

### Aggregate Count Data:

- 60 jurisdictional hospitals
- Leverages federalism
- Becomes further cleaved/compartmentalized



### Patient-Level Data

**Description:** Patient-level data, which are also known as line-level data, provide information for each COVID-19 case. Patients are never identified, but important information such as age, race, and ethnicity is often included. Reporting can lag because the information is detailed, and can take longer to collect.

**Source:** Line-level data is based on reporting from states, territories, and other jurisdictions.

**Where to find it:** CDC shares line-level data in [COVID Data Tracker](#), as well as in [patient-level data sets](#) that are made available to the public for research.

### Patient Level Data:

- Lags in data collection process
- "Can take longer to collect"
- Layered DELAY STRATEGY/RICO



### Death Counts

**Description:** Information about deaths from COVID-19.

**Source:** Death certificates provide the most accurate counts, but, the data collection process takes longer. Due to the lag time, numbers can initially be lower than in other published sources.

**Where to find it:** CDC's National Center for Health Statistics (NCHS) provides mortality data through [provisional death counts](#).

### Death Counts:

- "Most accurate"
- Lags in data collection process
- "Data collection process takes longer"
- Evidenced backend revisions
- Layered DELAY STRATEGY/RICO

## COVID-19 Data from Selected Hospitals

The National Hospital Care Survey (NHCS) collects data on patient care in hospital-based settings to describe patterns of health care delivery and utilization in the United States. Settings currently include inpatient and emergency departments (ED). Additionally, the NHCS contributes data that may inform public health emergencies as the survey is designed to capture emerging diseases and viruses that require hospitalizations, including COVID-19 encounters. The 2020 and 2021 NHCS are not yet fully operational so it is important to note that these data are not nationally representative.

The data are from 37 hospitals submitting inpatient and 37 hospitals submitting ED Uniform Bill (UB)-04 administrative claims from March 18, 2020–March 30, 2021. Even though the data are not nationally representative, they can provide insight on the impact of COVID-19 on various types of hospitals throughout the country. This information is not available in other hospital reporting systems. The NHCS data from these hospitals can show results by a combination of indicators related to COVID-19, such as length of inpatient stay, in-hospital mortality, comorbidities, and intubation or ventilator use. NHCS data allow for reporting on patient conditions and treatments within the hospital over time.



## COVID-19 Hospital Encounters by Urban-rural Location of the Hospital by Week From Selected Hospitals

COVID-19 Hospital Data

The National Hospital Care Survey (NHCS), conducted by the National Center for Health Statistics (NCHS), collects data on patient care in hospital-based settings to describe patterns of health care delivery and utilization in the United States. Settings currently include inpatient facilities and emergency departments (ED). The survey collects electronic data, Uniform Bill (UB-04) administrative claims or electronic health records, for all encounters in a calendar year from a nationally representative sample of 608 hospitals. Information collected includes diagnoses, procedures, demographics, discharge status, and patient identifiers (e.g., name and date of birth). Eligible hospitals are in the 50 states and the District of Columbia and include noninstitutional and nonfederal hospitals with six or more staffed inpatient beds. Hospitals are currently being received into the survey.

NHCS results provided on COVID-19 hospital use are from UB-04 administrative claims data from March 18, 2020 through March 30, 2021 from 37 hospitals that submitted inpatient data and 37 hospitals that submitted ED data. The data used in these figures are considered preliminary, and the results may change with subsequent releases. There will be updates every two months to the data file for the remaining months in 2021. The data are not nationally representative. Even though the data are not nationally representative, they can provide insight on the impact of COVID-19 on various types of hospitals throughout the country.

Results on this page show the percentage of confirmed COVID-19 encounters over time among all ED or inpatient encounters, by urban-rural location of the hospital. Data are presented for each setting (inpatient and ED), by week.

- A confirmed COVID-19 hospital encounter is defined as an any listed *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) diagnosis code of B97.29 and/or U07.1. Prior to April 1, 2020, CDC guidance stated to code a confirmed COVID-19 hospital encounter as B97.29. On April 1, 2020, the guidance changed to code confirmed COVID-19 hospital encounters as U07.1.
- The hospital urban-rural classification is based on the [NCHS urban-rural classification scheme for counties](#). There are three categories of urban-rural shown in the figure:
  - Large central and fringe metropolitan areas: Metropolitan statistical area (MSA) with a population of 1 million or more people.
  - Medium and small metropolitan areas: MSA with a population less than 1 million people.
  - Rural areas: Micropolitan (urban clusters with a population of at least 10,000 but less than 50,000) and noncore (everything else considered non-micropolitan) areas.

COVID-19 Hospital Data
<a href="#">COVID-19 hospital encounters by week</a>
<a href="#">COVID-19 in hospitals by urban-rural location of the hospital by week</a>
<a href="#">COVID-19 screenings at hospitals by week</a>
<a href="#">Intubation or ventilator use in the hospital among confirmed COVID-19 inpatient admissions by week</a>
<a href="#">In-hospital mortality among hospital confirmed COVID-19 encounters by week</a>
<a href="#">Co-occurrence of other respiratory illnesses for hospital confirmed COVID-19 encounters by week</a>



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Note the significance of the mid-April shift and expanded testing respective to expanded cases [by design].

## Reported Cases and Deaths by Country or Territory

The coronavirus COVID-19 is affecting 221 countries and territories. The day is reset after midnight GMT+0. The list of countries and their regional classification is based on the United Nations Geoscheme.

Sources are provided under "Latest News." [Learn more about Worldometer's COVID-19 data](#)



[Report coronavirus cases](#)



**#1 / US**  
**#109/China**  
**Statistical outlier**

COVID-19 CORONAVIRUS PANDEMIC

Last updated: September 20, 2021, 00:06 GMT

MAIN WEEKLY TRENDS  
Now Yesterday 2 Days Ago

All Europe North America Asia South America Africa Oceania

#	Country, Other	Total Cases	New Cases	Total Deaths	New Deaths	Total Recovered	New Recovered	Active Cases	Serious, Critical	Tot Cases/ 1M pop	Deaths/ 1M pop	Total Tests	Tests/ 1M pop	Population
	World	229,260,563	+349,955	4,704,927	+5,708	205,879,944	+380,088	18,675,692	99,210	29,412	603.6			
1	<b>USA</b>	42,900,813	+32,638	691,878	<b>+309</b>	32,503,536	<b>+20,310</b>	9,795,999	94,495	199,694	2,075	619,818,780	1,859,290	333,363,103
2	India	33,477,819	+30,809	445,165	<b>+296</b>	32,707,589	<b>+43,238</b>				319	552,340,168	395,519	1,396,494,481
3	Brazil	21,239,783	+9,458	590,786	<b>+239</b>	20,280,294					2,756	57,282,520	267,180	214,396,589
108	El Salvador	99,701		3,102	<b>+12</b>	89,326	<b>+5,984</b>				475	1,250,900	191,679	6,526,010
109	<b>China</b>	95,689	+66	4,636		90,126	<b>+52</b>				3	160,000,000	111,163	1,439,323,776
110	Rwanda	95,257	+140	1,210	<b>+4</b>	45,430	<b>+1</b>				91	2,684,809	201,239	13,341,422

1:109 - Lies outside of statistical probability



China influences the world through its proxies & it uses them to control one another. With Rothschild & Globalist entanglements, China itself is a proxy that also has a Deep State. Below is empirical evidence of China leveraging its WHO proxy to control its US proxy achieved with the installation of the Biden regime via COVID-19 [act of war (SARS-CoV-2)]. Legacy media [Chinese ownership or influence] is the reinforcement mechanism deeply sown into the contemporary American fabric. This enterprise fraud evidence [1:109] is another inverse relationship & statistical outlier. It translates to China continuing to drive the US into the ground while expanding to fill the voids caused by its forced US retraction. Evidence of a bio-WMD release has us at war since October 2019. The objective is to displace the US as the world's preeminent economic, political & military superpower. China is adhering to doctrine and leveraging compromised Americans to effectively achieve its economic, political & military objectives.

The more you look for something, the more you find it



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

The merger we're examining establishes a lane for China to steer internal US COVID-19 data and at the same time it establishes correlation in the two CDC data sets being used here. Our primary focus will become the Tables 1 & 3 data with 3 appearing in-part here at the bottom right.

**COVID-19 Mortality Overview**  
Provisional Death Counts for Coronavirus Disease 2019 (COVID-19)

**Contents**

- COVID-19 Mortality Overview
- Health Disparities
- Daily Updates of Totals by Week and State
- Excess Deaths Associated with COVID-19
- Weekly Updates by Select Demographic and Geographic Characteristics
- Index of Available Data Files
- Technical Notes

In response to the COVID-19 pandemic, NCHS is releasing provisional death data from the National Vital Statistics System (NVSS) on a [daily](#) and [weekly](#) basis. These data come directly from death certificates filed at the state and local level, and feature counts of COVID-19-related deaths by age, gender, race and Hispanic origin, place of death, and include information on other health conditions and comorbidities involved in these deaths. Estimates on excess deaths - the number of deaths exceeding the normal average total of deaths in recent years - are also included. The statistical summary below is updated weekly (usually on Wednesday), and includes links to corresponding data tables on the NCHS COVID-19 data page.

**Weekly Summary on COVID-19 Deaths**

NOTE: Due to delayed reporting of death certificates, this count is incomplete and less than counts from other sources besides NCHS. The result is a lag in the count totals of a few weeks, and as more data are received, these totals will likely equal or exceed counts reported by other sources through the same week.

**Deaths Attributed to COVID-19 on Death Certificates**

Data as of 9/29/2021

Total	2021	2020
687,172		

In at least 90% of these deaths, COVID-19 was listed as the underlying cause of death. For the remaining deaths, COVID-19 was listed as a contributing cause of death.

**Weekly Highs and Lows of COVID-19 Deaths**

Most Current 7-day period, week ending 9/29/2021	Highest Weekly Number of Deaths, week ending 9/29/2021	Lowest Weekly Number of Deaths, week ending 9/29/2021
2,530	25,953	1,500

**Place of Death**

Home or other place of residence	Healthcare facility
66.9% (459,483 deaths)	17.1% (117,255 deaths)

**Death by Age Group**

U.S. and older age group	45-64 age group	Under 45 age group
76.9% (528,246 deaths)	19.6% (134,647 deaths)	3.5% (24,279 deaths)

**Percentage of COVID-19 Deaths by Race & Hispanic Origin**

Non-Hispanic White	Hispanic	Non-Hispanic Black
62% (422,531 deaths)	18% (122,940 deaths)	15% (103,727 deaths)
4% (24,511 deaths)	1% (7,545 deaths)	0.2% (1,446 deaths)

**Most Frequently Listed Comorbidities with COVID-19 Deaths**

Influenza & Pneumonia	Hypertension	Diabetes
47.5% (323,962 deaths)	19.2% (131,037 deaths)	15.7% (107,171 deaths)
12.2% (83,241 deaths)	9.7% (66,114 deaths)	

**Total Excess Deaths**

Total Excess Deaths from 2/1/2020 to 9/18/2021
785,160

**Demonstrating data correlation**

**Reflects data being reported ["narrative"]**

**Reflects data respective to co-morbidities**

**Once "unskewed," 2020/2021 flu seasons revert to statistically unremarkable & far from "pandemic" standards [enterprise fraud/RICO]**



**681,927 as of 26 Sep 21**

## FOUNDATION: CHINA STEERING U.S. INTERNAL COVID DATA

**687,172 Deaths Attributed to COVID-19 on Death Certificates as of 25 Sep 21**

**Critical: How this data is determined & whose policies determine it**

Data as of 9/29/2021	Total	2021	2020
Deaths through week ending 9/25/2021	687,172		

In at least 90% of these deaths, COVID-19 was listed as the underlying cause of death. For the remaining deaths, COVID-19 was listed as a contributing cause of death.

**Guidance for Certifying Deaths Due to Coronavirus Disease 2019 (COVID-19)**

**Key Points**

- A COVID-19 is determined to be a cause of death, it should be reported on the death certificate.
- When reporting COVID-19 as a cause of death, use standard word terminology, such as "Coronavirus Disease 2019" or "COVID-19."
- Report pre-existing conditions that contributed to the death on Part 2 of the death certificate.

[Read Full Reporting Guidelines](#)

**INTERNATIONAL GUIDANCE FOR CERTIFICATION AND CLASSIFICATION CODING OF COVID-19 AS CAUSE OF DEATH**

World Health Organization

**Biography**

Dr. Tedros Adhanom Ghebreyesus

Dr. T. A. Ghebreyesus

### Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.**

**Data as of: 9/26/2021**

State	Attribute	Condition Group	Condition																	
United States	COVID-19 Deaths	All	COVID-19																	
Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]		All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years									
2020/2021	COVID-19	681,927	1,743	6,197	15,735	40,331	92,676	153,131	181,461	190,642	U									

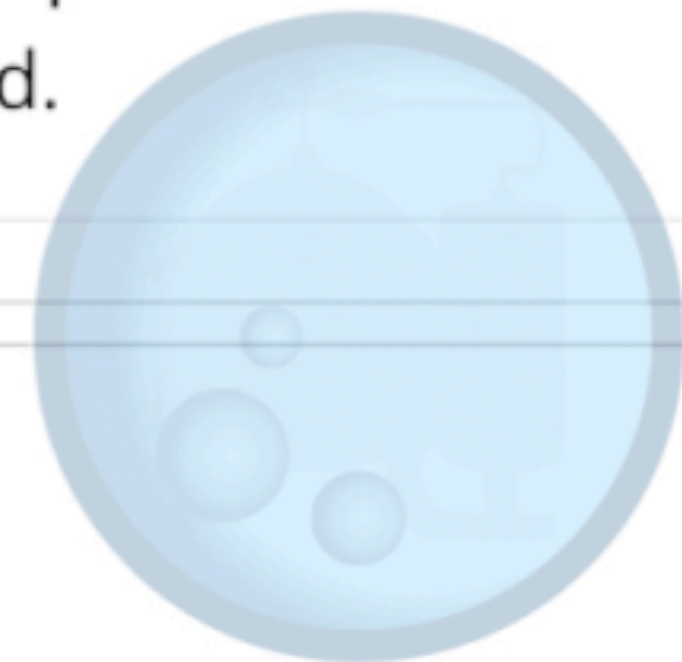


# Excess deaths

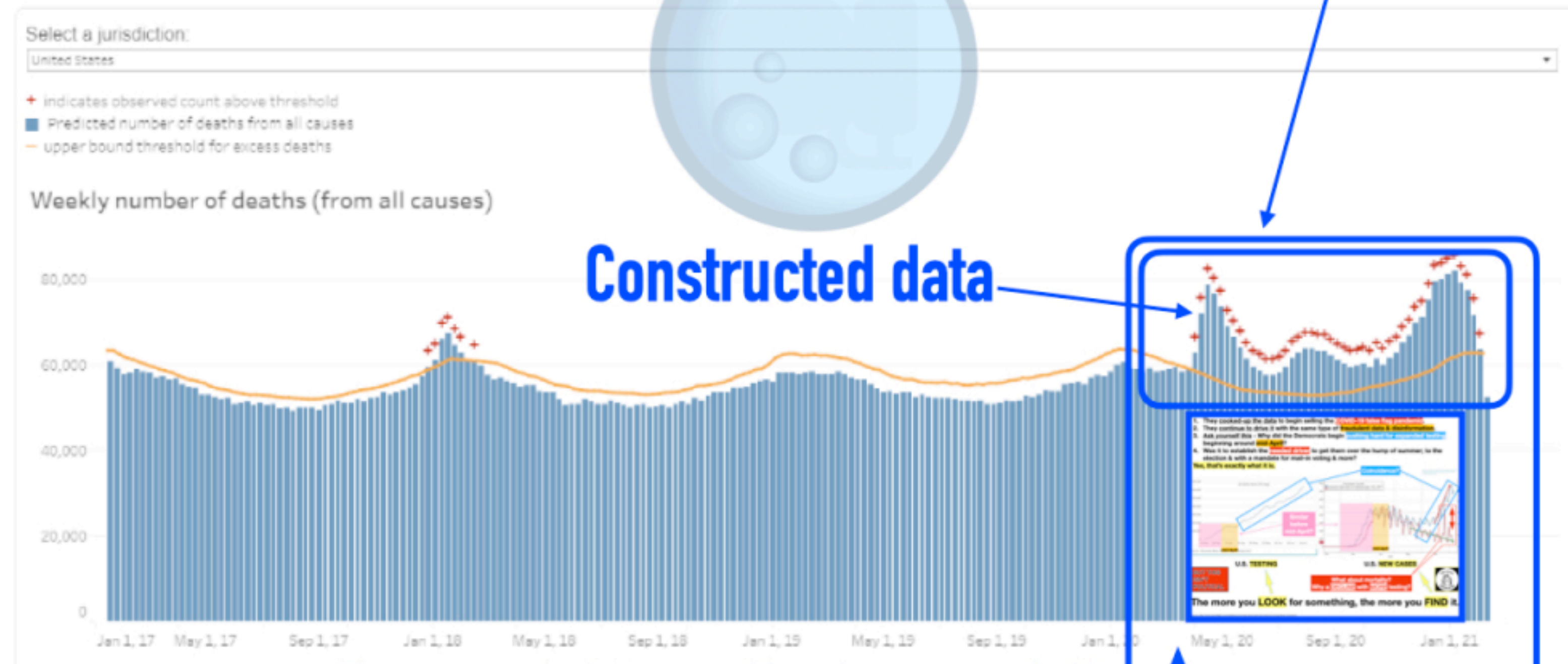
See the [NCHS Excess Deaths Data Visualization](#).

This data visualization presents data on weekly counts of all-cause mortality by jurisdiction of occurrence. Counts of deaths in the most recent weeks are compared with historical trends to determine whether the number of deaths in recent weeks is significantly higher than expected.

## MID-APRIL SHIFT: WHO/CDC moves benchmark measurement from declining mortality data to fictional "news cases" data as driven by RT-PCR testing [cycle thresholds]



### Co-morbidities harvested



The more you look for something, the more you find it

Deaths Attributed to COVID-19 on Death Certificates

Date as of	Total	2020	2019
6/15/2021	687,172		

In at least 90% of these deaths, COVID-19 was listed as the underlying cause of death. For the remaining deaths, COVID-19 was listed as a contributing cause of death.

1. Deaths for 2020 remain below the conventional threshold until 01 May 20 - 01 Jan 21
2. PCR testing/high cycle thresholds & "new cases" occur mid-April [shift from benchmark of mortality data]
3. Deaths surpassing threshold constructed with fraudulent data
4. NVSS diagnostic memos leverage "new cases" as driven by faulty-by-design RT-PCR tests to steer diagnoses to COVID



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

## THE DATA: CAUSE OF DEATH & DEATH CERTIFICATES

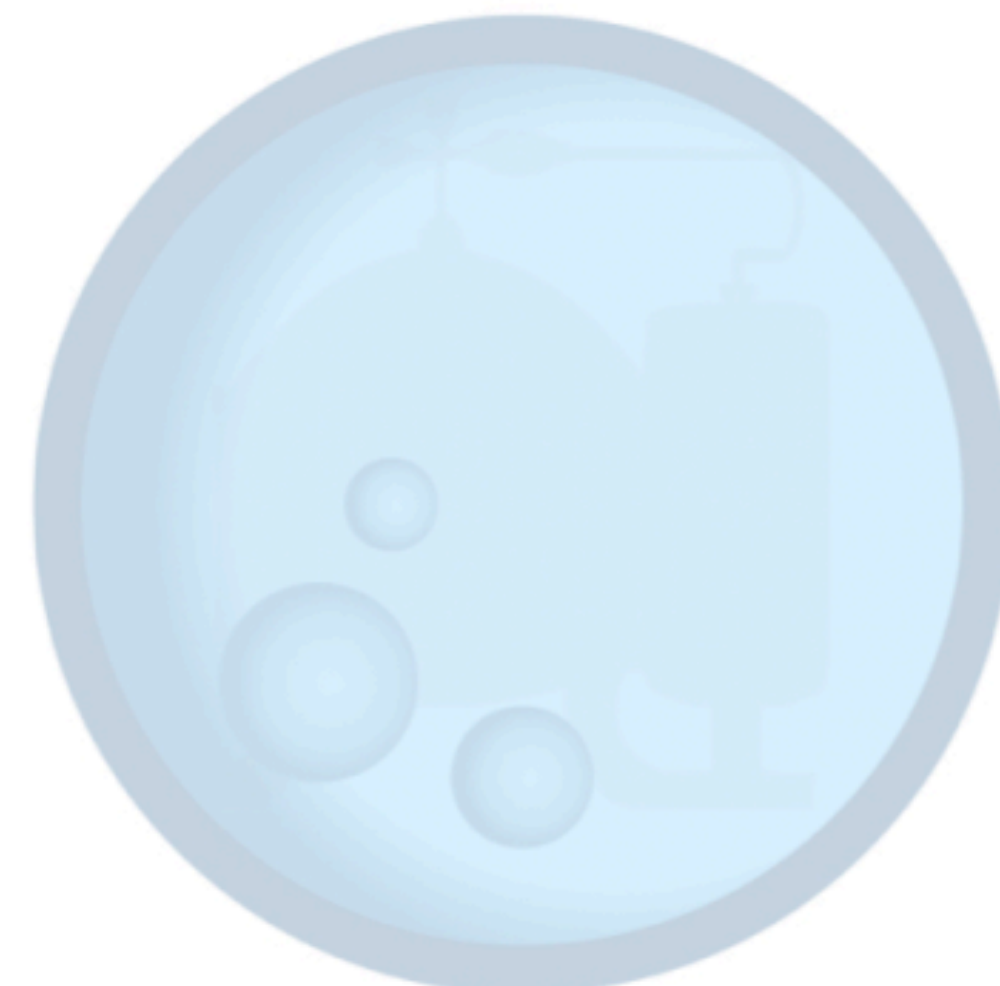
**5-8 WEEK ROLLING FRAUD PORTAL** Cause of death certified at local level by death certificate [federalism]

**INEXACT, FRAUD PORTAL** Certifier uses “best medical judgement”

**“A CAUSE” V. THE CAUSE** “COVID-19 is reported as a cause on the death certificate it is coded and counted as a death due to COVID-19 death”

Fraudulent “emergency” predication is by design “challenging”

The data is by design layered, compartmentalized, disaggregated, redundant, double-counted, revised away, etc. to obfuscate it from presenting as valid data indicating explicitly that there is no pandemic except by an evidenced & demonstrable construct of ENTERPRISE FRAUD



This mechanism rolls in time with a 5-8 week effective window [the CDC defines peak flu as an 8-week window beginning every 01 Dec] beginning on the initial issuance of each death certificate. This means that at the individual death certificate level and for an undetermined amount of death certificates [95% of them?] for 5-8 weeks the provisional death data could be incorrect. There are two evidenced bulk data revisions for sole-cause COVID-19 mortality data: 26 Aug 20 [94%] and 12 May 21 [95%.]

### Understanding Death Data Quality: Cause of Death from Death Certificates

Death certificates are a powerful tool for understanding how and why people die. Cause-of-death information is valuable to families and to public health – and getting it right matters.

#### How Death Certificates Work

When a person dies, the cause of death is determined by the certifier – the physician, medical examiner, or coroner who reports it on the death certificate. States register all death certificates and send them to the National Center for Health Statistics, where they are used to produce the nation’s official death statistics.

Certifiers are asked to use their best medical judgment based on the available information and their expertise. When a definitive diagnosis cannot be made, but the circumstances are compelling within a reasonable degree of certainty, certifiers may include the terms “probable” or “presumed” in the cause-of-death statement.

#### Cause of Death and COVID-19

When COVID-19 is reported as a cause of death on the death certificate, it is coded and counted as a death due to COVID-19. COVID-19 should not be reported on the death certificate if it did not cause or contribute to the death.

#### Things to Know About Cause-of-Death Data Quality

Getting high quality cause-of-death information can be challenging, especially during emergencies. Certifiers may be faced with heavy workloads, may not have access to complete information about the death, or may not be well trained in how to prepare good quality cause-of-death statements.

The quality of cause-of-death data depends on death certificates being complete and accurate.

- **Complete** means describing a clear chain of events from the immediate to the underlying cause of death, reporting any other conditions that contributed to death, and providing information that is specific.
- **Accurate** means reporting the correct conditions as causes of death.

Cause-of-death information is not perfect, but it is very useful. Current estimates are that about 20-30% of death certificates have issues with completeness. This does not mean they are inaccurate. However, higher quality information can give us an even better picture of what is happening.

#### Making Death Certificate Data Better

We are always working towards 100% completeness and accuracy of death certificates.

- We monitor the quality of the data with ongoing review of death certificates as they are received and by following up with state vital records offices to verify and correct inaccuracies.
- We provide trainings and tools to help certifiers, such as online courses to [improve cause-of-death reporting](#) and a [Cause of Death mobile app](#).
- We offer [death certificate reporting guidance](#) – and tailor advice to specific topics like [COVID-19](#) – to help certifiers better complete the cause-of-death section on the death certificate.

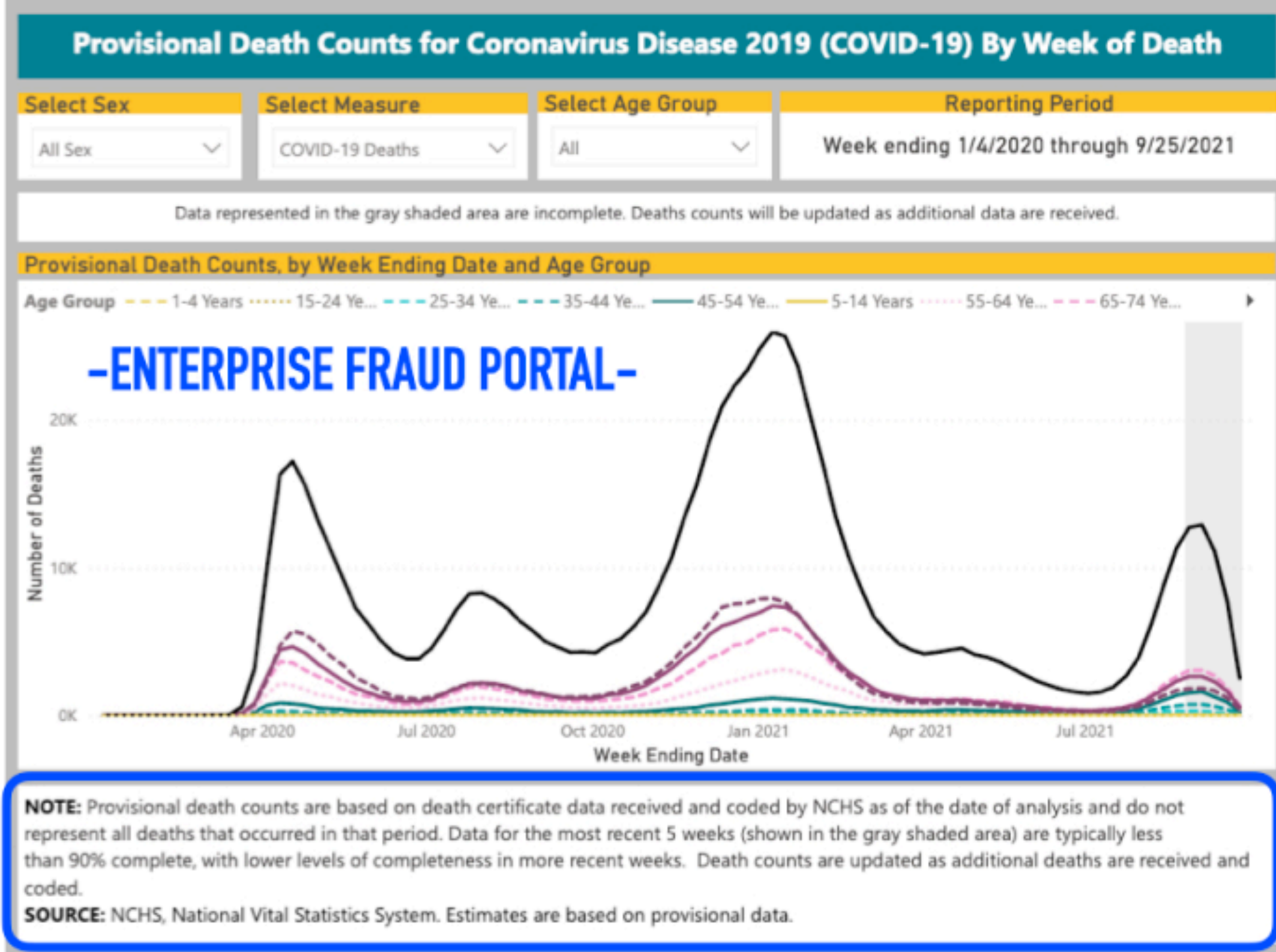


Centers for Disease Control and Prevention  
National Center for Health Statistics



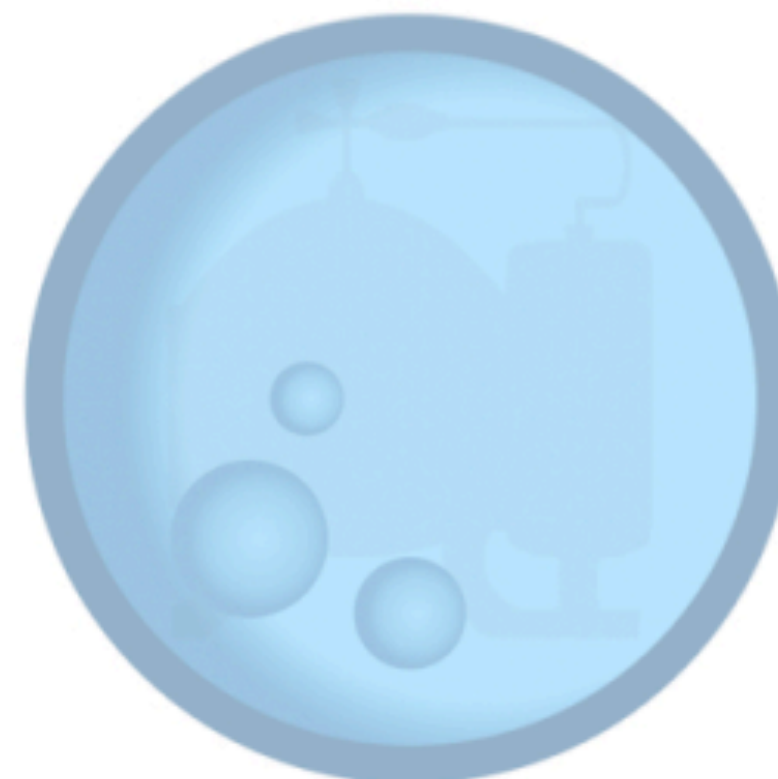
# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

ICD-10 Code U07.1 derives from the WHO. It's the emergency coding system established by the WHO that permits fraudulent data manipulation by means of death certificate issuance and provisional death counts that create massive portals for enterprise fraud in the 5-8 week rolling window.



**ROLLING 5-8 WEEK WINDOW OF PROVISIONAL DATA WITH BACK-END REVISION / CDC bulk data revisions on 26 Aug 20 & 12 May 21 apply / Evidenced RICO pattern: data drivers construct data, data is propagated in a closed-loop, data is revised away on an inconsequential backend.**

Provisional Death Counts Sourced as a data subset in Table 1 as with Table 3



## HOW IT WORKS

CODING DEATHS U07.1

"PROBABLE" "PRESUMED" U07.1/RICO

RICO PATTERN: DELAY STRATEGIES

## Understanding the Numbers: Provisional Death Counts and COVID-19

Provisional death counts deliver the most comprehensive picture of lives lost to COVID-19. These estimates are based on incoming death certificates, which are the most reliable source of death data and contain information not available anywhere else, including information about the place of death, other causes that contributed to the death, and race and ethnicity.

### How it works DEATH CERTIFICATES & PROVISIONAL DEATH COUNTS

The National Center for Health Statistics (NCHS) uses data from death certificates, which are sent to NCHS daily, to produce provisional COVID-19 death counts. These include deaths occurring within the 50 states, the District of Columbia, and Puerto Rico.

NCHS also provides summaries that examine deaths in specific categories and in greater geographic detail, such as deaths by county or by race and Hispanic origin.

COVID-19 deaths are identified using a new ICD-10 code. When COVID-19 is reported as a cause of death – or when it is listed as a "probable" or "presumed" cause – anywhere on the death certificate, the death is coded as U07.1. This can include cases with or without laboratory confirmation.

### Why these numbers are different than counts from other sources

Provisional death counts may not match counts from other sources, such as media reports or numbers from county health departments. Our counts often track 1-2 weeks behind other data because:

- **Death certificates take time to be completed.** There are many steps to filling out and submitting a death certificate. Waiting for test results can create additional delays.
- **States report at different rates.** Currently, 63% of all U.S. deaths are reported to NCHS within 10 days of the date of death, but there is significant variation between states.
- **It takes extra time to code COVID-19 deaths.** While 80% of death records are processed and coded electronically at NCHS within minutes, most deaths from COVID-19 cannot be coded electronically and must be coded by a person, which takes an average of 7 days.
- **Other reporting systems use different definitions or methods for counting deaths.**

### Things to know about the data

**Provisional counts are not final and are subject to change.** Counts from previous weeks are continually revised as more records are received and processed.

**Provisional data are not yet complete.** Counts will not include all deaths that occurred during a given time period, especially for more recent periods. However, the completeness of the data can be estimated by examining the average number of deaths reported in previous years.

**Death counts should not be compared across states.** Some states report deaths to NCHS on a daily basis, while other states report deaths weekly or monthly. State vital record reporting may also be affected or delayed by COVID-19 response activities.

To view the provisional death counts or for more detailed technical information, visit our [Provisional Death Counts for Coronavirus Disease \(COVID-19\)](#) page.

## BACKEND DATA REVISION [5-8 WEEK ROLLING WINDOW]



**-ENTERPRISE FRAUD PORTAL-**



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

The established "problematic data point" of [2020] mortality and the bulk data revisions required because of it draw this into conflict like with all else. In particular, we note the 5%-5% figures in both data sets [this is presented in more detail below.] They exactly represent the data the fraud construct [Table 3] below purports as being valid sole-cause COVID-19 data and then propagates but which later requires backend revisions for reconciliation.

**NOTE:** Provisional death counts are based on death certificate data received and coded by NCHS as of the date of analysis and do not represent all deaths that occurred in that period. Data for the most recent 5 weeks (shown in the gray shaded area) are typically less than 90% complete, with lower levels of completeness in more recent weeks. Death counts are updated as additional deaths are received and coded.

**SOURCE:** NCHS, National Vital Statistics System. Estimates are based on provisional data.

**-ENTERPRISE FRAUD PORTAL-**

**ROLLING 5-8 WEEK WINDOW OF PROVISIONAL DATA WITH BACKEND REVISION ALIGNED TO WHO / CDC bulk data revisions on 26 Aug 20 & 12 May 21 apply / Evidenced RICO Pattern: data drivers construct data, data is propagated in a closed-loop, data is revised away on an inconsequential backend.**

**DELAY STRATEGY RICO PATTERN**

**Provisional Death Counts Sourced as a data subset in Table 1 as with Table 3**

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: 9/26/2021

State	Attribute	Condition Group	Condition
United States	COVID-19 Deaths	All	COVID-19

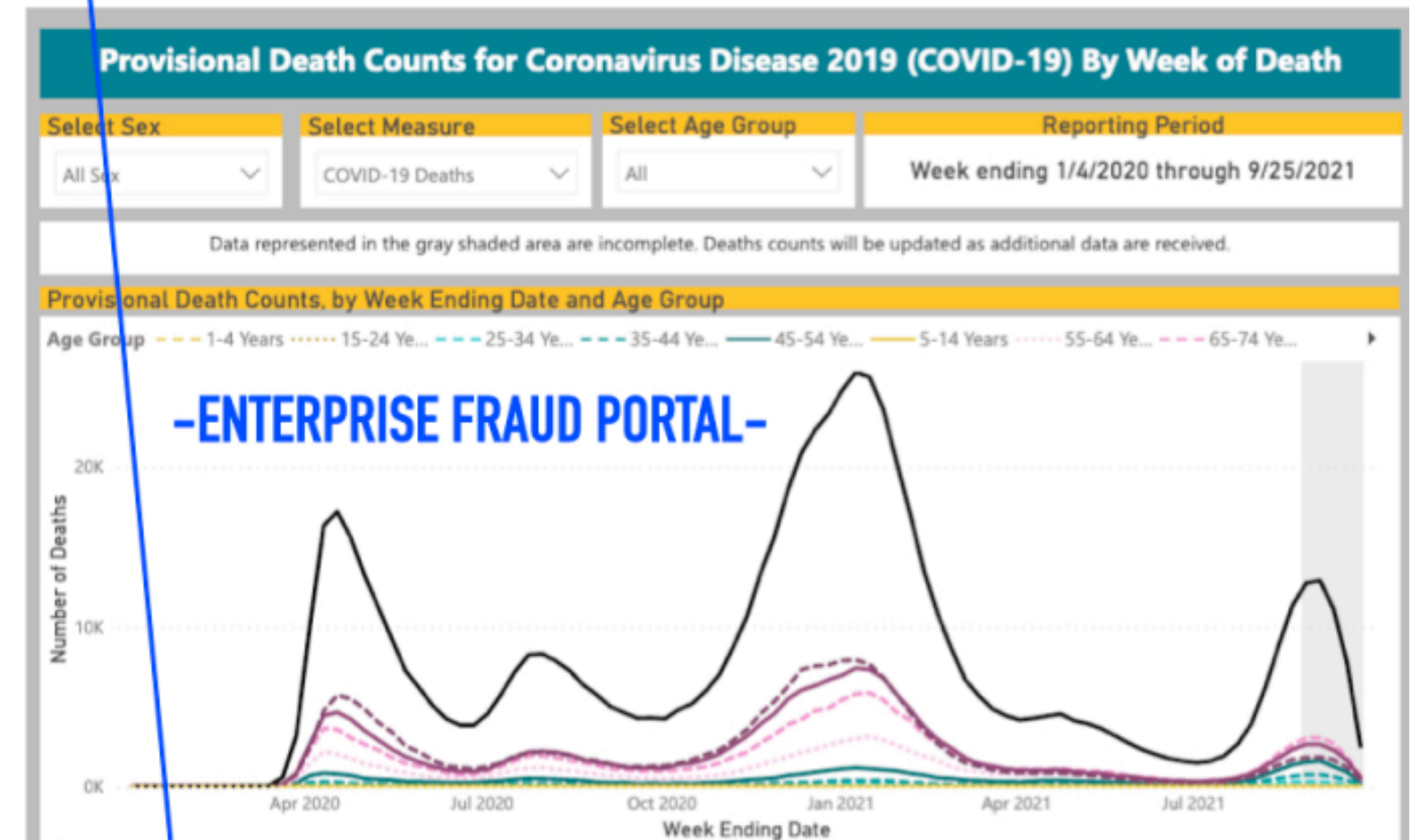
Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years
2020/2021	COVID-19	681,927	1,743	6,197	15,735	40,331	92,676	153,131	181,461	190,642

**681,927 [FRAUDULENT BY 95%]**

sin	cos	tan	ln	C	%
x <sup>2</sup>	x <sup>3</sup>	x <sup>4</sup>	x <sup>5</sup>	7	8
1/x	1/x <sup>2</sup>	1/y	EE	1	2
log	ln	e <sup>x</sup>	e	0	

34096.35

1. This number is skewed by 95%
2. For accurate value, apply at 5%
3. At 5%, actual COVID-19 deaths for COVID-19 as of 26 Sep 21 is 34,096
4. The upper limit on annual average flu deaths is 61,000
5. This puts both 2020 & 2021 in the category of a statistically unremarkable flu season



**NOTE:** Provisional death counts are based on death certificate data received and coded by NCHS as of the date of analysis and do not represent all deaths that occurred in that period. Data for the most recent 5 weeks (shown in the gray shaded area) are typically less than 90% complete, with lower levels of completeness in more recent weeks. Death counts are updated as additional deaths are received and coded.

**SOURCE:** NCHS, National Vital Statistics System. Estimates are based on provisional data.



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

# THE APPLIED BULK DATA REVISIONS

The established "problematic data point" of [2020] mortality and the bulk data revisions required because of it draw this into conflict like with all else. In particular, we note the 5%-5% figures in both data sets [this is presented in more detail below.] They exactly represent the data the fraud construct [Table 3] below purports as being valid sole-cause COVID-19 data and then propagates but which later requires backend revisions for reconciliation.

**ROLLING 5-8 WEEK WINDOW OF PROVISIONAL DATA WITH BACKEND REVISION ALIGNED TO WHO / CDC bulk data revisions on 26 Aug 20 & 12 May 21 apply / Evidenced RICO Pattern: data drivers construct data, data is propagated in a closed-loop, data is revised away on an inconsequential backend.**



## 26 AUG 20

Here is the data that the CDC released on Friday that deceitfully curtails it's long-publicized findings, which were used as justification to shutter the entire country and contributed to thousands of deaths (see nursing home policies) in communist, Marxist and revisionist style and so as to compartmentalize culpability for what I would expect will be legal traction of the highest order. Pay particular attention to the highlighted aspect near the bottom of the table below. [\(SOURCE\)](#)

**Table 2. Deaths involving coronavirus disease 2019 (COVID-19), pneumonia, and influenza reported to NCHS by place of death, United States, Week ending 2/1/2020 to 8/22/2020.\***  
Updated August 26, 2020

Place of death	All deaths involving COVID-19 (a) (1)	Deaths from all causes (b)	Deaths involving pneumonia, with or without COVID-19, excluding influenza (c) (2)	Deaths involving COVID-19 and pneumonia, including influenza (c) (3)	All deaths involving influenza, with or without COVID-19 (c) (4)
Total	153,504	1,776,421	144,294	70,527	6,945
Healthcare setting, inpatient	105,964	1,198,417	119,876	57,401	4,917
Healthcare setting, outpatient or emergency room	1,832	105,467	5,723	1,940	227
Healthcare setting, died on arrival	165	3,364	126	41	11
Decedent's home	8,820	307,362	11,549	1,742	1,499
Nursing home facility	4,485	111,428	2,964	2,021	314
Long-term care facility	36,676	319,497	21,073	6,626	122
Other	2,778	119,561	2,756	712	98
Place of death unknown	18	1,214	11	22	0

**NOTE:** Number of deaths reported in this table are the total number of deaths received and coded as of the date of analysis and do not represent all deaths that occurred in that period. Counts of deaths occurring before or after the reporting period are not included in the table. \*Data during this period are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS and processed for reporting purposes. This delay can range from 1 week to 8 weeks or more, depending on the jurisdiction and cause of death.

Deaths with confirmed or presumed COVID-19, coded to ICD-10 code U07.1.

Counts of deaths involving pneumonia include pneumonia deaths that also involve COVID-19 and exclude pneumonia deaths involving influenza.

Counts of deaths involving influenza include deaths with pneumonia or COVID-19 also listed as a cause of death.

### Comorbidities

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). For 8% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.6 additional conditions or causes per death. The number of deaths with each condition or cause is shown for all deaths and by age groups. For data on comorbidities, [Click here to download.](#)

Translated, on Friday, the CDC revised its numbers to reflect that **ONLY 6% OF THE REPORTED 153,504 COVID-19 DEATHS (9,210) were solely caused by COVID-19 and whereas the balance of ALL OF THOSE REPORTED DEATHS (the 144,294 deaths that ALL HAD COMORBIDITIES such as seasonal flu, pneumonia, diabetes or other significant underlying conditions) WERE INTENTIONALLY, DELIBERATELY AND PURPOSEFULLY COMMUNICATED TO THE AMERICAN PUBLIC TO ACHIEVE A POLITICAL NARRATIVE: PERHAPS A TREASONOUS ONE, THIS IS A FULL-CIRCLE EXPLANATION: We have used the CDC's own data sets to a) assert the fraudulent nature of the COVID-19 pandemic and to b) prove the COVID-19 pandemic as fraudulent.**

## BULK DATA REVISIONS

Before Revision	26 Aug 20 Revision	PROBLEMATIC BULK DATA REVISIONS	Before Revision	12 May 21 Revision
0%	→ 94%	Invalid Data	0%	→ 95%
100%	→ 6%	Valid Data	100%	→ 5%
0	→ 2.6	Average Underlying Co-morbidities	0	→ 4.0

**THIS IS THE DATA USED TO PREDICATE THE NATIONAL EMERGENCY & ISSUE GUIDELINES & MITIGATIONS.**

**WHAT IS THE NET EFFECT?**

**\*COMPORTING 5%**

## 12 MAY 21

The CDC did the exact same thing on 12 May 21 whereby the new numbers aggravate the matter with 55% being of the sole-cause data being revised away leaving only 5% of the remaining data as valid. Even worse, the number of leveraged co-morbidities increased to 4.0.

**POLITICAL MOONSHINE @Statecraft\_Discerned**  
30 · The Great Awakening

There are several significant timeline markers on the COVID-19 timeline - this is another. Much like the 26 Aug 20 CDC revision of COVID-19 mortality data (see 31 Aug 20 article) that revised away 94% of the bulk mortality data used to justify and implement guidelines and mitigations, the CDC has done so again circa 12 May 21.

Previously, the CDC advised that only 6% of all CV deaths were attributable solely to CV. The remaining 94% leveraged an average of 2.6 underlying co-morbidities ergo 94% of the data was fraudulent with only 6% valid. Notably, this generally aligns statistically with flu/pneumo data which disappeared inversely to the onset of CV and thus fitting precisely into the criminal construct.

In the 12 May 21 bulletin, the CDC revisions exacerbated the established fraud claims I've outlined so extensively and dating back to Jan/Feb of 2020. The CDC now advises that only a decreased 5% of CV deaths are attributable solely to CV while an increased 95% involve an increased average of 4.0 co-morbidities.

It's a real virus - bioengineered with gain of function and perhaps in other ways - and it's coming with real vaccinations but beyond that, the entire COVID-19 pandemic is a false flag political construct driven by harvested, cooked-up and propagated fraudulent data... broken record, dead horse kicked.

Article: [politicalmoonshine.com/2020/08/31/fake-pandem-...](https://politicalmoonshine.com/2020/08/31/fake-pandem-...)

CDC Source: [cdc.gov/nchs/nvss/vsn/covid\\_weekly/index.htm](https://cdc.gov/nchs/nvss/vsn/covid_weekly/index.htm)

### Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time period, jurisdiction, and other health conditions, [Click here to download.](#)

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: 5/18/2021

Year to which death occurred	Conditions contributing to death (other than COVID-19) or not listed on the death certificate (1)	All ages	0-14	15-44	45-64	65-74	75-84	85+	
2020-2021	Influenza and pneumonia	20,751	362	1,271	4,794	10,071	20,213	17,122	66,917
2020-2021	Chronic lower respiratory diseases	36,112	39	394	1,944	12,048	24,017	12,212	84,734
2020-2021	Acute respiratory distress syndrome	29,276	27	823	1,249	2,899	11,229	36,993	53,774
2020-2021	Respiratory failure	22,044	26	1,240	3,448	10,734	28,991	22,220	67,813
2020-2021	Respiratory arrest	21,470	28	171	178	868	3,492	3,124	40,841
2020-2021	Other diseases of the respiratory system	20,192	46	399	176	1,287	3,221	3,882	34,841
2020-2021	Septicemia	12,247	16	120	1,269	4,287	11,128	24,424	41,424
2020-2021	Schistosoma haematolyticum	11,942	12	117	136	1,201	7,424	22,242	21,862
2020-2021	Cerebral aneurysm	10,814	128	764	1,217	4,429	14,248	16,217	33,824
2020-2021	Cerebral infarction	10,288	26	47	292	874	3,124	7,778	12,561
2020-2021	Heart failure	10,217	29	49	713	1,628	1,244	12,941	18,121
2020-2021	Cardiomegaly	10,011	36	81	281	989	3,019	8,217	12,514
2020-2021	Other diseases of the circulatory system	10,214	129	222	721	1,822	4,689	8,734	16,411
2020-2021	Stroke	10,211	122	492	1,224	3,748	8,212	15,242	26,021
2020-2021	Myocardial infarction	10,210	21	224	264	869	3,019	7,211	12,514
2020-2021	Diabetes	10,042	168	1,241	1,241	1,241	1,241	1,241	10,042
2020-2021	Obesity	10,011	122	492	1,224	3,748	8,212	15,242	26,021
2020-2021	Hypertension	10,011	122	492	1,224	3,748	8,212	15,242	26,021

Do you know what happens if you take the CDC's fear porn mortality data at 5% and 6%? Let me tell you. It puts the number right smack in the middle of a typical annual flu season when the pandemic has seen flu/pneumo disappear inversely to it.



# Weekly Updates by Select Demographic and Geographic Characteristics

Provisional Death Counts for Coronavirus Disease 2019 (COVID-19)

Contents	
<a href="#">COVID-19 Mortality Overview</a>	<a href="#">Health Disparities</a>
<a href="#">Daily Updates of Totals by Week and State</a>	<a href="#">Excess Deaths Associated with COVID-19</a>
<b>Weekly Updates by Select Demographic and Geographic Characteristics</b>	<a href="#">Index of Available Data Files</a>
	<a href="#">Technical Notes</a>

**PRIMARY SOURCE DATA  
BEING EXAMINED**



**i** Note: Provisional death counts are based on death certificate data received and coded by the National Center for Health Statistics as of September 29, 2021. Death counts are delayed and may differ from other published sources (see Technical Notes). Counts will be updated every Wednesday by 5pm. Additional information will be added to this site as available.





## TABLES 1 & 3: 2020 & 2021

**Table 1. Deaths involving coronavirus disease 2019 (COVID-19), pneumonia, and influenza reported to NCHS by time-period, jurisdiction of occurrence, sex and age-group.** Data as of: 9/29/2021

State	Sex	Age Group	All Deaths involving COVID-19 [1]	Deaths from All Causes	Deaths involving Pneumonia [2]	Deaths involving COVID-19 and Pneumonia [2]	All Deaths involving Influenza [3]	Deaths involving Pneumonia, Influenza, or COVID-19 [4]
United States	All	All						
Year in which death occurred	Sex	Age Group	All Deaths involving COVID-19 [1]	Deaths from All Causes	Deaths involving Pneumonia [2]	Deaths involving COVID-19 and Pneumonia [2]	All Deaths involving Influenza [3]	Deaths involving Pneumonia, Influenza, or COVID-19 [4]
2020/2021	All Sexes	0-17 years	478	57,466	985	115	188	1,536
2020/2021	All Sexes	18-29 years	3,573	109,259	3,425	1,670	148	5,464
2020/2021	All Sexes	30-39 years	10,324	157,653	8,925	5,200	323	14,347
2020/2021	All Sexes	40-49 years	25,978	235,155	21,321	13,611	507	34,123
2020/2021	All Sexes	50-64 years	118,573	962,614	107,879	65,046	2,215	163,262
2020/2021	All Sexes	65-74 years	154,373	1,163,384	145,163	84,914	2,024	216,309
2020/2021	All Sexes	75-84 years	182,511	1,386,566	168,829	94,847	2,022	258,229
2020/2021	All Sexes	85 years and over	191,362	1,660,226	162,655	81,671	1,898	274,003
2020/2021	All Sexes	All Ages	687,172	5,732,323	619,182	347,074	9,325	967,273
2020/2021	Female	0-17 years	217	23,867	450	54	84	697
2020/2021	Female	18-29 years	1,381	29,361	1,339	669	70	2,118
2020/2021	Female	30-39 years	3,802	50,650	3,419	1,883	164	5,493
2020/2021	Female	40-49 years	9,296	85,329	8,182	4,858	224	12,824
2020/2021	Female	50-64 years	43,590	367,929	42,223	24,303	934	62,329
2020/2021	Female	65-74 years	61,304	487,634	58,189	33,266	883	86,996
2020/2021	Female	75-84 years	80,005	662,887	72,469	39,669	1,007	113,684
2020/2021	Female	85 years and over	109,310	1,008,026	86,035	42,339	1,125	154,001
2020/2021	Female	All Ages	308,905	2,715,683	272,306	147,041	4,491	438,142
2020/2021	Male	0-17 years	261	33,599	535	61	104	839
2020/2021	Male	18-29 years	2,192	79,898	2,086	1,001	78	3,346
2020/2021	Male	30-39 years	6,522	107,003	5,506	3,317	159	8,854
2020/2021	Male	40-49 years	16,682	149,826	13,139	8,753	283	21,299
2020/2021	Male	50-64 years	74,983	594,685	65,656	40,743	1,281	100,933
2020/2021	Male	65-74 years	93,069	675,750	86,974	51,648	1,141	129,313
2020/2021	Male	75-84 years	102,506	723,679	96,360	55,178	1,015	144,545
2020/2021	Male	85 years and over	82,052	652,200	76,620	39,332	773	120,002
2020/2021	Male	All Ages	378,267	3,016,640	346,876	200,033	4,834	529,131

### FOOTNOTES

NOTE: Empty data cells represent counts between 1-9 that have been suppressed in accordance with NCHS confidentiality standards. Number of deaths reported in this table are the total number of deaths received and coded as of the date of analysis and may not represent all deaths that occurred in that period. Counts of deaths occurring before or after the reporting period are not included in the table. Data during recent periods are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS and processed for reporting purposes. This delay can range from 1 week to 8 weeks or more, depending on the jurisdiction and cause of death. United States death counts include the 50 states, plus the District of Columbia and New York City. New York state estimates exclude New York City.

[1] Deaths with confirmed or presumed COVID-19, coded to ICD-10 code U07.1.

[2] Counts of deaths involving pneumonia (J12.0-J18.9) include pneumonia deaths that also involve COVID-19 and exclude pneumonia deaths involving influenza.

[3] Counts of deaths involving influenza (J09-J11) include deaths with pneumonia or COVID-19 also listed as a cause of death.

[4] Deaths with confirmed or presumed COVID-19, pneumonia, or influenza, coded to ICD-10 codes U07.1 or J09-J18.9.

[1] "Deaths with confirmed or presumed COVID-19, coded to ICD-10 Code U07.1."

[2] "Counts of death involving pneumonia [J12.0-J18.9] include pneumonia deaths that also involve COVID-19 and exclude pneumonia deaths involving influenza."

[3] "Counts of death involving pneumonia [J09-J11] include deaths with pneumonia or COVID-19 also listed as a cause of death."

[4] Deaths with confirmed or presumed COVID-19, pneumonia, or influenza, coded to ICD-10 codes U07.1 or J09-J18.9."

CODES: U07.1, J09-J18.9

## 1: DEATHS: COVID-19, FLU & PNEUMO

TABLE 1  
Complete Data Set  
[1], [2], [3] & [4]

[https://www.cdc.gov/nchs/nvss/vsrr/covid\\_weekly/](https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/)

TABLE 3  
Complete Data Set  
[1] Only

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: 9/26/2021

State	Attribute	Condition Group	Condition	Year						
United States	COVID-19 Deaths	All	All	All						
Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years
2021	Influenza and pneumonia	156,073	422	1,985	5,005	12,523	26,840	39,607	39,507	30,184
2021	Chronic lower respiratory diseases	24,449	43	129	301	859	3,122	6,429	7,989	5,577
2021	Adult respiratory distress syndrome	30,745	142	608	1,539	3,762	7,196	8,980	6,084	2,434
2021	Respiratory failure	123,905	305	1,319	3,670	9,282	21,022	32,353	32,440	23,513
2021	Respiratory arrest	6,188	16	79	163	439	907	1,353	1,596	1,635
2021	Other diseases of the respiratory system	15,157	78	218	488	1,228	2,702	3,858	3,906	2,679
2021	Hypertensive diseases	51,920	23	256	998	3,055	7,619	12,507	13,943	13,519
2021	Ischemic heart disease	29,343	14	64	261	1,075	3,427	6,980	9,075	8,447
2021	Cardiac arrest	38,544	120	538	1,344	3,348	6,854	9,439	9,303	7,598
2021	Cardiac arrhythmia	22,433	19	81	220	731	2,208	4,681	6,889	7,604
2021	Heart failure	21,780	20	94	239	725	1,990	4,372	6,344	7,996
2021	Cerebrovascular diseases	13,703	21	85	245	686	1,766	3,169	3,821	3,910
2021	Other diseases of the circulatory system	21,923	102	275	670	1,666	3,569	5,264	5,489	4,887
2021	Sepsis	30,412	114	385	1,158	2,849	6,217	8,746	7,111	3,832
2021	Malignant neoplasms	15,291	43	75	189	684	2,228	4,332	4,683	3,057
2021	Diabetes	44,634	69	381	1,289	3,745	8,460	12,679	11,446	6,565
2021	Obesity	15,806	213	870	1,851	3,099	4,175	3,643	1,616	339
2021	Alzheimer disease	7,050	0	1	0	11	61	471	2,062	4,444
2021	Vascular and unspecified dementia	18,051	0	1	3	18	233	1,508	5,458	10,830
2021	Renal failure	34,398	68	347	975	2,758	6,131	9,177	8,664	6,278
2021	Intentional and unintentional injury, poisoning, and other adverse events	7,508	73	155	311	586	1,156	1,676	1,753	1,798
2021	All other conditions and causes (residual)	122,457	519	1,480	3,512	8,717	19,533	29,915	31,371	27,409
2021	COVID-19	296,855	984	3,577	8,958	22,019	47,150	70,935	75,315	67,916
2020	Influenza and pneumonia	167,889	249	1,113	3,006	8,857	22,041	39,168	47,375	46,074
2020	Chronic lower respiratory diseases	34,914	43	118	272	836	3,381	8,391	11,559	10,313
2020	Adult respiratory distress syndrome	41,671	112	401	1,129	3,326	7,477	11,519	10,472	7,234
2020	Respiratory failure	138,062	188	791	2,173	6,753	17,355	32,498	40,335	37,966
2020	Respiratory arrest	8,111	15	50	130	342	879	1,608	2,237	2,850
2020	Other diseases of the respiratory system	14,876	37	124	307	774	1,955	3,448	4,125	4,106
2020	Hypertensive diseases	79,117	29	226	974	3,181	9,076	17,117	22,161	26,350
2020	Ischemic heart disease	43,158	6	53	227	1,008	3,770	8,863	13,521	15,708
2020	Cardiac arrest	43,817	90	361	952	2,783	6,336	10,275	11,394	11,625
2020	Cardiac arrhythmia	27,612	18	56	146	556	1,874	4,889	8,535	11,538
2020	Heart failure	29,217	12	63	198	656	2,169	4,905	8,424	12,789
2020	Cerebrovascular diseases	19,325	19	54	178	648	2,026	4,168	5,666	6,565
2020	Other diseases of the circulatory system	23,096	85	221	474	1,204	2,828	5,013	6,242	7,029
2020	Sepsis	35,702	72	262	753	2,443	5,931	10,012	9,604	6,624
2020	Malignant neoplasms	17,367	40	62	206	600	2,189	4,561	5,323	4,386
2020	Diabetes	62,537	84	352	1,258	3,893	9,857	16,881	17,475	12,735
2020	Obesity	15,074	167	633	1,378	2,487	3,746	3,904	2,168	590
2020	Alzheimer disease	15,491	0	0	3	9	131	998	4,442	9,908
2020	Vascular and unspecified dementia	42,649	0	1	4	44	562	3,689	12,617	25,731
2020	Renal failure	35,357	42	225	667	1,992	4,911	8,902	9,855	8,761
2020	Intentional and unintentional injury, poisoning, and other adverse events	6,618	62	164	210	360	765	1,232	1,641	2,183
2020	All other conditions and causes (residual)	142,339	382	1,087	2,498	6,804	17,395	32,273	39,613	42,282
2020	COVID-19	385,072	759	2,620	6,777	18,312	45,526	82,196	106,146	122,726

## 3: DEATHS: COVID-19 COMORBIDITIES



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Here' we're examining Table 1 deaths respective to the 4 categorized footnotes. Further, we examine how the coding [found in the footnotes] impacts the data sets and in what ways.

## Sex and Age

Table 1 has counts of deaths involving COVID-19 and other select causes of death by time-period in which the death occurred, sex and age group. For data on deaths involving COVID-19 by month, year, jurisdiction, sex, and age, [Click here to download](#). This data file contains two sets of age groups: (1) age-groups consistent with those used across COVID-19 surveillance pages, and (2) age groups that are routinely included in NCHS mortality reports. When analyzing file, the user should make sure to select only the desired age groups. Summing across all age categories provided will result in double counting deaths from certain age groups. For data on deaths involving COVID-19 by week, sex, and age (by NC age groups), [Click here to download](#). Data on deaths involving COVID-19 among ages 0-18 are available here: [Click here to download](#).



## TABLE 1

### FOOTNOTES

NOTE: Empty data cells represent counts between 1-9 that have been suppressed in accordance with NCHS confidentiality standards. Number of deaths reported in this table are the total number of deaths received and coded as of the date of analysis and may not represent all deaths that occurred in that period. Counts of deaths occurring before or after the reporting period are not included in the table. Data during recent periods are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS and processed for reporting purposes. This delay can range from 1 week to 8 weeks or more, depending on the jurisdiction and cause of death. United States death counts include the 50 states, plus the District of Columbia and New York City. New York state estimates exclude New York City.

[1] Deaths with confirmed or presumed COVID-19, coded to ICD-10 code U07.1.

[2] Counts of deaths involving pneumonia (J12.0-J18.9) include pneumonia deaths that also involve COVID-19 and exclude pneumonia deaths involving influenza.

[3] Counts of deaths involving influenza (J09-J11) include deaths with pneumonia or COVID-19 also listed as a cause of death.

[4] Deaths with confirmed or presumed COVID-19, pneumonia, or influenza, coded to ICD-10 codes U07.1 or J09-J18.9.

[1] "Deaths with confirmed or presumed COVID-19, coded to ICD-10 Code U07.1."

[2] "Counts of death involving pneumonia [J12.0-J18.9] include pneumonia deaths that also involve COVID-19 and exclude pneumonia deaths involving influenza."

[3] "Counts of death involving pneumonia [J09-J11] include deaths with pneumonia or COVID-19 also listed as a cause of death."

[4] Deaths with confirmed or presumed COVID-19, pneumonia, or influenza, coded to ICD-10 codes U07.1 or J09-J18.9."

CODES: U07.1, J09-J18.9

**Table 1. Deaths involving coronavirus disease 2019 (COVID-19), pneumonia, and influenza reported to NCHS by time-period, jurisdiction of occurrence, sex and age-group.**

Data as of:

9/29/2021

State			Sex		Age Group				
United States			All		All				
Year in which death occurred	Sex	Age Group	All Deaths involving COVID-19 [1]	Deaths from All Causes	Deaths involving Pneumonia [2]	Deaths involving COVID-19 and Pneumonia [2]	All Deaths involving Influenza [3]	Deaths involving Pneumonia, Influenza, or COVID-19 [4]	
2020/2021	[1st US case: 20 Jan 20]								
2020/2021	All Sexes	0-17 years	478	57,466	985	115	188	1,536	
2020/2021	All Sexes	18-29 years	3,573	109,259	3,425	1,670	148	5,464	
2020/2021	All Sexes	30-39 years	10,324	157,653	8,925	5,200	323	14,347	
2020/2021	All Sexes	40-49 years	25,978	235,155	21,321	13,611	507	34,123	
2020/2021	All Sexes	50-64 years	118,573	962,614	107,879	65,046	2,215	163,262	
2020/2021	All Sexes	65-74 years	154,373	1,163,384	145,163	84,914	2,024	216,309	
2020/2021	All Sexes	75-84 years	182,511	1,386,566	168,829	94,847	2,022	258,229	
2020/2021	All Sexes	85 years and over	191,362	1,660,226	162,655	81,671	1,898	274,003	
2020/2021	All Sexes	All Ages	687,172	5,732,323	619,182	347,074	9,325	967,273	
2020/2021	Female	0-17 years	217	23,867	450	54	84	697	
2020/2021	Female	18-29 years	1,381	29,361	1,339	669	70	2,118	
2020/2021	Female	30-39 years	3,802	50,650	3,419	1,883	164	5,493	
2020/2021	Female	40-49 years	9,296	85,329	8,182	4,858	224	12,824	
2020/2021	Female	50-64 years	43,590	367,929	42,223	24,303	934	62,329	
2020/2021	Female	65-74 years	61,304	487,634	58,189	33,266	883	86,996	

Yearly

Monthly

Total





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

It's all further complicated by understanding that we already possess and have exhibited 2020 mortality data making the CDC's choices here problematic to logically deduce outside the explanation of enterprise fraud.

**2019: Total Deaths: 2,854,838**

Notes: The population figures for year 2019 are bridged-race estimates of the July 1 resident population, from the Vintage 2019 postcensal series released by NCHS on July 9, 2020. The population figures for year 2018 are bridged-race estimates of the July 1 resident population, from the Vintage 2018 postcensal series released by NCHS on June 28, 2019. The population figures for year 2017 are bridged-race estimates of the July 1 resident population, from the Vintage 2017 postcensal series released by NCHS on June 27, 2018. The population figures for year 2016 are bridged-race estimates of the July 1 resident population, from the Vintage 2016 postcensal series released by NCHS on June 26, 2017. The population figures for year 2015 are bridged-race estimates of the July 1 resident population, from the Vintage 2015 postcensal series released by NCHS on June 28, 2016. The population figures for year 2014 are bridged-race estimates of the July 1 resident population, from the Vintage 2014 postcensal series released by NCHS on June 30, 2015. The population figures for year 2013 are bridged-race estimates of the July 1 resident population, from the Vintage 2013 postcensal series released by NCHS on June 26, 2014. The population figures for year 2012 are bridged-race estimates of the July 1 resident population, from the Vintage 2012 postcensal series released by NCHS on June 13, 2013. The population figures for year 2011 are bridged-race estimates of the July 1 resident population, from the Vintage 2011 postcensal series released by NCHS on July 18, 2012. Population figures for 2010 are April 1 Census counts. The population figures for years 2001 - 2009 are bridged-race estimates of the July 1 resident population, from the revised intercensal county-level 2000 - 2009 series released by NCHS on October 26, 2012. Population figures for 2000 are April 1 Census counts. Population figures for 1999 are from the 1990-1999 intercensal series of July 1 estimates. Population figures for the infant age groups are the number of live births. Note: Rates and population figures for years 2001 - 2009 differ slightly from previously published reports, due to use of the population estimates which were available at the time of release.

**Messages:**  
Rows with zero Deaths are hidden, but the Population values in those rows are included in the totals. Use Quick Options above to show zero rows.

Cause of death ↓	Year	Deaths ↑↓	Population ↑↓	Crude Rate Per 100,000 ↑↓
U01.4 (Terrorism involving firearms)	2019	20	328,239,523	0.0
	Total	20	328,239,523	0.0
U07.0 (Vaping related disorder)	2019	7	328,239,523	Unreliable
	Total	7	328,239,523	Unreliable
Total		27	328,239,523	0.0

**2020/2021 DATA NOT AVAILABLE "CODING"**

**2019 DATA** ↑ **2019 DATA**

**2019 CODES: U07.1, J09-J18.9**

27 Dec 19: 1st legacy media report  
20 Jan 20: 1st case  
**NO DATA FOR 2019**  
**U07.1 DIDN'T EXIT IN 2019**

**Messages:**  
Rows with zero Deaths are hidden, but the Population values in those rows are included in the totals. Use Quick Options above to show zero rows.

Cause of death ↓	Year	Deaths ↑↓	Population ↑↓	Crude Rate Per 100,000 ↑↓
J09 (Influenza due to identified avian influenza virus)	2019	153	328,239,523	0.0
Total		153	328,239,523	0.0
J10.0 (Influenza with pneumonia, influenza virus identified)	2019	1,491	328,239,523	0.5
Total		1,491	328,239,523	0.5
J10.1 (Influenza with other respiratory manifestations, influenza virus identified)	2019	1,599	328,239,523	0.5
Total		1,599	328,239,523	0.5
J10.8 (Influenza with other manifestations, influenza virus identified)	2019	69	328,239,523	0.0
Total		69	328,239,523	0.0
J11.0 (Influenza with pneumonia, virus not identified)	2019	1,363	328,239,523	0.4
Total		1,363	328,239,523	0.4
J11.1 (Influenza with other respiratory manifestations, virus not identified)	2019	1,190	328,239,523	0.4
Total		1,190	328,239,523	0.4
J11.8 (Influenza with other manifestations, virus not identified)	2019	37	328,239,523	0.0
Total		37	328,239,523	0.0
J12.0 (Adenoviral pneumonia)	2019	21	328,239,523	0.0
Total		21	328,239,523	0.0
J12.1 (Respiratory syncytial virus pneumonia)	2019	99	328,239,523	0.0
Total		99	328,239,523	0.0
J12.2 (Parainfluenza virus pneumonia)	2019	61	328,239,523	0.0
Total		61	328,239,523	0.0
J12.3 (Human metapneumovirus pneumonia)	2019	53	328,239,523	0.0
Total		53	328,239,523	0.0
J12.8 (Other viral pneumonia)	2019	43	328,239,523	0.0
Total		43	328,239,523	0.0
J12.9 (Viral pneumonia, unspecified)	2019	307	328,239,523	0.1
Total		307	328,239,523	0.1
J13 (Pneumonia due to Streptococcus pneumoniae)	2019	266	328,239,523	0.1
Total		266	328,239,523	0.1
J14 (Pneumonia due to Haemophilus influenzae)	2019	91	328,239,523	0.0
Total		91	328,239,523	0.0
J15.0 (Pneumonia due to Klebsiella pneumoniae)	2019	145	328,239,523	0.0
Total		145	328,239,523	0.0
J15.1 (Pneumonia due to Pseudomonas)	2019	308	328,239,523	0.1
Total		308	328,239,523	0.1
J15.2 (Pneumonia due to staphylococcus)	2019	647	328,239,523	0.2
Total		647	328,239,523	0.2
J15.3 (Pneumonia due to streptococcus, group B)	2019	2	328,239,523	Unreliable
Total		2	328,239,523	Unreliable
J15.4 (Pneumonia due to other streptococci)	2019	252	328,239,523	0.1
Total		252	328,239,523	0.1
J15.5 (Pneumonia due to Escherichia coli)	2019	49	328,239,523	0.0
Total		49	328,239,523	0.0
J15.6 (Pneumonia due to other aerobic Gram-negative bacteria)	2019	67	328,239,523	0.0
Total		67	328,239,523	0.0
J15.7 (Pneumonia due to Mycoplasma pneumoniae)	2019	58	328,239,523	0.0
Total		58	328,239,523	0.0
J15.8 (Other bacterial pneumonia)	2019	28	328,239,523	0.0
Total		28	328,239,523	0.0
J15.9 (Bacterial pneumonia, unspecified)	2019	2,267	328,239,523	0.7
Total		2,267	328,239,523	0.7
J16.0 (Chlamydial pneumonia)	2019	1	328,239,523	Unreliable
Total		1	328,239,523	Unreliable
J18.0 (Bronchopneumonia, unspecified)	2019	656	328,239,523	0.2
Total		656	328,239,523	0.2
J18.1 (Lobar pneumonia, unspecified)	2019	1,338	328,239,523	0.4
Total		1,338	328,239,523	0.4
J18.2 (Hypostatic pneumonia, unspecified)	2019	32	328,239,523	0.0
Total		32	328,239,523	0.0
J18.8 (Other pneumonia, organism unspecified)	2019	8	328,239,523	Unreliable
Total		8	328,239,523	Unreliable
J18.9 (Pneumonia, unspecified)	2019	37,082	328,239,523	11.3
Total		37,082	328,239,523	11.3

**CDC MAKES CODING DATA UNAVAILABLE FOR 2020/2021**

**CDC CITES 2019 MORTALITY DATA WHY?**

U.S. Department of Health & Human Services | USA.gov | CDC Website Exit Disclaimer

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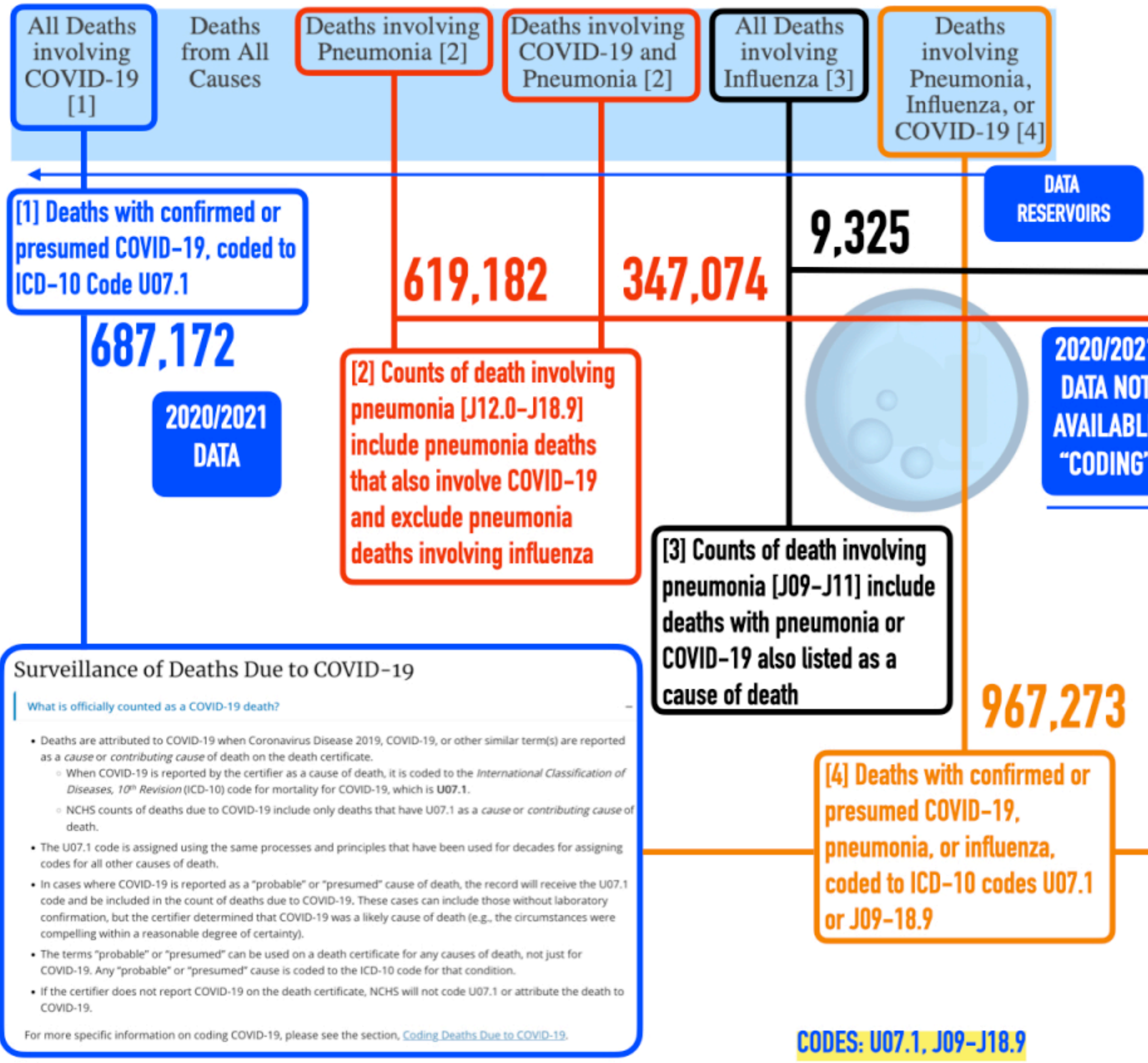
Privacy | FOIA | No Fear Act | OIG | Nondiscrimination | Accessibility

<https://wonder.cdc.gov/controller/datarequest/D/76;jsessionid=BB4ADCFF0BFE37CFA4247EA85268>



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Why is the CDC suppressing this data?



Messages: Rows with zero Deaths are hidden, but the Population values in those rows are included in the totals. Use Quick Options above to show zero rows.

Cause of death	2019 DATA	Year	Deaths	Population	Crude Rate Per 100,000
J09 (Influenza due to identified avian influenza virus)	2019	153	328,239,523	0.0	
Total	153	328,239,523	0.0		
J10.0 (Influenza with pneumonia, influenza virus identified)	2019	1,491	328,239,523	0.5	
Total	1,491	328,239,523	0.5		
J10.1 (Influenza with other respiratory manifestations, influenza virus identified)	2019	1,599	328,239,523	0.5	
Total	1,599	328,239,523	0.5		
J10.8 (Influenza with other manifestations, influenza virus identified)	2019	69	328,239,523	0.0	
Total	69	328,239,523	0.0		
J11.0 (Influenza with pneumonia, virus not identified)	2019	1,363	328,239,523	0.4	
Total	1,363	328,239,523	0.4		
J11.1 (Influenza with other respiratory manifestations, virus not identified)	2019	1,190	328,239,523	0.4	
Total	1,190	328,239,523	0.4		
J11.8 (Influenza with other manifestations, virus not identified)	2019	37	328,239,523	0.0	
Total	37	328,239,523	0.0		
J12.0 (Adenoviral pneumonia)	2019	21	328,239,523	0.0	
Total	21	328,239,523	0.0		
J12.1 (Respiratory syncytial virus pneumonia)	2019	99	328,239,523	0.0	
Total	99	328,239,523	0.0		
J12.2 (Parainfluenza virus pneumonia)	2019	61	328,239,523	0.0	
Total	61	328,239,523	0.0		
J12.3 (Human metapneumovirus pneumonia)	2019	53	328,239,523	0.0	
Total	53	328,239,523	0.0		
J12.8 (Other viral pneumonia)	2019	43	328,239,523	0.0	
Total	43	328,239,523	0.0		
J12.9 (Viral pneumonia, unspecified)	2019	307	328,239,523	0.1	
Total	307	328,239,523	0.1		
J13 (Pneumonia due to Streptococcus pneumoniae)	2019	266	328,239,523	0.1	
Total	266	328,239,523	0.1		
J14 (Pneumonia due to Haemophilus influenzae)	2019	91	328,239,523	0.0	
Total	91	328,239,523	0.0		
J15.0 (Pneumonia due to Klebsiella pneumoniae)	2019	145	328,239,523	0.0	
Total	145	328,239,523	0.0		
J15.1 (Pneumonia due to Pseudomonas)	2019	308	328,239,523	0.1	
Total	308	328,239,523	0.1		
J15.2 (Pneumonia due to staphylococcus)	2019	647	328,239,523	0.2	
Total	647	328,239,523	0.2		
J15.3 (Pneumonia due to streptococcus, group B)	2019	2	328,239,523	Unreliable	
Total	2	328,239,523	Unreliable		
J15.4 (Pneumonia due to other streptococci)	2019	252	328,239,523	0.1	
Total	252	328,239,523	0.1		
J15.5 (Pneumonia due to Escherichia coli)	2019	49	328,239,523	0.0	
Total	49	328,239,523	0.0		
J15.6 (Pneumonia due to other aerobic Gram-negative bacteria)	2019	67	328,239,523	0.0	
Total	67	328,239,523	0.0		
J15.7 (Pneumonia due to Mycoplasma pneumoniae)	2019	58	328,239,523	0.0	
Total	58	328,239,523	0.0		
J15.8 (Other bacterial pneumonia)	2019	28	328,239,523	0.0	
Total	28	328,239,523	0.0		
J15.9 (Bacterial pneumonia, unspecified)	2019	2,267	328,239,523	0.7	
Total	2,267	328,239,523	0.7		
J16.0 (Chlamydial pneumonia)	2019	1	328,239,523	Unreliable	
Total	1	328,239,523	Unreliable		
J18.0 (Bronchopneumonia, unspecified)	2019	656	328,239,523	0.2	
Total	656	328,239,523	0.2		
J18.1 (Lobar pneumonia, unspecified)	2019	1,338	328,239,523	0.4	
Total	1,338	328,239,523	0.4		
J18.2 (Hypostatic pneumonia, unspecified)	2019	32	328,239,523	0.0	
Total	32	328,239,523	0.0		
J18.8 (Other pneumonia, organism unspecified)	2019	8	328,239,523	Unreliable	
Total	8	328,239,523	Unreliable		
J18.9 (Pneumonia, unspecified)	2019	37,082	328,239,523	11.3	
Total	37,082	328,239,523	11.3		

### Surveillance of Deaths Due to COVID-19

What is officially counted as a COVID-19 death?

- Deaths are attributed to COVID-19 when Coronavirus Disease 2019, COVID-19, or other similar term(s) are reported as a *cause or contributing cause* of death on the death certificate.
  - When COVID-19 is reported by the certifier as a cause of death, it is coded to the *International Classification of Diseases, 10th Revision (ICD-10)* code for mortality for COVID-19, which is U07.1.
  - NCHS counts of deaths due to COVID-19 include only deaths that have U07.1 as a *cause or contributing cause* of death.
- The U07.1 code is assigned using the same processes and principles that have been used for decades for assigning codes for all other causes of death.
- In cases where COVID-19 is reported as a "probable" or "presumed" cause of death, the record will receive the U07.1 code and be included in the count of deaths due to COVID-19. These cases can include those without laboratory confirmation, but the certifier determined that COVID-19 was a likely cause of death (e.g., the circumstances were compelling within a reasonable degree of certainty).
- The terms "probable" or "presumed" can be used on a death certificate for any causes of death, not just for COVID-19. Any "probable" or "presumed" cause is coded to the ICD-10 code for that condition.
- If the certifier does not report COVID-19 on the death certificate, NCHS will not code U07.1 or attribute the death to COVID-19.

For more specific information on coding COVID-19, please see the section, [Coding Deaths Due to COVID-19](#).

CODES: U07.1, J09-J18.9



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Here you see additional evidence of data sourcing along with 2020 mortality data. Again, we note that the CDC is making only 2019 available.

Image Capture: 05 Oct 21

National Center for Health Statistics

Deaths and Mortality

Data are for the U.S.

- Number of deaths: 2,854,838
- Death rate: 869.7 deaths per 100,000 population

Source: National Vital Statistics System - Mortality Data (2019) via CDC WONDER

Life expectancy: 78.8 years

Infant Mortality rate: 5.58 deaths per 1,000 live births

Source: Mortality in the United States, 2019, data tables for figures 1-5

Number of deaths for leading causes of death:

- Heart disease: 659,041
- Cancer: 599,601
- Accidents (unintentional injuries): 173,040
- Chronic lower respiratory diseases: 156,979
- Stroke (cerebrovascular diseases): 150,005
- Alzheimer's disease: 121,499
- Diabetes: 87,647
- Nephritis, nephrotic syndrome, and nephrosis: 51,565
- Influenza and Pneumonia: 49,783
- Intentional self-harm (suicide): 47,511

Source: Mortality in the United States, 2019, data table for figure 2

More data: reports and tables

- Mortality in the United States, 2018
- Deaths: Leading Causes for 2017 [PDF - 2 MB]
- Trends in Deaths from Health, United States
- United States Life Tables: 2018 [PDF - 2 MB]
- U.S. State Life Tables, 2018 [PDF - 643 KB]
- Mortality Among Adults Aged 25 and Over by Marital Status: United States, 2010-2017
- Mortality Patterns Between Five States With Highest Death Rates and Five States With Lowest Death Rates: United States, 2017
- Mortality Trends by Race and Ethnicity Among Adults Aged 25 and over: United States 2000-2017
- Dementia Mortality in the United States, 2000-2017 [PDF - 611 KB]
- Hospitalization, Readmission, and Death Experience of Noninstitutionalized Medicare Fee-for-service Beneficiaries Aged 65 and Over

All years 2017 & 2018

More data: query tools

- CDC Wonder - Underlying Cause of Death

Related Links

- Linked birth and infant death data
- Mortality Statistics
- Where to Write for Vital Records

Where is 2020 mortality data?  
 Why does the CDC avoid publication for easy access to 2020 mortality data?  
 Does this comport with already evidenced efforts to scrub 2020 mortality data?  
 Is it because 2020 mortality data is evidenced to directly conflict with fraudulently constructed COVID data?

This is evidenced by the 2020 mid-April shift from the benchmark pandemic measurement of MORTALITY DATA to the contrived, fictional & constructed "NEW CASES" data.

2020 mortality is the PROBLEMATIC DATA POINT that causes the enterprise fraud construct to spiral into a slate of problems & solutions defined by the construct itself & when understood, provide a fulsome comprehension of how the fraud construct functions; to the extent that accurate predictions of the Criminal Enterprise are precise & routine.

THE PROBLEMATIC SINGLE DATA POINT CREATING CONFLICT IS THE IRRECONCILABLE & FINITE NUMBER OF ANNUAL [2020] TOTAL U.S. DEATHS [MORTALITY DATA], WHICH IS THE CONVENTIONAL BENCHMARK MEASUREMENT FOR PANDEMICS. ONE SOLUTION FOR THIS WILL BE THE "MID-APRIL SHIFT" AWAY FROM DECLINING MORTALITY DATA TO FRAUDULENT "NEW CASE DATA." THIS CAUSES THE NEED FOR A "DATA DRIVER" & POSITIONS PCR/CT & NVSS.

PROJECTED LATE IN 2020 WITH INCOMPLETE DATA/6TH DEADLIEST CDC'S FINAL/12TH DEADLIEST

TOTAL U.S. DEATHS RANKED BY YEAR 2010-2020

Calculations:

Average deaths per year  
 1999-2018: 50,567,774/20= 2,528,389

Range 1/01 Jan 20 to 12 May 20:  
 365-132=233 days> 132 days

Range 2/01 13 May 20 to 31 Dec 20:  
 365-132=233 days> 233 days

Range 1/actual total deaths  
 01 Jan 20 to 12 May 20: 944,251

Range 1/calculated average deaths per day  
 01 Jan 20 to 12 May 20: 944,251/132= 7153.4

Range 2/projected total deaths  
 12 May 20 - 31 Dec 20: 7,153.4x233= 1,666,746

COMBINED U.S. TOTAL PROJECTED DEATHS FOR 2020:  
 1,666,746+944,251= 2,610,997

Rank	Year	Deaths
1st	2018	2,839,205
2nd	2017	2,813,503
3rd	2016	2,744,248
4th	2015	2,712,630
5th	2014	2,626,418
6th	2020	2,610,997
7th	2013	2,596,993
8th	2012	2,543,279
9th	2011	2,515,458
10th	2010	2,468,435

QUESTIONS:

- In the last 10 years, 2020 is only 6th deadliest so how can a "pandemic" exist?
- How can there be a "pandemic" in a year where the mortality rate projects lower than the previous 5-years?
- Where are the COVID deaths coming from?
- Fraudulent mixing of co-morbidities to drive fraudulent data?
- Were the COVID deaths "harvested" from regular mortality data much like ballots were "harvested" and to accomplish a political objective?
- Was the objective to steal the election?
- Is this about a VIRUS or is this about China, the CCP and the end of America?

FACTCHECK.ORG

A PROJECT OF THE ANNENBERG PUBLIC POLICY CENTER

USA Deaths by Year

Year	Deaths	Population	Rate
2009	2,437,163	306,771,529	0.8%
2010	2,468,435	309,346,863	0.8%
2011	2,515,458	311,718,847	0.8%
2012	2,543,279	314,102,623	0.8%
2013	2,596,993	316,427,395	0.8%
2014	2,626,418	318,907,401	0.8%
2015	2,712,630	321,418,820	0.8%
2016	2,744,248	323,071,342	0.8%
2017	2,813,503	325,147,121	0.9%
2018	2,839,205	327,167,439	0.9%
2019	2,794,146	328,239,523	0.9%
2020	2,533,214	330,619,870	0.8%
<b>Avg:</b>	<b>2,635,391</b>	<b>319,411,564</b>	<b>0.8%</b>

CDC - CENSUS - USA TODAY (Nov 22, 2020)



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Table 3 contains co-morbidity deaths only in footnote domain 1. First, we begin by examining the introductory notes and footnotes for Table 3 and it's here we slow down to provide explanations for them [1-4 introductory] and 1-10 footnotes.]

**TABLE 3: COMORBIDITIES & OTHER CONDITIONS:** Data is derived from WHO ICD-10/U07.1 coding & permits portals for fraudulent data manipulation by incomplete provisional data sets that rely on death certificate completion, layering, redundant counting & coding & suppression of certain data due to policy. 4 specific introductory and 10 specific footnote domains were identified to warrant more fulsome investigation under RICO.

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age group. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

Year in which death occurred	Conditions contributing to death when COVID-19 was listed on the death certificate (1)	All ages	Age group					Total
			0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	
2020-2021	Influenza and pneumonia	521,962	671	3,098	6,211	25,490	48,881	76,771
2020-2021	Chronic lower respiratory diseases	39,262	86	247	571	1,899	6,264	14,823
2020-2021	Acute respiratory distress syndrome	72,424	274	1,089	2,069	7,098	14,871	26,499
2020-2021	Respiratory failure	261,947	493	2,105	3,843	16,219	36,371	64,952
2020-2021	Respiratory arrest	14,234	71	129	241	761	1,734	3,361
2020-2021	Other diseases of the respiratory system	36,211	114	742	791	3,262	4,837	7,366
2020-2021	Hypertensive disease	115,277	72	482	1,472	6,234	14,899	29,624
2020-2021	Ischemic heart disease	72,361	24	117	449	2,043	7,197	13,667
2020-2021	Cardiac arrest	62,361	219	938	2,296	6,214	13,194	26,714
2020-2021	Cardiac arrhythmias	36,262	37	137	366	1,297	4,982	9,579
2020-2021	Heart failure	36,262	32	137	427	1,291	4,124	9,277
2020-2021	Conduction system diseases	36,262	46	139	423	1,234	3,792	7,517
2020-2021	Other diseases of the circulatory system	48,019	187	496	1,144	3,876	6,397	12,277
2020-2021	Septicemia	36,224	196	947	1,911	5,292	13,148	26,796
2020-2021	Septic shock	12,416	63	137	366	1,294	4,411	8,691
2020-2021	Septicemia with organ dysfunction	107,271	133	710	2,247	7,038	18,317	36,993
2020-2021	Shock	36,262	188	1,269	3,229	1,046	7,813	15,517
2020-2021	Sepsis	36,262	9	0	0	0	105	1,889

## TABLE 3 Comorbidities and other conditions

Table 3 shows the **1** types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). **2** number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age group **3** For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For death **4** with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**\*Refer to text of article for explanations of points 1-4 & 1-10.**

## FOOTNOTES

**1** NOTE: Empty data cells represent counts between 1-9 that have been suppressed in accordance with NCHS confidentiality standards. Conditions contributing to the death were identified using **2** International Classification of Diseases, Tenth Revision (ICD-10). Deaths involving more than one condition (**3** deaths involving both diabetes and respiratory arrest) were counted in both totals. To avoid counting the same death multiple times, the numbers for different conditions should not be summed **4** Some deaths involve more than one of the same condition category (e.g. deaths involving unintentional and intentional injury often include two or more injury ICD-10 codes) **5** number of mentions presented on the table above represents the number of instances where the condition was cited on the death certificate **6** Number of deaths and number of mentions reported in this table are tabulated from deaths received and coded as of the date of analysis and do not represent all deaths that occurred in that period. Data for this table **7** derived from a cut of the National Vital Statistics System (NVSS) database taken at a particular time, separate from other surveillance tables on this page which are tabulated on the date of update. As a result **8** the total number of COVID-19 deaths in this table may not match other surveillance tables on this page **9** Data during recent periods are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS and processed for reporting purposes. This delay can range from 1 week to 8 weeks or more, depending on the jurisdiction and cause of death. United States death counts include the 50 states, plus the District of Columbia and New York City. New York state estimates exclude New York City.

**10** [1] Deaths with confirmed or presumed COVID-19, coded to ICD-10 code U07.1.





[https://www.cdc.gov/nchs/nvss/vsrr/covid\\_weekly/](https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/)

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: 9/26/2021

State	Attribute	Condition Group	Condition											
United States	COVID-19 Deaths	All	All	Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years
2020/2021	Influenza and pneumonia	323,962	671	3,098	8,011	21,380	48,881	78,775	86,882	76,258				
2020/2021	Chronic lower respiratory diseases	59,363	86	247	573	1,695	6,503	14,820	19,548	15,890				
2020/2021	Adult respiratory distress syndrome	72,416	254	1,009	2,668	7,088	14,673	20,499	16,556	9,668				
2020/2021	Respiratory failure	261,967	493	2,110	5,843	16,035	38,377	64,851	72,775	61,479				
2020/2021	Respiratory arrest	14,299	31	129	293	781	1,786	2,961	3,833	4,485				
2020/2021	Other diseases of the respiratory system	30,033	115	342	795	2,002	4,657	7,306	8,031	6,785				
2020/2021	Hypertensive diseases	131,037	52	482	1,972	6,236	16,695	29,624	36,104	39,869				
2020/2021	Ischemic heart disease	72,501	20	117	488	2,083	7,197	15,843	22,596	24,155				
2020/2021	Cardiac arrest	82,361	210	899	2,296	6,131	13,190	19,714	20,697	19,223				
2020/2021	Cardiac arrhythmia	50,045	37	137	366	1,287	4,082	9,570	15,424	19,142				
2020/2021	Heart failure	50,997	32	157	437	1,381	4,159	9,277	14,768	20,785				
2020/2021	Cerebrovascular diseases	33,028	40	139	423	1,334	3,792	7,337	9,487	10,475				
2020/2021	Other diseases of the circulatory system	45,019	187	496	1,144	2,870	6,397	10,277	11,731	11,916				
2020/2021	Sepsis	66,114	186	647	1,911	5,292	12,148	18,758	16,715	10,456				
2020/2021	Malignant neoplasms	32,658	83	137	395	1,284	4,417	8,893	10,006	7,443				
2020/2021	Diabetes	107,171	153	733	2,547	7,638	18,317	29,560	28,921	19,300				
2020/2021	Obesity	30,880	380	1,503	3,229	5,586	7,921	7,547	3,784	929				
2020/2021	Alzheimer disease	22,541	0	1	3	20	192	1,469	6,504	14,352				

### 26 AUG 20

## BULK DATA REVISIONS

Before Revision: 0%

26 Aug 20 Revision: 94%

PROBLEMATIC BULK DATA REVISIONS

Invalid Data

Before Revision: 0%

12 May 21 Revision: 95%

100% → 6%

Valid Data

100% → 5%

0 → 2.6

Average Underlying Co-morbidities

0 → 4.0

THIS IS THE DATA USED TO PREDICATE THE NATIONAL EMERGENCY & ISSUE GUIDELINES & MITIGATIONS.

WHAT IS THE NET EFFECT?

1. Sole-cause COVID mortality at 5%
2. Fraudulent mortality data still at 95% [comporting with existing positions: 26 Aug 20 & 12 May 21 bulk data revisions]
3. Evidence of co-morbidity harvesting contained in the data set is identifiable by sifting the 4.0 underlying conditions: flu/pneumo, heart disease, diabetes & pneumonia
4. If the condition doesn't filter as an underlying condition, then the underlying condition is attributed to fraudulent sole-cause COVID



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

This presents as evidence of data steering/co-morbidity harvesting with compartmentalization and suppression.

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**All flu/pneumo goes to COVID but no COVID goes to flu/pneumo**

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: 9/26/2021

State	Attribute	Condition Group	Condition											
United States	COVID-19 Deaths	All	Influenza and pneumonia	Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years
				2020/2021	Influenza and pneumonia	323,962	671	3,098	8,011	21,380	48,881	78,775	86,882	76,258

**CODING TO HARVEST MORBIDITIES**



**FLU/PNEUMO**

**ALL V. COVID-19**

**Evidence of RICO pattern steering diagnoses through coding manipulation / coding to harvest morbidities & steering them to COVID-19**

**323,962 V. 0**

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: (Blank)

State	Attribute	Condition Group	Condition											
United States	COVID-19 Deaths	COVID-19	Influenza and pneumonia	Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years

Table footnote: "Empty data cells represent counts between 1-9 that have been suppressed in accordance with NCHS confidentiality standards."



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

This presents as evidence of data steering/co-morbidity harvesting with compartmentalization and suppression.

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**All heart disease goes to COVID but no COVID goes to heart disease**

**CODING TO HARVEST MORBIDITIES**

**HEART DISEASE**



**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: 9/26/2021

State	Attribute	Condition Group	Condition																	
United States	COVID-19 Deaths	All	Ischemic heart disease																	
Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years										
2020/2021	Ischemic heart disease	72,501	20	117	488	2,083	7,197	15,843	22,596	24,155	12									

**Evidence of RICO pattern steering diagnoses through coding manipulation / coding to harvest morbidities & steering them to COVID-19**

**ALL V. COVID-19**

**72,501 V. 0**

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: (Blank)

State	Attribute	Condition Group	Condition																	
United States	COVID-19 Deaths	COVID-19	Ischemic heart disease																	
Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years										

**Table footnote: "Empty data cells represent counts between 1-9 that have been suppressed in accordance with NCHS confidentiality standards."**



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

This presents as evidence of data steering/co-morbidity harvesting with compartmentalization and suppression.

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**All diabetes goes to COVID but no COVID goes to diabetes**

Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.											Data as of:
											9/26/2021
State	Attribute	Condition Group	Condition								
United States	COVID-19 Deaths	All	Diabetes								
Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years	
2020/2021	Diabetes	107,171	153	733	2,547	7,638	18,317	29,560	28,921	19,200	E

**CODING TO HARVEST MORBIDITIES**

**DIABETES**



**Evidence of RICO pattern steering diagnoses through coding manipulation / coding to harvest morbidities & steering them to COVID-19**

**ALL V. COVID-19**

**107,171 V. 0**

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.											Data as of:
											(Blank)
State	Attribute	Condition Group	Condition								
United States	COVID-19 Deaths	COVID-19	Diabetes								
Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years	

**Table footnote: "Empty data cells represent counts between 1-9 that have been suppressed in accordance with NCHS confidentiality standards."**



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

This presents as evidence of data steering/co-morbidity harvesting with compartmentalization and suppression.

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: 9/26/2021

State	Attribute	Condition Group	Condition											
United States	COVID-19 Deaths	All	Obesity	Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years
				2020/2021	Obesity	30,880	380	1,503	3,229	5,586	7,921	7,547	3,784	929

**All obesity goes to COVID but no COVID goes to obesity**

**CODING TO HARVEST MORBIDITIES**



**OBESITY**

**ALL V. COVID-19**

**Evidence of RICO pattern steering diagnoses through coding manipulation / coding to harvest morbidities & steering them to COVID-19**

**30,880 V. 0**

## Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

**Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group.** Data as of: (Blank)

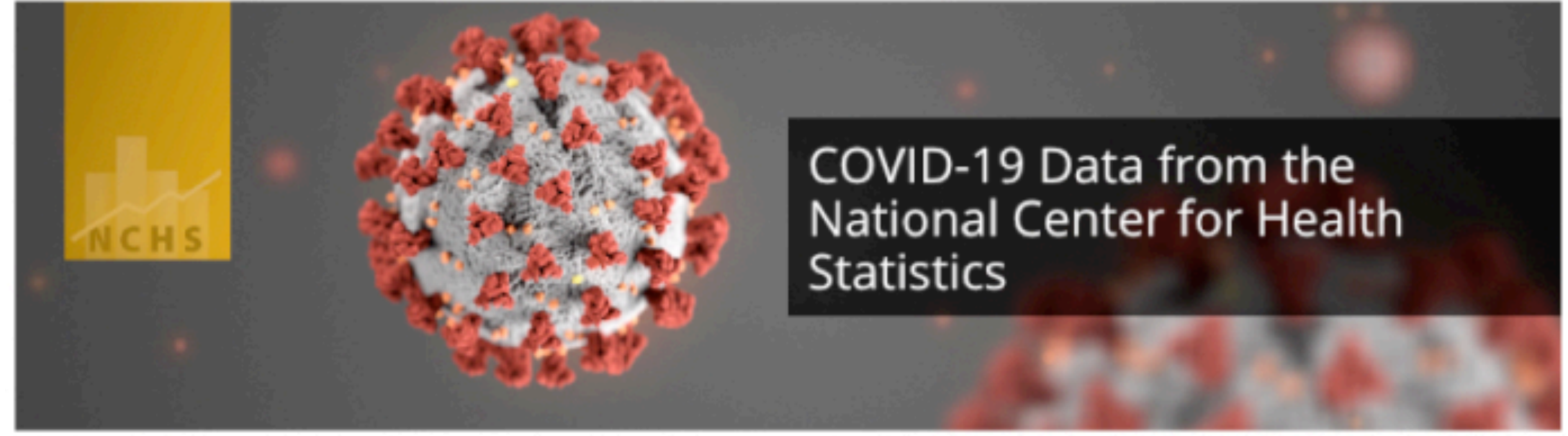
State	Attribute	Condition Group	Condition											
United States	COVID-19 Deaths	COVID-19	Obesity	Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years

Table footnote: "Empty data cells represent counts between 1-9 that have been suppressed in accordance with NCHS confidentiality standards."



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Note the identified merger coming from the CDC as it relates to coding. This is where China and the NVSS marry to deliver the ICD-10 to the US and the massive fraud portals it delivers.



NCHS collects, analyzes, and disseminates information on the health of the nation. In response to the COVID-19 pandemic, NCHS is providing the most recent data available on deaths, mental health, and access to health care, loss of work due to illness, and telemedicine from the vital statistics system, the NCHS Research and Development Survey, and through a partnership with the U.S. Census Bureau.

For general information including symptoms, testing, and community safety, visit <https://www.cdc.gov>.

[Articles on NCHS Response to Coronavirus Disease 2019 \(COVID-19\)](#)



**Deaths**

Access provisional death counts based on information obtained from death certificates.



**Cause-of-Death Certification**

Guidance for certifiers on how to report deaths due to COVID-19 on death certificates.



**Births and Pregnancies**

Access provisional data on births and COVID-19 cases among pregnant women and newborns.



**Health Care Access, Telemedicine, and Mental Health**

Data from NCHS' partnership with the U.S. Census Bureau on the Household Pulse Survey.



**Health Care Access, Telemedicine, and Loss of Work Due to Illness**

Data from NCHS' research survey RANDS during COVID-19.



**Hospital Data**

Data from NCHS' National Hospital Care Survey describing patient care in hospital-based settings.



**Long-term Care and COVID-19**

COVID-19-related data for residential care communities and adult day services centers


Merger of US Criminal Enterprise & China/RICO



**Coding**

Causes of death are coded according to the *International Classification of Diseases, 10th Revision (ICD-10)*. On January 31, 2020, the World Health Organization (WHO) established a new emergency code for COVID-19: **U07.1**.

[WHO | Emergency use ICD codes for COVID-19 disease outbreak](#)



**ICD-10 Code**


**U07.1 - COVID-19**

**Excludes:** Coronavirus infection, unspecified site (B34.2) and Severe acute respiratory syndrome (SARS), unspecified (U04.9)

The WHO has provided a second code, U07.2, for clinical or epidemiological diagnosis of COVID-19 where a laboratory confirmation is inconclusive or not available. Because laboratory test results are not typically reported on death certificates in the United States, NCHS did not implement U07.2 for mortality statistics.

MERGER

Guidance for Certifying Deaths Due to Coronavirus Disease 2019 (COVID-19)



**Key Points**

- If COVID-19 is determined to be a cause of death, it should be reported on the death certificate.
- When reporting COVID-19 as a cause of death, use standard WHO terminology, such as "Coronavirus Disease 2019" or "COVID-19."
- Report pre-existing conditions that contributed to the death in Part II of the death certificate.

NVSS / existing work & positions

<https://www.cdc.gov/nchs/covid19/index.htm>

Permits China to steer US infection & mortality data through its proxy - Tedros/WHO



# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Here we note the direct application of ICD-10 down through the NVSS and to medical providers writ large.



## Coding Deaths Due to COVID-19 <https://www.cdc.gov/nchs/faq.htm#CodingDeathsDu>

Is there an ICD-10 code for COVID-19?

Yes, there is an *International Classification of Diseases, 10<sup>th</sup> Revision* (ICD-10) code for mortality for COVID-19. The code is **U07.1**.

This is an emergency code that was issued by the World Health Organization (WHO) in January 2020 to identify deaths from COVID-19 and help track the new and evolving pandemic.

For more information, see [Notification of New ICD Code Introduced for COVID-19](#).

The World Health Organization also issued another code, **U07.2**, for "COVID-19, virus not identified." Why didn't NCHS implement this code?

The WHO issued a second ICD-10 code, **U07.2**, for clinical or epidemiological diagnosis of COVID-19 where a laboratory confirmation was inconclusive or not available. Because certifiers in the U.S. do not typically report laboratory test results on death certificates, NCHS did not implement U07.2 for mortality statistics. When laboratory confirmation is inconclusive or unavailable, certifiers determine and report the causes of death on the death certificate based on medical history, medical records, autopsy report (if available), and other relevant sources of information.

For more information, see [Notification of New ICD Code Introduced for COVID-19](#).

How is COVID-19 coded when it is reported on the death certificate?

Terms in the cause-of-death section on death certificates indicating COVID-19 are coded to **U07.1**. These terms include, but are not limited to:

- COVID-19,
- Coronavirus Disease 2019,
- COVID, and
- SARS-CoV-2.

In addition, if any of the above terms are reported as a "probable" or "presumed" cause of death on the death certificate, the code U07.1 would be assigned. Certifiers can use "probable" or "presumed" for any cause of death if they determine with a reasonable degree of medical certainty that a condition caused or contributed to the death. NCHS regularly accepts these terms when they are used with any condition reported as a cause of death on a death certificate. **Any condition reported by the certifier as a "probable" or "presumed" cause of death is assigned the code for that condition.**

If "pending COVID-19 testing" is reported on the death certificate, it will *not* be coded as U07.1 and will require that the certifier provide an update when the test results are available. If an update is not received, NCHS follows up with state registrars on these records.

If COVID-19 is reported in the cause-of-death section of the certificate, but the manner of death is "pending," U07.1 is tentatively assigned for the term "COVID-19," but these records also require follow-up.

If the certifier reports "COVID-19 exposure" or "possible COVID-19 exposure," the code U07.1 is *not* assigned. NCHS does *not* code exposures. A person may be exposed to COVID-19, but that does not mean the patient became infected with the virus, developed the disease (exhibited its signs or symptoms), or that it was a condition that caused or contributed to death. **Certifiers are asked to only report medical conditions that they determine to be a cause or contributing cause of death on the death certificate.**

More general terms like "Coronavirus" without an indication of the specific strain will be coded to B34.2, "Coronavirus infection, unspecified site." NCHS will query the state registrar about records with the B34.2 code. If the state registrar confirms that it was *not* the 2019 strain, the code will remain B34.2 and the death will *not* be counted as due to COVID-19. If the state registrar indicates that it was specifically COVID-19 that caused or contributed to the death, the code will be changed to U07.1.

What if COVID-19 is reported in Part II, other significant conditions contributing to death, of the cause-of-death section on the death certificate? How are these records coded?

If COVID-19 is reported in Part II, the term will be assigned the U07.1 code and the death will be counted as due to COVID-19. Part II is for reporting other significant conditions that contributed to the death, but are not a part of the sequence of conditions directly leading to the death in Part I. For more information, see the [2003 U.S. Standard Certificate of Death](#) and [Q&A on what is officially counted as a COVID-19 death](#).



**COVID-19 Alert No. 2**  
March 24, 2020

**New ICD code introduced for COVID-19 deaths**  
This email is to alert you that a newly-introduced ICD code has been implemented to accurately capture mortality data for Coronavirus Disease 2019 (COVID-19) on death certificates.

Please read carefully and forward this email to the state statistical staff in your office who are involved in the preparation of mortality data, as well as others who may receive questions when the data are released.

**What is the new code?**  
The new ICD code for **Coronavirus Disease 2019 (COVID-19)** is **U07.1** and below is how it will appear in formal tabular list format.

**U07.1 COVID-19**  
**Excludes:** Coronavirus infection, unspecified site (B34.2)  
Severe acute respiratory syndrome [SARS], unspecified (U04.9)

The WHO has provided a second code, **U07.2** for clinical or epidemiological diagnosis of COVID-19 where a laboratory confirmation is inconclusive or not available. Because laboratory test results are not typically reported on death certificates in the U.S., NCHS is not planning to implement U07.2 for mortality statistics.

**When will it be implemented?**  
Immediately.

**Will COVID-19 be the underlying cause?**  
The underlying cause depends upon what and where conditions are reported on the death certificate. However, the rules for coding and selection of the underlying cause of death are expected to result in COVID-19 being the underlying cause more often than not.

**What happens if certifiers report terms other than the suggested terms?**  
If a death certificate reports coronavirus without identifying a specific strain or explicitly specifying that it is not COVID-19, NCHS will ask the states to follow up to verify whether or not the coronavirus was COVID-19. As long as the phrase used indicates the 2019 coronavirus strain, NCHS expects to assign the new code. However, it is preferable and more straightforward for certifiers to use the standard terminology (COVID-19).

**What happens if the terms reported on the death certificate indicate uncertainty?**  
If the death certificate reports terms such as "probable COVID-19" or "likely COVID-19," these terms would be assigned the new ICD code. It is not likely that NCHS will follow up on these cases. If "pending COVID-19 testing" is reported on the death certificate, this would be considered a pending record. In this scenario, NCHS would expect to receive an updated record, since the code will likely result in R99. In this case, **NCHS will ask the states to follow up to verify if test results confirmed that the decedent had COVID-19.**

**Do I need to make any changes at the jurisdictional level to accommodate the new ICD code?**  
Not necessarily, but you will want to confirm that your systems and programs do not behave as if U07.1 is an unknown code.

**Should "COVID-19" be reported on the death certificate only with a confirmed test?**  
COVID-19 should be reported on the death certificate for all decedents where the disease caused or is assumed to have caused or contributed to death. Certifiers should include as much detail as possible based on their knowledge of the case, medical records, laboratory testing, etc. If the decedent had other chronic conditions such as COPD or asthma that may have also contributed, these conditions can be reported in Part II. (See attached Guidance for Certifying COVID-19 Deaths)

Coinciding with the arrival of the first U.S. bulk sets of infection & mortality data, a direct path for the application of Chinese policy to US internal COVID data occurs with CDC/NVSS memo #2, 24 Mar 20 [12 days after WHO declared a global pandemic]

WHO/Tedros introduce a new ICD Code under fraudulent "EMERGENCY" predication [compartmentalization] as coinciding with Biden's January 2021 inauguration

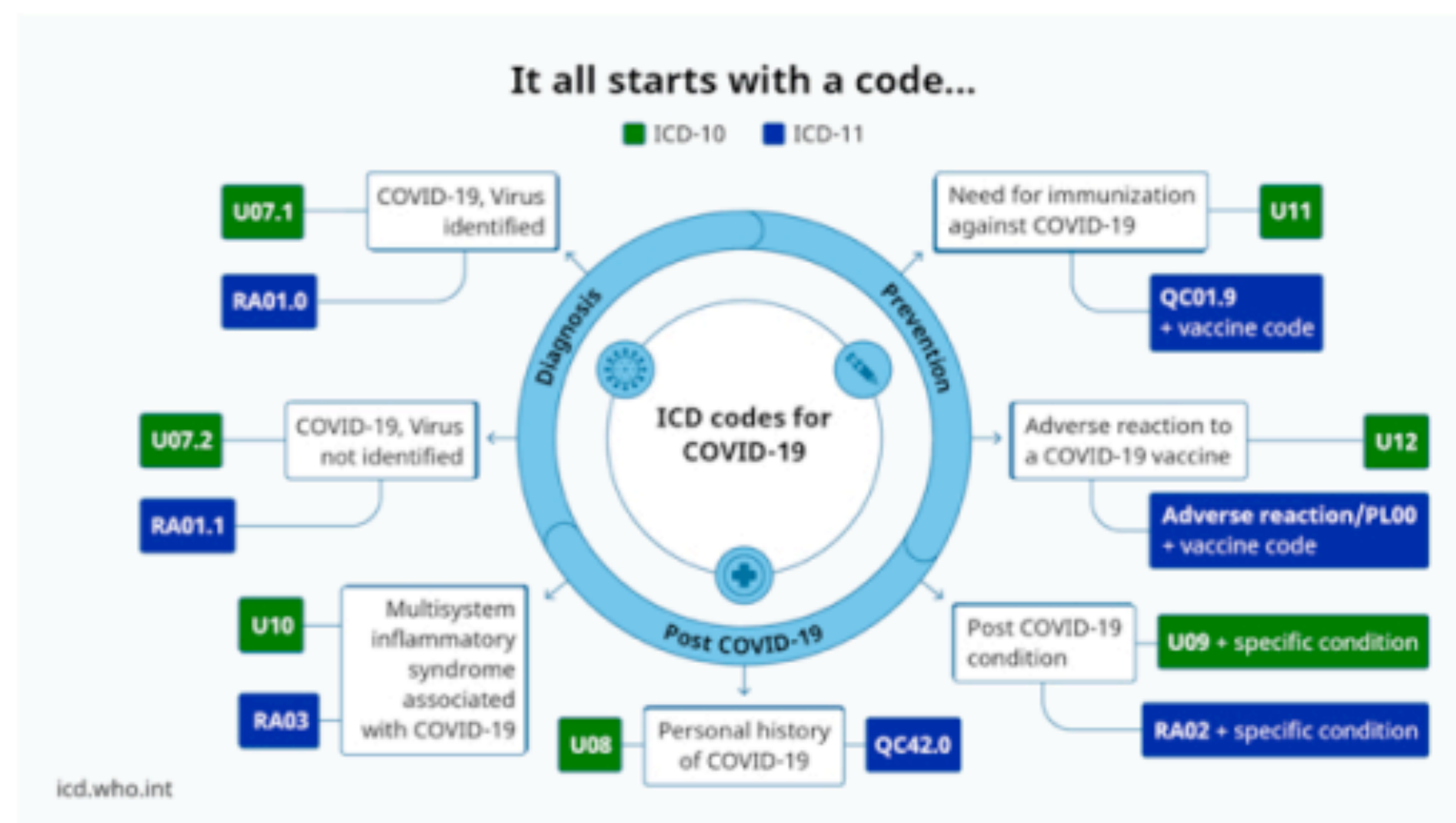


# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



Here we note the direct linkage to the WHO's ICD-10 as it stares us right in the face – "It all starts with a code..." We also immediately grab onto updates already issued to the ICD-10.

Home / Classifications / Classification of Diseases (ICD) / Emergency use ICD codes for COVID-19 disease outbreak

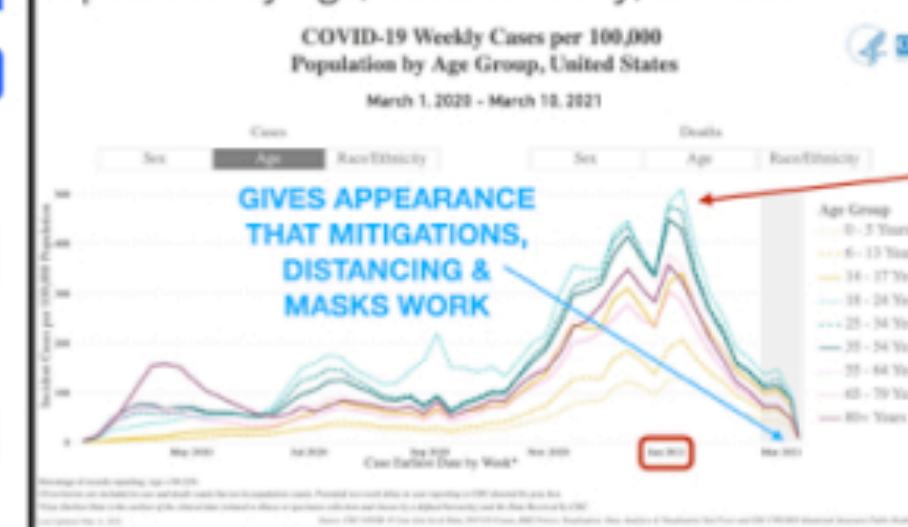


Predicted  
30 Nov 20

Confirmed 20 Jan 21

Confirmed March 2021

COVID-19 Weekly Cases and Deaths per 100,000 Population by Age, Race/Ethnicity, and Sex



## International guidelines for certification and classification (coding) of COVID-19 as cause of death

This document provides instructions for coding and certification of deaths due to COVID-19. The instructions align with the WHO definition of deaths caused by COVID-19 and ICD, and ensure feasibility in all settings.

The coding guidelines are very technical and only include some template cases. Questions may arise in daily work due to the inexorable richness of medical language and practice in certification. Support can be provided through the closest WHO-FIC Collaborating Centre (<https://www.who.int/groups/who-family-of-international-classifications-network>) or icd@who.int.

The guidelines for certifiers aim at physicians and show best practice. Certifiers should receive their instructions as a separate document, without the coding guidelines.

### Translations:

Arabic Chinese French Portuguese Russian Spanish

## Emergency use ICD codes for COVID-19 disease outbreak

UPDATE

Since the beginning of the pandemic and in response to member state requests, the classification and terminologies unit has been progressively activating emergency codes for COVID-19 in ICD-10 and ICD-11 after consultation with the relevant committees and reference groups of the WHO Family of International Classifications (WHO-FIC) Network.

**February 2020** Emergency codes were activated for COVID-19:

- confirmed diagnosis of COVID-19
- clinical or epidemiological diagnosis (suspected or probable) of COVID-19

**April 2020** International guidelines for certification and classification (coding) of COVID-19 as cause of death were published in 7 languages.

**September 2020** A set of additional codes upon request by member states were activated to be able to document or flag conditions that occur in the context of COVID-19. In particular the need for disambiguation between acute disease, late effects or lengthy course led to the neutral formulation "post-covid". This term does not pre-empt any etiopathological links, and leaves space for linking any condition to a preceding acute COVID.

- Personal history of COVID-19
- Post COVID-19 condition
- Multisystem inflammatory syndrome associated with COVID-19

**January 2021** A set of additional codes were activated for:

- Immunization to prevent COVID-19
- Adverse reaction to a COVID-19 vaccine.

**NOTE:** Coincides with Biden's inauguration / 30 Nov 20 prediction confirmed 20 Jan 21 & later in March with empirical COVID data / 20 Jan 21 within 45 minutes of Biden's inauguration, Tedros/WHO drop RT-PCR test cycle thresholds back to conventional levels eliminating the fraudulent data-driving aspect of abundant false positive test results with anomalously high CTs as existing from 27 Dec 19 – 20 Jan 21.



### Coding

Causes of death are coded according to the International Classification of Diseases, 10th Revision (ICD-10). On January 31, 2020, the World Health Organization (WHO) established a new emergency code for COVID-19 (U07.1).

WHO's Emergency use ICD codes for COVID-19 disease outbreak

### ICD-10 Code

U07.1 - COVID-19

Excludes: Coronavirus infection, unspecified site (B24.2) and Severe acute respiratory syndrome (SARS), unspecified (B24.1)

The WHO has provided a second code, U07.2, for clinical or epidemiological diagnosis of COVID-19 where a laboratory confirmation is inconclusive or not available. Because laboratory test results are not typically reported on death certificates in the United States, NCHS did not implement U07.2 for mortality statistics.





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

The update reflects the current news cycle pertaining to deaths relative to vaccination status, vaccine reactions and other identified areas of importance.

## UPDATE: WHO EMERGENCY CODING / ICD-10

The update reflects the current news cycle pertaining to deaths relative to vaccination status, vaccine reactions and other identified areas of importance.

### UPDATE Updates 3 & 4 in relation to COVID-19 coding in ICD-10

A set of additional categories has been agreed to be able to document or flag presentation for:

- conditions that occur in the context of COVID-19
- immunization to prevent COVID-19 and,
- an adverse reaction to a COVID-19 vaccine.

Both three-character and four-character codes have been defined to respond to the different levels of coding depth that is in place in different countries.<sup>1</sup>

#### Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49)

#### U08 Personal history of COVID-19

##### U08.9 Personal history of COVID-19, unspecified

*Note:* This optional code is used to record an earlier episode of COVID-19, confirmed or probable that influences the person's health status, and the person no longer suffers of COVID-19. This code should not be used for primary mortality tabulation.

#### U09 Post COVID-19 condition

##### U09.9 Post COVID-19 condition, unspecified

*Note:* This optional code serves to allow the establishment of a link with COVID-19. This code is not to be used in cases that still are presenting COVID-19.

#### U10 Multisystem inflammatory syndrome associated with COVID-19

##### U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified

- Cytokine storm
- Kawasaki-like syndrome
- Paediatric Inflammatory Multisystem Syndrome (PIMS)
- Multisystem Inflammatory Syndrome in Children (MIS-C)

Temporally associated with COVID-19

*Excludes:* Mucocutaneous lymph node syndrome [Kawasaki] (M30.3)

*NOTE:* Coincides with Biden's inauguration / 30 Nov 20 prediction confirmed 20 Jan 21 & later in March with empirical COVID data / 20 Jan 21 within 45 minutes of Biden's inauguration, Tedros/WHO drop RT-PCR test cycle thresholds back to conventional levels eliminating the fraudulent data-driving aspect of abundant false positive test results with anomalously high CTs as existed from 27 Dec 19 - 20 Jan 21.

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The guidelines for certifiers aim at physicians and show best practice. Certifiers should receive their instructions as a separate document, without the coding guidelines.  
Translations:  
Arabic Chinese French Portuguese Russian Spanish

COVID-19 coding updates

Update 3 & 4 in relation to COVID-19 coding in ICD-10

A set of additional categories were activated in ICD-10 to be able to document or flag presentation for conditions that occur in the context of COVID-19

- Personal history of COVID-19
- Post COVID-19 condition
- Multisystem inflammatory syndrome associated with COVID-19
- Immunization to prevent COVID-19
- Adverse reaction to a COVID-19 vaccine

Translations:  
Arabic Chinese French Portuguese Russian Spanish

**ENTERPRISE FRAUD/RICO:**  
Evidence in additional "emergency" coding emblematic of concerns regarding breakthrough cases, vaccine injuries & deaths, "Delta" variant designs, harvested co-morbidity data management, etc.



"Technological constraints" cause reliance on "international codes" [ICD-10].

<sup>1</sup> It is further noted that technological constraints may require bridge national coding to the international codes until an update of the relevant IT systems allows use of the international codes.

#### U11 Need for immunization against COVID-19

##### U11.9 Need for immunization against COVID-19, unspecified

*Note:* This code should not be used for international comparison or for primary mortality coding. This optional code is intended to be used when a person who may or may not be sick encounters health services for the specific purpose of receiving a COVID-19 vaccine.

Prophylactic COVID-19 vaccination

*Excludes:* immunization not carried out (Z28.-)

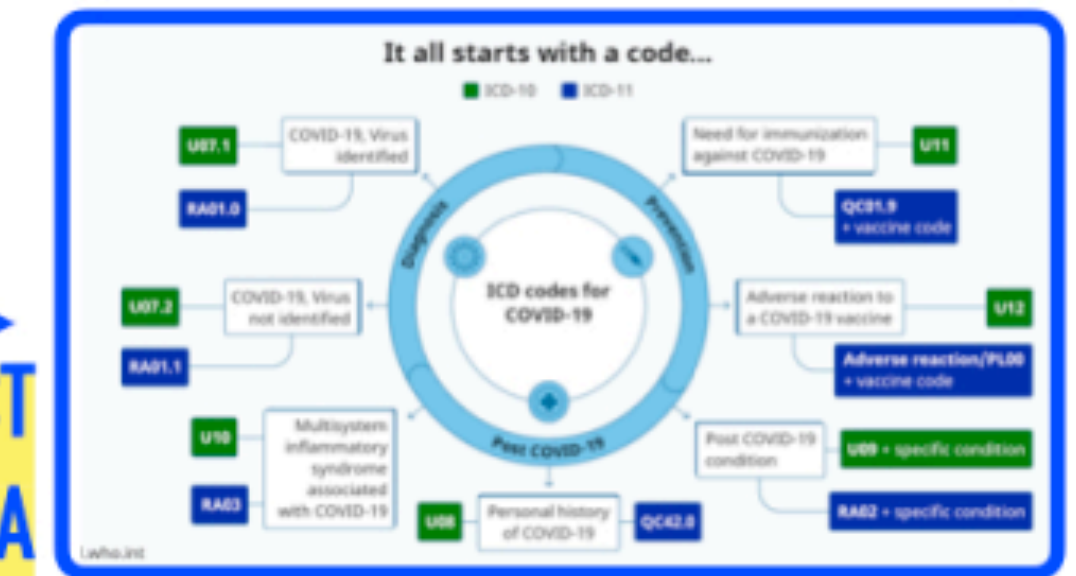
#### U12 COVID-19 vaccines causing adverse effects in therapeutic use

##### U12.9 COVID-19 vaccines causing adverse effects in therapeutic use, unspecified

*Note:* This code is to be used as an external cause code (i.e. as a subcategory under Y59 *Other and unspecified vaccines and biological substances*). In addition to this, a code from another chapter of the classification should be used indicating the nature of the adverse effect.

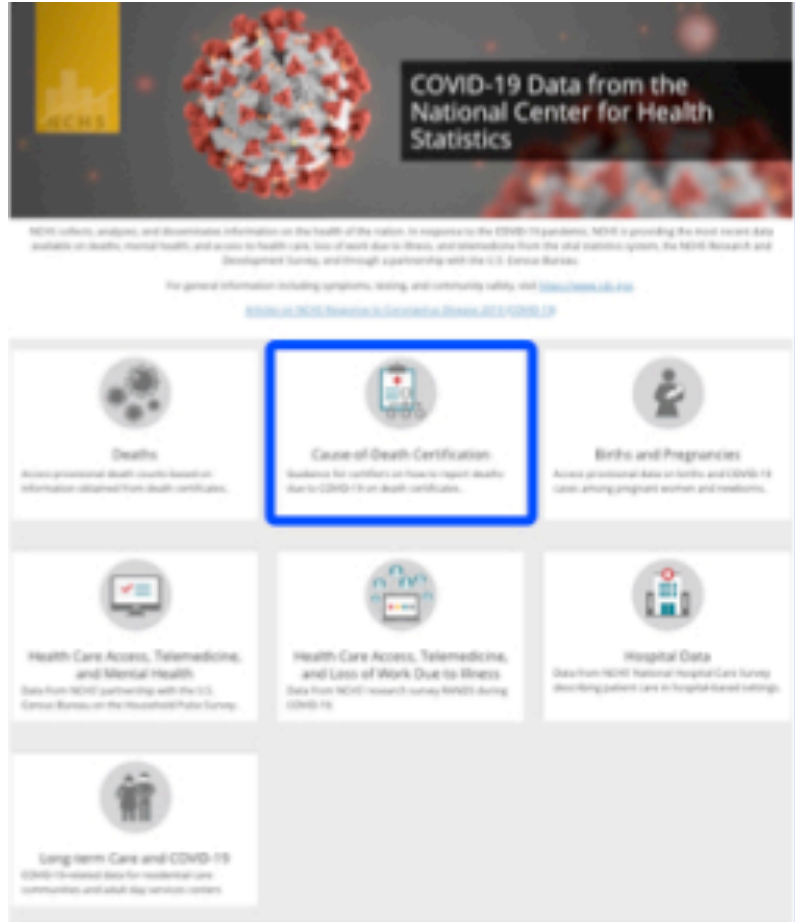
Correct administration of COVID-19 vaccine in prophylactic therapeutic use as the cause of any adverse effect.

**TRIGGER: DIRECT DEFERRAL TO CHINA**

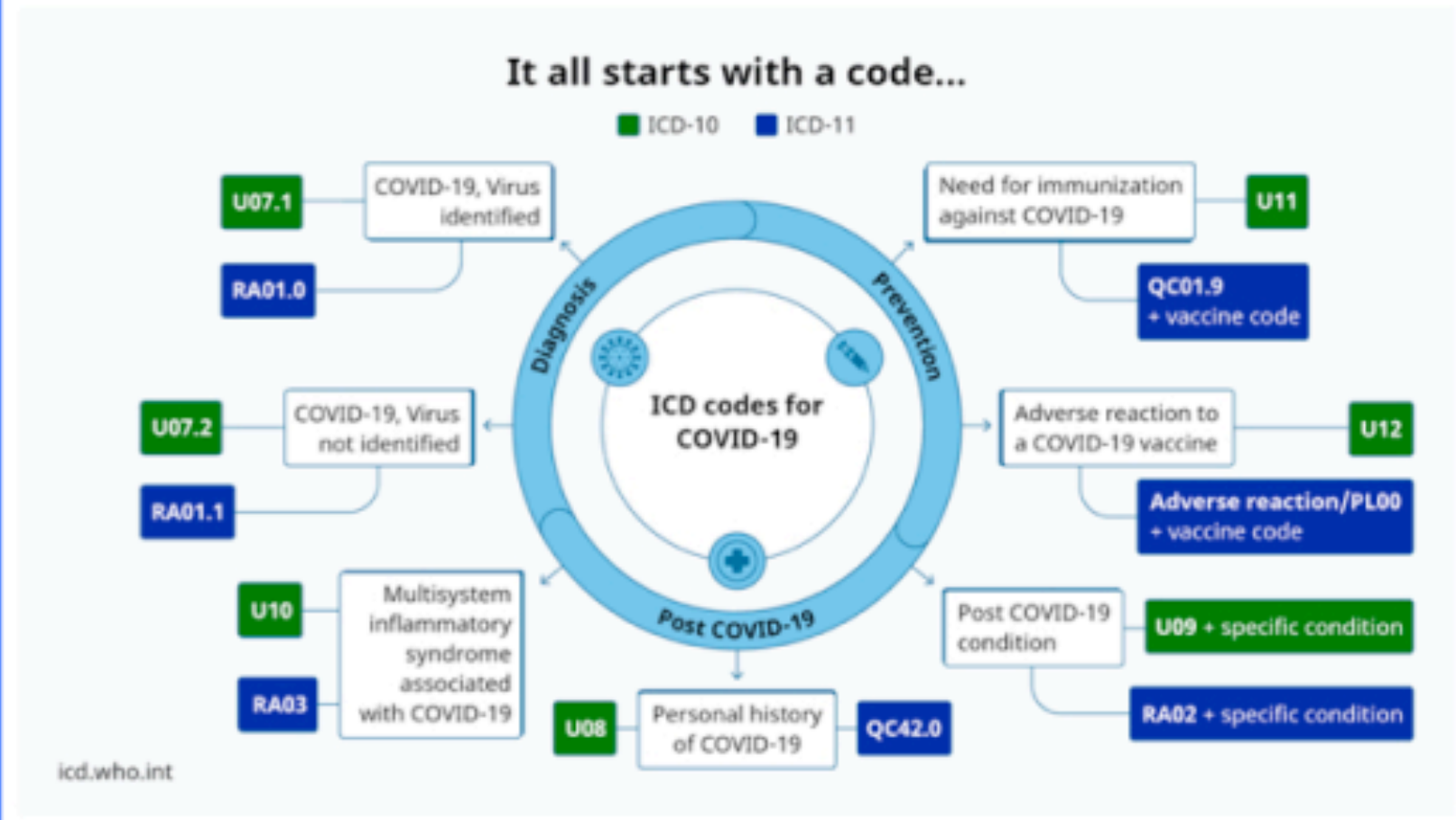




# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



Home / Classifications / Classification of Diseases (ICD) / Emergency use ICD codes for COVID-19 disease outbreak



## Emergency use ICD codes for COVID-19 disease outbreak

Since the beginning of the pandemic and in response to member state requests, the classification and terminologies unit has been progressively activating emergency codes for COVID-19 in ICD-10 and ICD-11 after consultation with the relevant committees and reference groups of the WHO Family of International Classifications (WHO-FIC) Network.

**February 2020** Emergency codes were activated for COVID-19:

- confirmed diagnosis of COVID-19
- clinical or epidemiological diagnosis (suspected or probable) of COVID-19

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- Personal history of COVID-19
- Post COVID-19 condition
- Multisystem inflammatory syndrome associated with COVID-19

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- Immunization to prevent COVID-19
- Adverse reaction to a COVID-19 vaccine.



The entire pandemic is predicated by an "emergency." Eviscerating the predicate for the emergency opens a legal portal to end the pandemic.

### International guidelines for certification and classification (coding) of COVID-19 as cause of death

This document provides instructions for coding and certification of deaths due to COVID-19. The instructions align with the WHO definition of deaths caused by COVID-19 and ICD, and ensure feasibility in all settings.

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Translations:

[Arabic](#) [Chinese](#) [French](#) [Portuguese](#) [Russian](#) [Spanish](#)

### COVID-19 coding updates

#### Update 3 & 4 in relation to COVID-19 coding in ICD-10

A set of additional categories were activated in ICD-10 to be able to document or flag presentation for conditions that occur in the context of COVID-19

- Personal history of COVID-19
- Post COVID-19 condition
- Multisystem inflammatory syndrome associated with COVID-19
- Immunization to prevent COVID-19
- Adverse reaction to a COVID-19 vaccine

Translations:

[Arabic](#) [Chinese](#) [French](#) [Portuguese](#) [Russian](#) [Spanish](#)

## INTERNATIONAL GUIDELINES FOR CERTIFICATION & CLASSIFICATION [CODING] OF COVID-19 AS CAUSE OF DEATH



**Coding**

Cases of death are coded according to the International Classification of Diseases, 10th Revision (ICD-10). On January 21, 2020, the World Health Organization (WHO) established a new emergency code for COVID-19, U07.1.

WHO - Emergency use ICD codes for COVID-19 disease outbreak

**ICD-10 Code**

U07.1 - COVID-19

**Excludes:** Coronavirus infection, unspecified site (B04.2) and Severe acute respiratory syndrome (SARS), unspecified (U04.9)

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# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



## COVID-19 - GUIDELINES FOR DEATH CERTIFICATION AND CODING

### 1. PURPOSE OF THE DOCUMENT

This document describes certification and classification (coding) of deaths related to COVID-19. The primary goal is to identify all deaths due to COVID-19.

A simplified section specifically addresses the persons that fill in the medical certificate of cause of death. It should be distributed to certifiers separate from the coding instructions.

### 2. DEFINITION FOR DEATHS DUE TO COVID-19

A death due to COVID-19 is defined for surveillance purposes as a death resulting from a clinically compatible illness, in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID disease (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death.

A death due to COVID-19 may not be attributed to another disease (e.g. cancer) and should be counted independently of preexisting conditions that are suspected of triggering a severe course of COVID-19.

### 3. GUIDELINES FOR CERTIFYING COVID-19 AS A CAUSE OF DEATH

In view of COVID-19 it is important to record and report deaths due to COVID-19 in a uniform way.

#### A- RECORDING COVID-19 ON THE MEDICAL CERTIFICATE OF CAUSE OF DEATH

**COVID-19** should be recorded on the medical certificate of cause of death for ALL decedents where the disease caused, or is assumed to have caused, or contributed to death.

#### B- TERMINOLOGY

The use of official terminology, **COVID-19**, should be used for all certification of this cause of death.

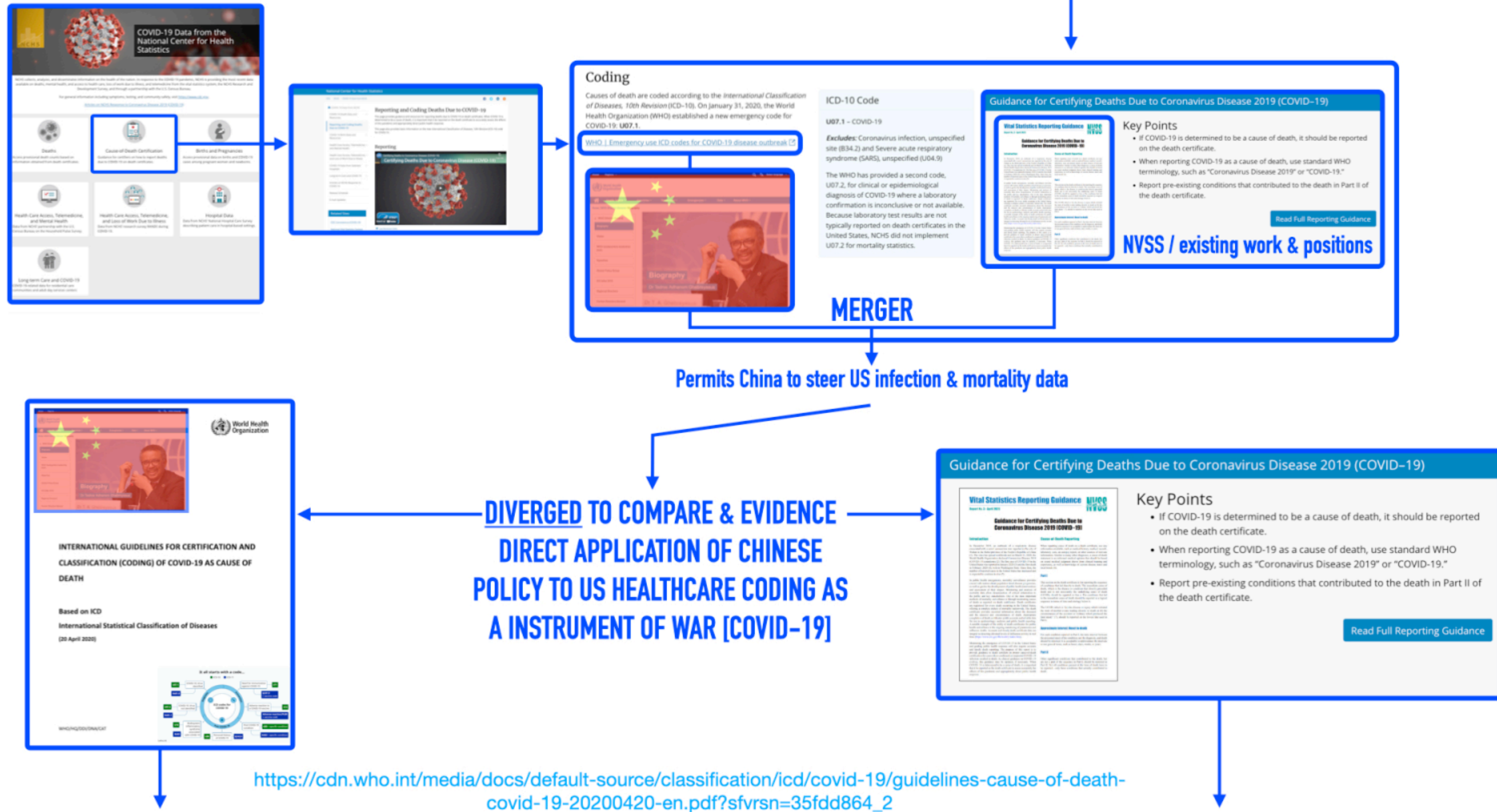
As there are many types of coronaviruses, it is recommended not to use “coronavirus” in place of COVID-19. This helps to reduce uncertainty for the classification or coding and to correctly monitor these deaths.





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS

Here, we take our merger and diverge it so we can compare like samples from the WHO/China on the left and the NVSS/US on the right. Draw your own analysis.





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



**DIVERGED:** For each WHO [China] example on the left, examine the NVSS [US] comparisons on the right for similarities & direct overlays. This permits China to steer internal US COVID data & the results are an evidenced & unmitigated disaster caused by enterprise fraud.

## C- CHAIN OF EVENTS

Specification of the causal sequence leading to death in Part 1 of the certificate is important. For example, in cases when COVID-19 causes pneumonia and fatal respiratory distress, both pneumonia and respiratory distress should be included, along with COVID-19, in Part 1. Certifiers should include as much detail as possible based on their knowledge of the case, as from medical records, or about laboratory testing.

Here, on the International Form of Medical Certificate of Cause of Death, is an example of how to certify this chain of events for deaths due to COVID-19 in Part 1:

Frame A: Medical data: Part 1 and 2			
<b>1</b> Report disease or condition directly leading to death on line a  Report chain of events in due to order (if applicable)  State the underlying cause on the lowest used line		Cause of death	Time interval from onset to death
	a	Acute respiratory distress syndrome	2 days
	b	Due to: Pneumonia	10 days
	c	Due to: COVID-19 (test positive)	14 days
	d	Due to:	
		Underlying cause of death	
<b>2</b> Other significant conditions contributing to death (time intervals can be included in brackets after the condition)			
<b>Manner of death:</b>			
<input checked="" type="checkbox"/> Disease		<input type="checkbox"/> Assault	
<input type="checkbox"/> Accident		<input type="checkbox"/> Legal intervention	
<input type="checkbox"/> Intentional self harm		<input type="checkbox"/> War	
		<input type="checkbox"/> Could not be determined	
		<input type="checkbox"/> Pending investigation	
		<input type="checkbox"/> Unknown	

Note: This is a typical course with a certificate that has been filled in correctly. Please remember to indicate whether the virus causing COVID-19 had been identified in the defunct.

## D- COMORBIDITIES

There is increasing evidence that people with existing chronic conditions or compromised immune systems due to disability are at higher risk of death due to COVID-19. Chronic conditions may be non-communicable diseases such as coronary artery disease, chronic obstructive pulmonary disease (COPD), and diabetes or disabilities. If the decedent had existing chronic conditions, such as these, they should be reported in Part 2 of the medical certificate of cause of death.

### Vital Statistics Reporting Guidance

#### Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19

##### Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Comment:** In this case, the acute respiratory acidosis was the immediate cause of death, so it was reported on line a. Acute respiratory acidosis was precipitated by the COVID-19 infection, which was reported below it on line b. In Part I, the COPD and hypertension were contributing causes but were not a part of the causal sequence in Part I, so those conditions were reported in Part II.

**Scenario I**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of) event(s)-disease, injury, or complication(s)-that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory acidosis

b. COVID-19

c. \_\_\_\_\_

d. \_\_\_\_\_

Approximate interval: Onset to death

3 days

1 week

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

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

Chronic obstructive pulmonary disease, hypertension

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:  Not pregnant within past year  Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to 1 year before death  Unknown if pregnant within the past year

37. MANNER OF DEATH:  Natural  Homicide  Accident  Pending investigation  Suicide  Could not be determined

### Vital Statistics Reporting Guidance

##### Scenario III: An 86-year-old female with an unconfirmed case of COVID-19

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the

patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Comment:** Although no testing was done, the coroner determined that the likely UCOD was COVID-19 given the patient's symptoms and exposure to an infected individual. Therefore, COVID-19 was reported on the lowest line used in Part I. Her ischemic stroke was considered a factor that contributed to her death but was not a part of the direct causal sequence in Part I, so it was reported in Part II.

**Scenario III**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of) event(s)-disease, injury, or complication(s)-that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory illness

b. Probable COVID-19

c. \_\_\_\_\_

d. \_\_\_\_\_

Approximate interval: Onset to death

1 day

5 days

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

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

Ischemic stroke

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:  Not pregnant within past year  Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to 1 year before death  Unknown if pregnant within the past year

37. MANNER OF DEATH:  Natural  Homicide  Accident  Pending investigation  Suicide  Could not be determined



### Vital Statistics Reporting Guidance

##### Scenario II: A 34-year-old female with no significant past medical history

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next

2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Comment:** In this case, the immediate cause of death was ARDS, so it was reported on line a. as a consequence of pneumonia, which was reported on line b. The underlying cause of death (UCOD) was COVID-19 so it was reported on line c., the lowest line used in Part I.

**Scenario II**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of) event(s)-disease, injury, or complication(s)-that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory distress syndrome

b. Pneumonia

c. COVID-19

d. \_\_\_\_\_

Approximate interval: Onset to death

2 days

10 days

10 days

33. WAS AN AUTOPSY PERFORMED?  Yes  No

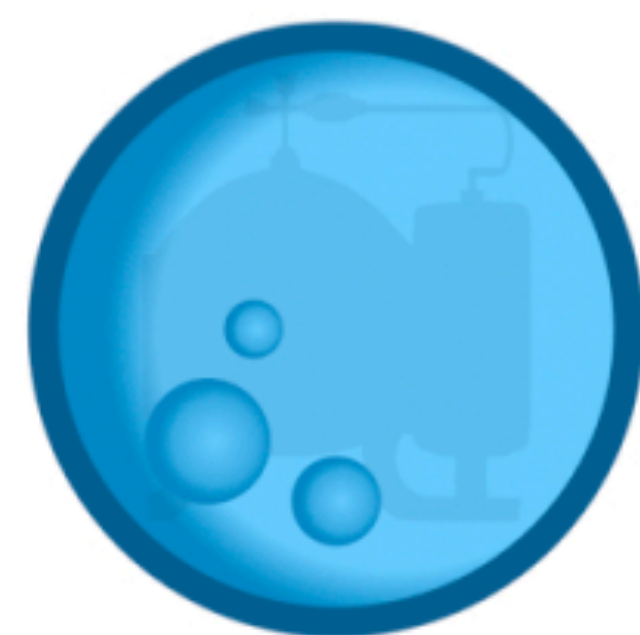
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

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

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:  Not pregnant within past year  Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to 1 year before death  Unknown if pregnant within the past year

37. MANNER OF DEATH:  Natural  Homicide  Accident  Pending investigation  Suicide  Could not be determined





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



**DIVERGED:** For each WHO [China] example on the left, examine the NVSS [US] comparisons on the right for similarities & direct overlays. This permits China to steer internal US COVID data & the results are an evidenced & unmitigated disaster caused by enterprise fraud.

Here, on the International Form of Medical Certificate of Cause of Death, are examples of how to certify this chain of events for deaths due to COVID-19 in Part 1, with comorbidities reported in Part 2:

**Frame A: Medical data: Part 1 and 2**

1	Cause of death	Time interval from onset to death
Report disease or condition directly leading to death on line a	a Acute respiratory distress syndrome	2 days
Report chain of events in due to order (if applicable)	b Due to: Pneumonia	10 days
State the underlying cause on the lowest used line	c Due to: Suspected COVID-19	12 days
<b>Underlying cause of death</b>		
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)	Coronary artery disease [5 years], Type 2 diabetes [14 Years], Chronic obstructive pulmonary disease [8 years]	

**Manner of death:**

<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

Note: This is a typical course with a certificate that is filled in correctly. COVID-19 cases may have comorbidity. The comorbidity is recorded in Part 2.

**Frame A: Medical data: Part 1 and 2**

1	Cause of death	Time interval from onset to death
Report disease or condition directly leading to death on line a	a Acute respiratory distress syndrome	2 days
Report chain of events in due to order (if applicable)	b Due to: Pneumonia	10 days
State the underlying cause on the lowest used line	c Due to: COVID-19	10 days
<b>Underlying cause of death</b>		
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)	Cerebral palsy [10 Years]	

**Manner of death:**

<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

Note: This is a typical course with a certificate that has been filled in correctly. COVID-19 cases may have comorbidity. The comorbidity is recorded in Part 2.

## Vital Statistics Reporting Guidance

### Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19

#### Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Comment:** In this case, the acute respiratory acidosis was the immediate cause of death, so it was reported on line a. Acute respiratory acidosis was precipitated by the COVID-19 infection, which was reported below it on line b. In Part I, the COPD and hypertension were contributing causes but were not a part of the causal sequence in Part I, so those conditions were reported in Part II.

**Scenario I**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of) acute diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventilator fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (final disease or condition resulting in death)

a. Acute respiratory acidosis

b. COVID-19

Sequitely list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

c. \_\_\_\_\_

d. \_\_\_\_\_

e. \_\_\_\_\_

f. \_\_\_\_\_

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DO TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:

Not pregnant within past year

Pregnant at time of death

Not pregnant, but pregnant within 42 days of death

Not pregnant, but pregnant 43 days to 1 year before death

Unknown if pregnant within the past year

37. MANNER OF DEATH

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined

Approximate interval from onset to death: 3 days, 1 week

## Vital Statistics Reporting Guidance

### Scenario II: A 34-year-old female with no significant past medical history

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next

2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Comment:** In this case, the immediate cause of death was ARDS, so it was reported on line a, as a consequence of pneumonia, which was reported on line b. The underlying cause of death (UCOD) was COVID-19 so it was reported on line c, the lowest line used in Part I.

**Scenario II**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of) acute diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventilator fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (final disease or condition resulting in death)

a. Acute respiratory distress syndrome

b. Pneumonia

c. COVID-19

Sequitely list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

d. \_\_\_\_\_

e. \_\_\_\_\_

f. \_\_\_\_\_

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DO TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:

Not pregnant within past year

Pregnant at time of death

Not pregnant, but pregnant within 42 days of death

Not pregnant, but pregnant 43 days to 1 year before death

Unknown if pregnant within the past year

37. MANNER OF DEATH

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined

Approximate interval from onset to death: 2 days, 10 days, 10 days

## Vital Statistics Reporting Guidance

### Scenario III: An 86-year-old female with an unconfirmed case of COVID-19

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the

patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Comment:** Although no testing was done, the coroner determined that the likely UCOD was COVID-19 given the patient's symptoms and exposure to an infected individual. Therefore, COVID-19 was reported on the lowest line used in Part I. Her ischemic stroke was considered a factor that contributed to her death but was not a part of the direct causal sequence in Part I, so it was reported in Part II.

**Scenario III**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of) acute diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventilator fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (final disease or condition resulting in death)

a. Acute respiratory illness

b. Probable COVID-19

Sequitely list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

c. \_\_\_\_\_

d. \_\_\_\_\_

e. \_\_\_\_\_

f. \_\_\_\_\_

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DO TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:

Not pregnant within past year

Pregnant at time of death

Not pregnant, but pregnant within 42 days of death

Not pregnant, but pregnant 43 days to 1 year before death

Unknown if pregnant within the past year

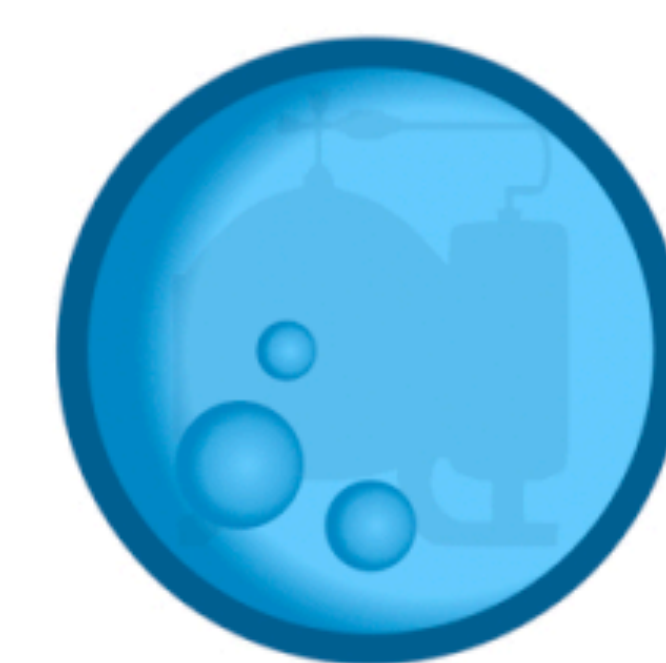
37. MANNER OF DEATH

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined

Approximate interval from onset to death: 1 day, 5 days





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



**DIVERGED:** For each WHO [China] example on the left, examine the NVSS [US] comparisons on the right for similarities & direct overlays. This permits China to steer internal US COVID data & the results are an evidenced & unmitigated disaster caused by enterprise fraud.

## E- OTHER EXAMPLES

**Frame A: Medical data: Part 1 and 2**

1 Report disease or condition directly leading to death on line a	Cause of death	Time interval from onset to death	a	Respiratory failure	2 days
			b	Due to: Pneumonia	8 days
			c	Due to: Pregnancy complicated by COVID-19	12 days
			d	Due to:	
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		Underlying cause of death			

**Manner of death:**

<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

**For women, was the deceased pregnant?**

<input checked="" type="checkbox"/> At time of death	<input type="checkbox"/> Within 42 days before the death
<input type="checkbox"/> Between 43 days up to 1 year before death	<input type="checkbox"/> Unknown

Did the pregnancy contribute to the death?

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
---	-----------------------------	----------------------------------

Note: This is a typical course with a certificate is filled in correctly. In case of a pregnancy, puerperium or birth leading to death in conjunction with COVID-19, please record the sequence of events as usual, and remember to enter the additional detail for pregnancies in frame B of the certificate of cause of death.

**Frame A: Medical data: Part 1 and 2**

1 Report disease or condition directly leading to death on line a	Cause of death	Time interval from onset to death	a	Acute respiratory distress syndrome	3 days
			b	Due to: COVID-19	One week
			c	Due to:	
			d	Due to:	
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		HIV disease [5 years]			

**Manner of death:**

<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

Note: This is a typical course with a certificate that is filled in correctly. The certifier has identified HIV disease as contributing to the death and recorded it in **Part 2**.

## Vital Statistics Reporting Guidance

### Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19

#### Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Comment:** In this case, the acute respiratory acidosis was the immediate cause of death, so it was reported on line a. Acute respiratory acidosis was precipitated by the COVID-19 infection, which was reported below it on line b. In Part I, the COPD and hypertension were contributing causes but were not a part of the causal sequence in Part I, so those conditions were reported in Part II.

**Scenario I**

**CAUSE OF DEATH (See instructions and examples)**

13. **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 the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory acidosis

b. COVID-19

c. \_\_\_\_\_

d. \_\_\_\_\_

Approximate Interval: Onset to death

3 days

1 week

12 days

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

Chronic obstructive pulmonary disease, hypertension

16. **WAS AN AUTOPSY PERFORMED?**  Yes  No

17. **WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?**  Yes  No

18. **SEX AND TOBACCO USE CONTRIBUTED TO DEATH?**

19. **IF FEMALE:**

20. **MANNER OF DEATH:**

21.  Natural  Homicide

22.  Accident  Pending investigation

23.  Suicide  Could not be determined

## Vital Statistics Reporting Guidance

### Scenario II: A 34-year-old female with no significant past medical history

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next

2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Comment:** In this case, the immediate cause of death was ARDS, so it was reported on line a. as a consequence of pneumonia, which was reported on line b. The underlying cause of death (UCOD) was COVID-19 so it was reported on line c, the lowest line used in Part I.

**Scenario II**

**CAUSE OF DEATH (See instructions and examples)**

13. **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 the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory distress syndrome

b. Pneumonia

c. COVID-19

d. \_\_\_\_\_

Approximate Interval: Onset to death

2 days

10 days

10 days

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

16. **WAS AN AUTOPSY PERFORMED?**  Yes  No

17. **WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?**  Yes  No

18. **SEX AND TOBACCO USE CONTRIBUTED TO DEATH?**

19. **IF FEMALE:**

20. **MANNER OF DEATH:**

21.  Natural  Homicide

22.  Accident  Pending investigation

23.  Suicide  Could not be determined

## Vital Statistics Reporting Guidance

### Scenario III: An 86-year-old female with an unconfirmed case of COVID-19

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the

patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Comment:** Although no testing was done, the coroner determined that the likely UCOD was COVID-19 given the patient's symptoms and exposure to an infected individual. Therefore, COVID-19 was reported on the lowest line used in Part I. Her ischemic stroke was considered a factor that contributed to her death but was not a part of the direct causal sequence in Part I, so it was reported in Part II.

**Scenario III**

**CAUSE OF DEATH (See instructions and examples)**

13. **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 the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory illness

b. Probable COVID-19

c. \_\_\_\_\_

d. \_\_\_\_\_

Approximate Interval: Onset to death

1 day

5 days

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

Ischemic stroke

16. **WAS AN AUTOPSY PERFORMED?**  Yes  No

17. **WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?**  Yes  No

18. **SEX AND TOBACCO USE CONTRIBUTED TO DEATH?**

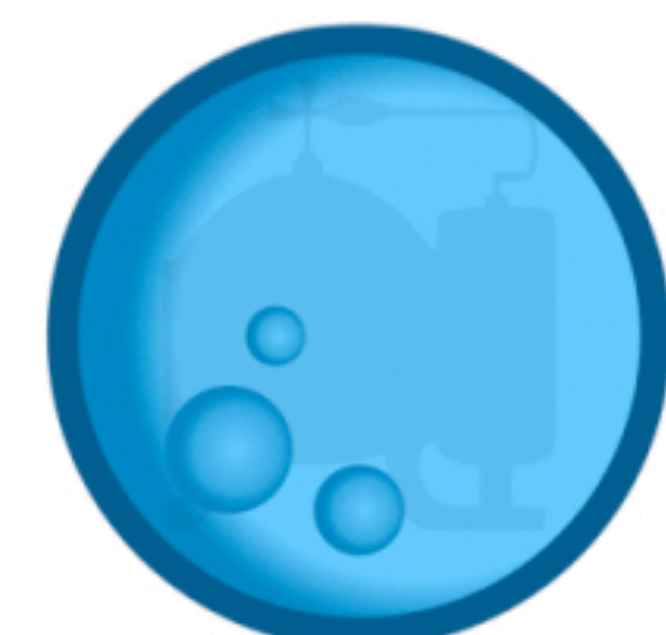
19. **IF FEMALE:**

20. **MANNER OF DEATH:**

21.  Natural  Homicide

22.  Accident  Pending investigation

23.  Suicide  Could not be determined





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



**DIVERGED:** For each WHO [China] example on the left, examine the NVSS [US] comparisons on the right for similarities & direct overlays. This permits China to steer internal US COVID data & the results are an evidenced & unmitigated disaster caused by enterprise fraud.

The examples below show recording of cases where death may have been influenced by COVID-19, but death was caused by another disease or an accident.

Frame A: Medical data: Part 1 and 2			
1 Report disease or condition directly leading to death on line a		Cause of death	Time interval from onset to death
	a	Hypovolaemic shock	1 day
	b	Due to: Aortic dissection	1 day
	c	Due to: Motor vehicle accident	2 days
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		COVID-19	
Manner of death:			
<input type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined	
<input checked="" type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation	
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown	

NOT COVID-19 DEATH

Note: Persons with COVID-19 may die of other diseases or accidents, such cases are not deaths due to COVID-19 and should not be certified as such. In case you think that COVID-19 aggravated the consequences of the accident, you may report COVID-19 in Part 2. Please remember to indicate the manner of death and record in part 1 the exact kind of an incident or other external cause.

Frame A: Medical data: Part 1 and 2			
1 Report disease or condition directly leading to death on line a		Cause of death	Time interval from onset to death
	a	Heart failure	1 day
	b	Due to: Myocardial infarction	5 days
	c	Due to:	
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		COVID-19	
Manner of death:			
<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined	
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation	
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown	

NOT COVID-19 DEATH

Note: Persons with COVID-19 may die due to other conditions such as myocardial infarction. Such cases are not deaths due to COVID-19 and should not be certified as such.

## Vital Statistics Reporting Guidance

### Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19

**Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease**

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Comment:** In this case, the acute respiratory acidosis was the immediate cause of death, so it was reported on line a. Acute respiratory acidosis was precipitated by the COVID-19 infection, which was reported below it on line b. In Part I, the COPD and hypertension were contributing causes but were not a part of the causal sequence in Part I, so those conditions were reported in Part II.

Scenario I		
<b>CAUSE OF DEATH (See instructions and examples)</b> 33. PART I. Enter the (date of onset)-disease, injury, or complication that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.		
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute respiratory acidosis	Approximate interval from onset to death: 3 days
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. COVID-19	1 week
34. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.		
Chronic obstructive pulmonary disease, hypertension		
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		
37. MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		

## Vital Statistics Reporting Guidance

### Scenario II: A 34-year-old female with no significant past medical history

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next

2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Comment:** In this case, the immediate cause of death was ARDS, so it was reported on line a, as a consequence of pneumonia, which was reported on line b. The underlying cause of death (UCOD) was COVID-19 so it was reported on line c, the lowest line used in Part I.

Scenario II		
<b>CAUSE OF DEATH (See instructions and examples)</b> 33. PART I. Enter the (date of onset)-disease, injury, or complication that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.		
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute respiratory distress syndrome	Approximate interval from onset to death: 2 days
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. Pneumonia	10 days
	c. COVID-19	10 days
34. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.		
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		
36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		
37. MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		

## Vital Statistics Reporting Guidance

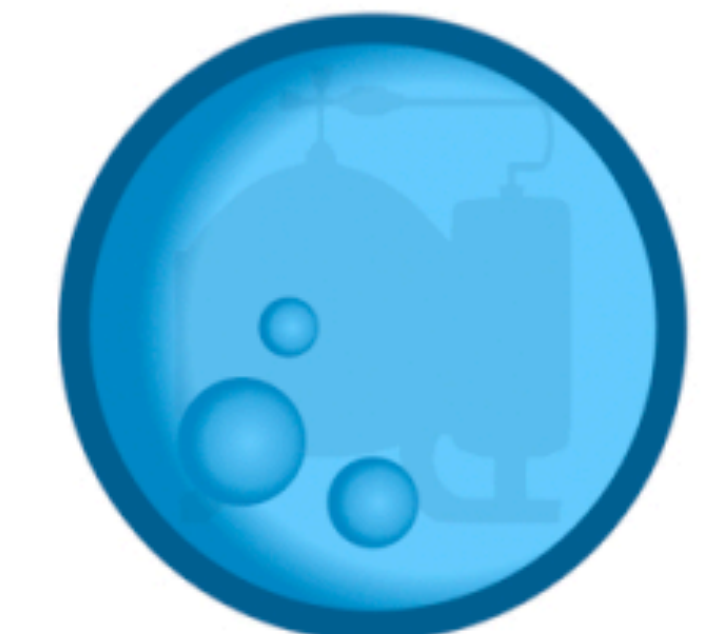
### Scenario III: An 86-year-old female with an unconfirmed case of COVID-19

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the

patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Comment:** Although no testing was done, the coroner determined that the likely UCOD was COVID-19 given the patient's symptoms and exposure to an infected individual. Therefore, COVID-19 was reported on the lowest line used in Part I. Her ischemic stroke was considered a factor that contributed to her death but was not a part of the direct causal sequence in Part I, so it was reported in Part II.

Scenario III		
<b>CAUSE OF DEATH (See instructions and examples)</b> 33. PART I. Enter the (date of onset)-disease, injury, or complication that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.		
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Ischemic stroke	Approximate interval from onset to death: 1 day
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. Probable COVID-19	5 days
34. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.		
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		
37. MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



**DIVERGED:** For each WHO [China] example on the left, examine the NVSS [US] comparisons on the right for similarities & direct overlays. This permits China to steer internal US COVID data & the results are an evidenced & unmitigated disaster caused by enterprise fraud.

## 4. GUIDELINES FOR CODING COVID-19 FOR MORTALITY

This document provides information about the ICD-10 codes for COVID-19 and includes mortality classification (coding) instructions for statistical tabulation in the context of COVID-19. It includes a reference to the WHO case definitions for surveillance.

New ICD-10 codes for COVID-19:

- U07.1 COVID-19, virus identified  
<https://icd.who.int/browse10/2019/en#/U07.1>
- U07.2 COVID-19, virus not identified
  - Clinically-epidemiologically diagnosed COVID-19
    - Probable COVID-19
    - Suspected COVID-19

<https://icd.who.int/browse10/2019/en#/U07.2>

Details of the updates to ICD-10 are available online at:

<https://www.who.int/classifications/icd/icd10updates/en/>

Origins of ICD-10 coding  
direct application to US  
internal data curation

### A- ICD-10 Cause of Death coding of COVID-19

Certifiers use a range of terms to describe COVID-19 as a cause of death, a sample can be found in the annex of this document.

**Steers death certificates to COVID**

Although both categories, U07.1 (COVID-19, virus identified) and U07.2 (COVID-19, virus not identified) are suitable for cause of death coding, it is recognized that in many countries detail as to the laboratory confirmation of COVID-19 will NOT be reported on the death certificate. In the absence of this detail, it is recommended, for mortality purposes only, to code COVID-19 provisionally to U07.1 unless it is stated as “probable” or “suspected”.

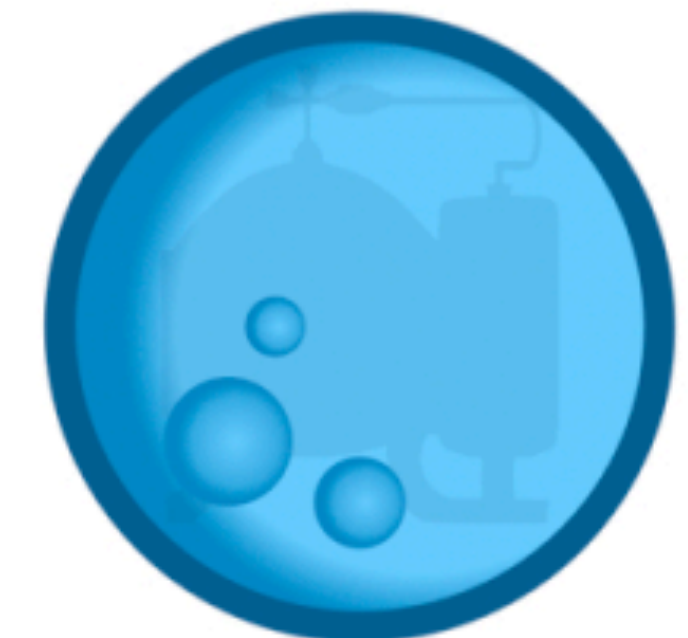
**Steers death certificates away from flu**

The international rules and guideline for selecting the underlying cause of death for statistical tabulation apply when COVID-19 is reported on a death certificate but, given the intense public health requirements for data, COVID-19 is not considered as due to, or as an obvious consequence of, anything else in analogy to the coding rules applied for INFLUENZA. Further to this, there is no provision in the classification to link COVID-19 to other causes or modify its coding in any way.

With reference to section 4.2.3 of volume 2 of ICD-10, the purpose of mortality classification (coding) is to produce the most useful cause of death statistics possible. Thus, whether a sequence is listed as ‘rejected’ or ‘accepted’ may reflect interests of importance for public health rather than what is acceptable from a purely medical point of view. Therefore, always apply these instructions, whether they can be considered medically correct or not. Individual countries should not correct what is



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# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



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assumed to be an error, since changes at the national level will lead to data that are less comparable to data from other countries, and thus less useful for analysis.

A manual plausibility check is recommended for certificates where COVID-19 is reported, in particular for certificates where COVID-19 was reported but not selected as the underlying cause of death for statistical tabulation.

## B- CHAIN OF EVENTS

Here, on the International Form of Medical Certificate of Cause of Death, is an example of how to code this chain of events and select the underlying cause of death for deaths due to COVID-19 in Part 1:

Frame A: Medical data: Part 1 and 2			
1 Report disease or condition directly leading to death on line a  Report chain of events in due to order (if applicable)  State the underlying cause on the lowest used line		Cause of death	Time interval from onset to death
	a	Acute respiratory distress syndrome	J80 2 days
	b	Due to: Pneumonia	J18.9 10 days
	c	Due to: COVID-19 (test positive)	U07.1 14 days
d	Due to:		
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		Underlying cause of death	
<b>Manner of death:</b>			
<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined	
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation	
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown	

Note: Select COVID-19 as underlying cause of death. Step SP3 applies as causes have been reported on more than one line in Part 1 and the condition reported first on the lowest used line (COVID-19) can cause all the conditions, pneumonia (J18.9) and acute respiratory distress syndrome (J80), mentioned on the lines above. [See ICD-10 2016 and later, Volume 2, Section 4.2.1].



## Vital Statistics Reporting Guidance

**Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19**  
**Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease**

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Scenario I**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of events—disease, injury, or complication) that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death):

a. Acute respiratory acidosis

b. COVID-19

c.

d.

Approximate interval from onset to death:

3 days

1 week

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  No

36. IF FEMALE:

Not pregnant within past year

Pregnant at time of death

Not pregnant, but pregnant within 42 days of death

Not pregnant, but pregnant 43 days to 1 year before death

Unknown if pregnant within the past year

37. MANNER OF DEATH:

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined

**Comment:** In this case, the acute respiratory acidosis was the immediate cause of death, so it was reported on line a. Acute respiratory acidosis was precipitated by the COVID-19 infection, which was reported below it on line b. In Part I, the COPD and hypertension were contributing causes but were not a part of the causal sequence in Part I, so those conditions were reported in Part II.

## Vital Statistics Reporting Guidance

**Scenario II: A 34-year-old female with no significant past medical history**

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next 2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Scenario II**

**CAUSE OF DEATH (See instructions and examples)**

32. PART I. Enter the (chain of events—disease, injury, or complication) that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death):

a. Acute respiratory distress syndrome

b. Pneumonia

c. COVID-19

d.

Approximate interval from onset to death:

2 days

10 days

10 days

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  No

36. IF FEMALE:

Not pregnant within past year

Pregnant at time of death

Not pregnant, but pregnant within 42 days of death

Not pregnant, but pregnant 43 days to 1 year before death

Unknown if pregnant within the past year

37. MANNER OF DEATH:

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined

**Comment:** Although no testing was done, the coroner determined that the likely UCOD was COVID-19 given the patient's symptoms and exposure to an infected individual. Therefore, COVID-19 was reported on the lowest line used in Part I. Her ischemic stroke was considered a factor that contributed to her death but was not a part of the direct causal sequence in Part I, so it was reported in Part II.





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



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## C- COMORBIDITIES

Here, on the International Form of Medical Certificate of Cause of Death, are examples of how to code this chain of events and select the underlying cause of death for deaths due to COVID-19 in Part 1, with comorbidities reported in Part 2:

**Frame A: Medical data: Part 1 and 2**

1	Report disease or condition directly leading to death on line a	Cause of death	Time interval from onset to death
	a	Acute respiratory distress syndrome	J80 2 days
	b	Due to: Pneumonia	J18.9 10 days
	c	Due to: Suspected COVID-19	U07.2 12 days
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)			
		Coronary artery disease [5 years], Type 2 diabetes [14 Years], Chronic obstructive pulmonary disease [8 years]	I25.1, E11.9, J44.9

**Manner of death:**

<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

Note: Code all entries in Part 1 and 2, and in this example select COVID-19, specified as suspected (the case has virus not confirmed) as underlying cause of death. Step SP3 applies as causes have been reported on more than one line in Part 1 and the condition reported first on the lowest used line (COVID-19) can cause all the conditions, pneumonia (J18.9) and acute respiratory distress syndrome (J80), mentioned on the lines above. [See ICD-10 2016 and later, Volume 2, Section 4.2.1].

**Frame A: Medical data: Part 1 and 2**

1	Report disease or condition directly leading to death on line a	Cause of death	Time interval from onset to death
	a	Acute respiratory distress syndrome	J80 2 days
	b	Due to: Pneumonia	J18.9 10 days
	c	Due to: COVID-19	U07.1 10 days
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)			
		Cerebral palsy [10 Years]	G80.9

**Manner of death:**

<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

Note: Code all entries in Part 1 and 2, and in this example select COVID-19 as underlying cause of death (the case probably has been tested positive). Step SP3 applies as causes have been reported on

## Vital Statistics Reporting Guidance

### Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19

#### Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Comment:** In this case, the acute respiratory acidosis was the immediate cause of death, so it was reported on line a. Acute respiratory acidosis was precipitated by the COVID-19 infection, which was reported below it on line b. In Part I, the COPD and hypertension were contributing causes but were not a part of the causal sequence in Part I, so those conditions were reported in Part II.

**Scenario I**

**CAUSE OF DEATH (See instructions and examples)**

33. PART I. Enter the (date of death), disease, injury, or complication that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory acidosis 3 days

b. COVID-19 1 week

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

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

35. WAS AN AUTOPSY PERFORMED?  Yes  No

36. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

37. MANNER OF DEATH

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined

## Vital Statistics Reporting Guidance

### Scenario II: A 34-year-old female with no significant past medical history

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next

2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Comment:** In this case, the immediate cause of death was ARDS, so it was reported on line a. as a consequence of pneumonia, which was reported on line b. The underlying cause of death (UCOD) was COVID-19 so it was reported on line c., the lowest line used in Part I.

**Scenario II**

**CAUSE OF DEATH (See instructions and examples)**

33. PART I. Enter the (date of death), disease, injury, or complication that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory distress syndrome 2 days

b. Pneumonia 10 days

c. COVID-19 10 days

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

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

35. WAS AN AUTOPSY PERFORMED?  Yes  No

36. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

37. MANNER OF DEATH

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined

## Vital Statistics Reporting Guidance

### Scenario III: An 86-year-old female with an unconfirmed case of COVID-19

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the

patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Comment:** Although no testing was done, the coroner determined that the likely UCOD was COVID-19 given the patient's symptoms and exposure to an infected individual. Therefore, COVID-19 was reported on the lowest line used in Part I. Her ischemic stroke was considered a factor that contributed to her death but was not a part of the direct causal sequence in Part I, so it was reported in Part II.

**Scenario III**

**CAUSE OF DEATH (See instructions and examples)**

33. PART I. Enter the (date of death), disease, injury, or complication that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute respiratory illness 1 day

b. Probable COVID-19 5 days

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

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

35. WAS AN AUTOPSY PERFORMED?  Yes  No

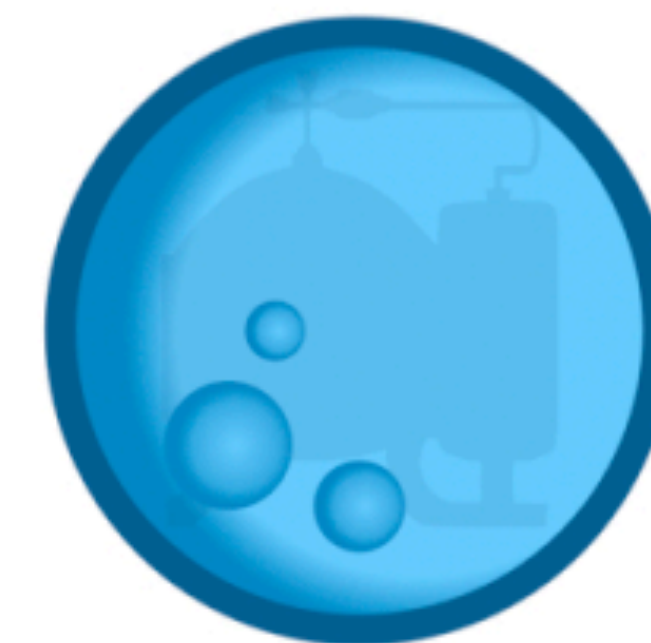
36. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

37. MANNER OF DEATH

Natural  Homicide

Accident  Pending investigation

Suicide  Could not be determined





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



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more than one line in Part 1 and the condition reported first on the lowest used line (COVID-19) can cause all the conditions, pneumonia (J18.9) and acute respiratory distress syndrome (J80), mentioned on the lines above. [See ICD-10 2016 and later, Volume 2, Section 4.2.1].

## D- OTHER EXAMPLES

Frame A: Medical data: Part 1 and 2			
1	Report disease or condition directly leading to death on line a	Cause of death	Time interval from onset to death
	Report chain of events in due to order (if applicable)	a Respiratory failure <i>Code both, O99.5 and J96.9</i>	2 days
	State the underlying cause on the lowest used line	b Due to: Pneumonia <i>Code both, O99.5 and J18.9</i>	8 days
		c Due to: Pregnancy complicated by COVID-19 <i>Code both, O98.5 and U07.1</i>	12 days
2	Other significant conditions (intervals can be included in brackets after the condition)	Underlying cause of death	

Note: Code all entries in Part 1 and 2, and in this example select other viral diseases complicating pregnancy, childbirth and the puerperium (O98.5) as underlying cause of death. Step SP3 applies as causes have been reported on more than one line in Part 1 and the condition reported first on the lowest used line (other viral diseases complicating pregnancy, childbirth and the puerperium) can cause all the conditions, pneumonia (O99.5 and J18.9) and acute respiratory distress syndrome (O99.5 and J80), mentioned on the lines above. [See ICD-10 2016 and later, Volume 2, Section 4.2.1]. Use additional code to retain COVID-19. [See ICD-10 2016 and later, Volume 2, Section 4.2.8 Special instructions on maternal mortality (Step M4)].

## Vital Statistics Reporting Guidance

**Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19**  
**Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease**

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Scenario I**

CAUSE OF DEATH (See instructions and examples)		Approximate interval from onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute respiratory acidosis	3 days
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. COVID-19	1 week
	c.	
	d.	

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

Chronic obstructive pulmonary disease, hypertension

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:

37. MANNER OF DEATH

38. NATURE OF DEATH

## Vital Statistics Reporting Guidance

**Scenario II: An 86-year-old female with an unconfirmed case of COVID-19**

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Scenario II**

CAUSE OF DEATH (See instructions and examples)		Approximate interval from onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute respiratory illness	1 day
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. Probable COVID-19	5 days
	c.	
	d.	

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

Ischemic stroke

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:

37. MANNER OF DEATH

38. NATURE OF DEATH



## Vital Statistics Reporting Guidance

**Scenario II: A 34-year-old female with no significant past medical history**

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next 2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Comment:** In this case, the immediate cause of death was ARDS, so it was reported on line a. as a consequence of pneumonia, which was reported on line b. The underlying cause of death (UCOD) was COVID-19 so it was reported on line c., the lowest line used in Part I.

**Scenario II**

CAUSE OF DEATH (See instructions and examples)		Approximate interval from onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute respiratory distress syndrome	2 days
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. Pneumonia	10 days
	c. COVID-19	10 days
	d.	

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

33. WAS AN AUTOPSY PERFORMED?  Yes  No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

36. IF FEMALE:

37. MANNER OF DEATH

38. NATURE OF DEATH





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**Frame A: Medical data: Part 1 and 2**

1 Report disease or condition directly leading to death on line a  Report chain of events in due to order (if applicable)  State the underlying cause on the lowest used line	Cause of death	Time interval from onset to death
	a Acute respiratory distress syndrome J80	3 days
	b Due to: COVID-19 U07.1	One week
	c Due to: HIV disease B24	5 years
	d Due to:	
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		
<b>Manner of death:</b>		
<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

Note: The certifier should have added the HIV disease as a comorbidity in Part 2 of the certificate, however the selection rules of ICD allow to identify COVID-19 as underlying cause of death. (COVID-19) is reported in a sequence ending with a terminal condition (Acute respiratory distress syndrome due to COVID-19). Mortality coding rule step SP4 applies as causes have been reported on more than one line in Part 1 and the condition reported first on the lowest used line (HIV disease) cannot cause all the conditions. [See ICD-10 2016 and later, Volume 2, Section 4.2.1].

**Frame A: Medical data: Part 1 and 2**

1 Report disease or condition directly leading to death on line a  Report chain of events in due to order (if applicable)  State the underlying cause on the lowest used line	Cause of death	Time interval from onset to death
	a Hypovolaemic shock T79.4	1 day
	b Due to: Aortic dissection S25.0	1 day
	c Due to: Motor vehicle accident V89.2	2 days
	d Due to:	
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		
COVID-19 U07.1		
<b>Manner of death:</b>		
<input type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined
<input checked="" type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation
<input type="checkbox"/> Intentional self harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown

Note: Code all entries in Part 1 and 2, and in this example select motor vehicle accident (V89.2) as underlying cause of death. Step SP3 applies as causes have been reported on more than one line in Part 1 and the condition reported first on the lowest used line, motor vehicle accident (V89.2), can cause all the conditions, traumatic aortic dissection (S25.0) and traumatic hypovolemic shock (T79.4), mentioned on the lines above. [See ICD-10 2016 and later, Volume 2, Section 4.2.1].

**NOT COVID-19 DEATH**



## Vital Statistics Reporting Guidance

### Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19

#### Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Comment:** In this case, the acute respiratory acidosis was the immediate cause of death, so it was reported on line a. Acute respiratory acidosis was precipitated by the COVID-19 infection, which was reported below it on line b. In Part I, the COPD and hypertension were contributing causes but were not a part of the causal sequence in Part I, so those conditions were reported in Part II.

#### Scenario I

**CAUSE OF DEATH (See instructions and examples)**

30. PART I. Enter the (date of death) disease, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Acute respiratory acidosis 3 days

b. COVID-19 1 week

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

31. WAS AN AUTOPSY PERFORMED?  Yes  No

32. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

33. DID TOXICOLOGIC USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

34. IF FEMALE:  Not pregnant within past year  Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to 1 year before death  Unknown if pregnant within the past year

35. MANNER OF DEATH:  Natural  Homicide  Accident  Pending investigation  Suicide  Could not be determined

36. CHRONIC OBSTRUCTIVE PULMONARY DISEASE, HYPERTENSION

## Vital Statistics Reporting Guidance

### Scenario II: A 34-year-old female with no significant past medical history

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next

2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Comment:** In this case, the immediate cause of death was ARDS, so it was reported on line a, as a consequence of pneumonia, which was reported on line b. The underlying cause of death (UCOD) was COVID-19 so it was reported on line c, the lowest line used in Part I.

#### Scenario II

**CAUSE OF DEATH (See instructions and examples)**

30. PART I. Enter the (date of death) disease, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Acute respiratory distress syndrome 2 days

b. Pneumonia 10 days

c. COVID-19 10 days

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

31. WAS AN AUTOPSY PERFORMED?  Yes  No

32. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

33. DID TOXICOLOGIC USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

34. IF FEMALE:  Not pregnant within past year  Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to 1 year before death  Unknown if pregnant within the past year

35. MANNER OF DEATH:  Natural  Homicide  Accident  Pending investigation  Suicide  Could not be determined

## Vital Statistics Reporting Guidance

### Scenario III: An 86-year-old female with an unconfirmed case of COVID-19

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the

patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Comment:** Although no testing was done, the coroner determined that the likely UCOD was COVID-19 given the patient's symptoms and exposure to an infected individual. Therefore, COVID-19 was reported on the lowest line used in Part I. Her ischemic stroke was considered a factor that contributed to her death but was not a part of the direct causal sequence in Part I, so it was reported in Part II.

#### Scenario III

**CAUSE OF DEATH (See instructions and examples)**

30. PART I. Enter the (date of death) disease, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Acute respiratory illness 1 day

b. Probable COVID-19 5 days

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

31. WAS AN AUTOPSY PERFORMED?  Yes  No

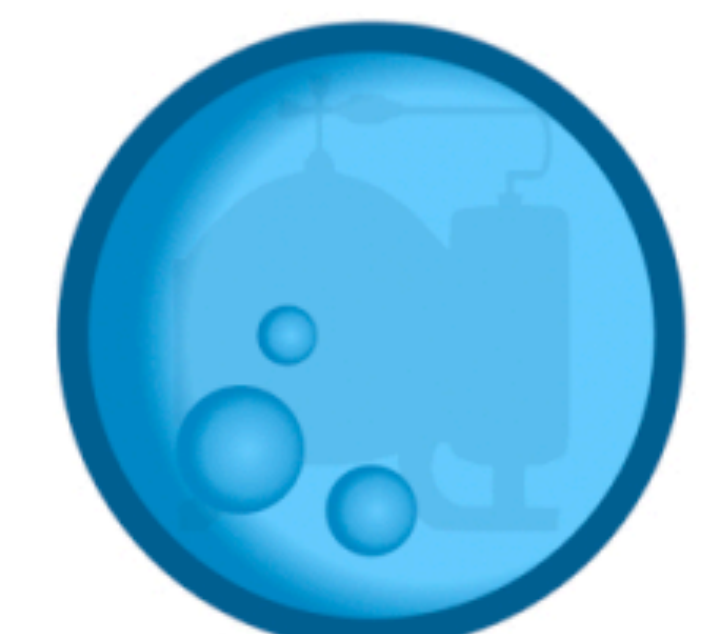
32. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No

33. DID TOXICOLOGIC USE CONTRIBUTE TO DEATH?  Yes  Probably  No  Unknown

34. IF FEMALE:  Not pregnant within past year  Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to 1 year before death  Unknown if pregnant within the past year

35. MANNER OF DEATH:  Natural  Homicide  Accident  Pending investigation  Suicide  Could not be determined

36. Ischemic stroke





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



**DIVERGED:** For each WHO [China] example on the left, examine the NVSS [US] comparisons on the right for similarities & direct overlays. This permits China to steer internal US COVID data & the results are an evidenced & unmitigated disaster caused by enterprise fraud.

Frame A: Medical data: Part 1 and 2			
<b>1</b> Report disease or condition directly leading to death on line a  Report chain of events in due to order (if applicable)  State the underlying cause on the lowest used line		Cause of death	Time interval from onset to death
	a	Heart failure	I50.9 1 day
	b	Due to: Myocardial infarction	I21.9 5 days
	c	Due to:	
	d	Due to:	
<b>2</b> Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		COVID-19	U07.1
<b>Manner of death:</b>			
<input checked="" type="checkbox"/> Disease	<input type="checkbox"/> Assault	<input type="checkbox"/> Could not be determined	
<input type="checkbox"/> Accident	<input type="checkbox"/> Legal intervention	<input type="checkbox"/> Pending investigation	
<input type="checkbox"/> Intentional self-harm	<input type="checkbox"/> War	<input type="checkbox"/> Unknown	

Note: Code all entries in Part 1 and 2, and in this example select acute myocardial infarction (I21.9) as underlying cause of death. Step SP3 applies as causes have been reported on more than one line in Part 1 and the condition reported first on the lowest used line, myocardial infarction (I21.9), can cause the condition, heart failure (I50.9), mentioned on the line above. [See ICD-10 2016 and later, Volume 2, Section 4.2.1].

NOT COVID-19 DEATH



## Vital Statistics Reporting Guidance

**Appendix. Scenarios and Example Certifications for Deaths Due to COVID-19**  
**Scenario I: A 77-year-old male with a history of hypertension and chronic obstructive pulmonary disease**

A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in moderate respiratory distress. His chest x-ray demonstrated hyperinflation and his arterial blood gas was consistent with severe respiratory acidosis. Testing of respiratory specimens indicated COVID-19. He was admitted to the ICU and despite aggressive treatment, he developed worsening respiratory acidosis and sustained a cardiac arrest on day 3 of admission.

**Scenario I**

CAUSE OF DEATH (See instructions and examples)		Approximate Interval: Onset to death
32. PART I. Enter the chain of events, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.	Acute respiratory acidosis	3 days
IMMEDIATE CAUSE (Final disease or condition resulting in death)	COVID-19	1 week
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.		
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I		33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Chronic obstructive pulmonary disease, hypertension		34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	37. MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined

## Vital Statistics Reporting Guidance

**Scenario II: A 34-year-old female with no significant past medical history**

A 34-year-old female with no significant past medical history presented to her primary care physician complaining of 6 days of fever, cough, and myalgias. She was found to be febrile, hypotensive, and hypoxic. She was admitted to the hospital and underwent a CT scan of the chest, which revealed diffuse ground-glass opacification indicative of viral pneumonia. Respiratory specimens were sent for testing and rRT-PCR confirmed COVID-19. Her condition deteriorated over the next 2 days and she developed acute respiratory distress syndrome (ARDS). She was transferred to the ICU and started on positive pressure ventilation. Despite aggressive resuscitation, the patient expired on hospital day 4.

**Scenario II**

CAUSE OF DEATH (See instructions and examples)		Approximate Interval: Onset to death
32. PART I. Enter the chain of events, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.	Acute respiratory distress syndrome	2 days
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Pneumonia	10 days
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.	COVID-19	10 days
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I		33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	36. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	37. MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined

## Vital Statistics Reporting Guidance

**Scenario III: An 86-year-old female with an unconfirmed case of COVID-19**

An 86-year-old female passed away at home. Her husband reported that she was nonambulatory after suffering an ischemic stroke 3 years ago. He stated that 5 days prior, she developed a high fever and severe cough after being exposed to an ill family member who subsequently was diagnosed with COVID-19. Despite his urging, she refused to go to the hospital, even when her breathing became more labored and temperature escalated. She was unresponsive that morning and her husband phoned emergency medical services (EMS). Upon EMS arrival, the patient was pulseless and apneic. Her husband stated that he and his wife had advanced directives and that she was not to be resuscitated. After consulting with medical command, she was pronounced dead and the coroner was notified.

**Scenario III**

CAUSE OF DEATH (See instructions and examples)		Approximate Interval: Onset to death
32. PART I. Enter the chain of events, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.	Acute respiratory illness	1 day
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Probable COVID-19	5 days
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.		
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I		33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Ischemic stroke		34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	36. IF FEMALE: <input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	37. MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



**DIVERGED:** For each WHO [China] example on the left, examine the NVSS [US] comparisons on the right for similarities & direct overlays. This permits China to steer internal US COVID data & the results are an evidenced & unmitigated disaster caused by enterprise fraud.



## 5. ANNEX

Examples of terms used by certifiers to describe COVID-19 and that can be coded as synonyms of COVID-19:

- COVID Positive
- Coronavirus Pneumonia
- COVID-19 Infection
- Sars-Cov-2 Infection (Coronavirus Two Infection)
- COVID-19 Coronavirus
- Infection – COVID-19 (Coroner Informed)
- Hospital Acquired Pneumonia - COVID-Positive
- Corona Virus two infection (SARS-Cov-2)
- Corona Virus Pneumonia (COVID-19)
- Coronavirus-Two Infection
- Novel coronavirus

**DATA RESERVOIR**

**Steers death certificates away from co-morbidities & to COVID-19**

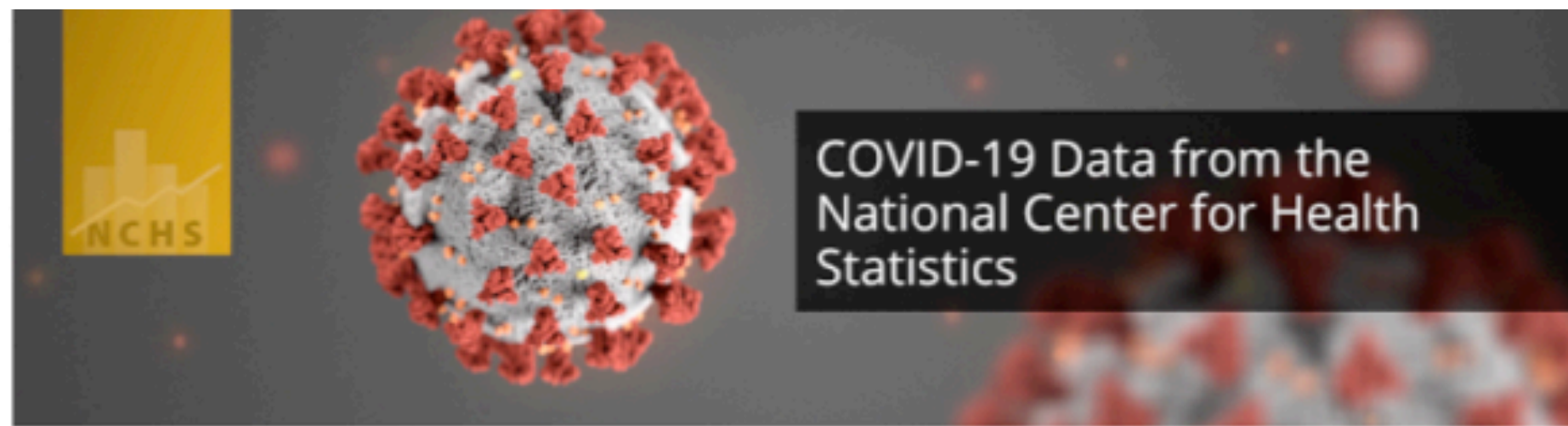
**CO-MORBIDITY HARVESTING**

**THIS SPACE LEFT EMPTY**





# ANALYSIS / ICD-10-CM CODING MECHANISMS / HIERARCHICAL & SEQUENCED DIAGNOSTICS



NCHS collects, analyzes, and disseminates information on the health of the nation. In response to the COVID-19 pandemic, NCHS is providing the most recent data available on deaths, mental health, and access to health care, loss of work due to illness, and telemedicine from the vital statistics system, the NCHS Research and Development Survey, and through a partnership with the U.S. Census Bureau.

For general information including symptoms, testing, and community safety, visit <https://www.cdc.gov>.

[Articles on NCHS Response to Coronavirus Disease 2019 \(COVID-19\)](#)

**Deaths**  
Access provisional death counts based on information obtained from death certificates.

**Cause-of-Death Certification**  
Guidance for certifiers on how to report deaths due to COVID-19 on death certificates.

**Births and Pregnancies**  
Access provisional data on births and COVID-19 cases among pregnant women and newborns.

**Health Care Access, Telemedicine, and Mental Health**  
Data from NCHS' partnership with the U.S. Census Bureau on the Household Pulse Survey.

**Health Care Access, Telemedicine, and Loss of Work Due to Illness**  
Data from NCHS' research survey RANDS during COVID-19.

**Hospital Data**  
Data from NCHS' National Hospital Care Survey describing patient care in hospital-based settings.

**Long-term Care and COVID-19**  
COVID-19-related data for residential care communities and adult day services centers.

**Merger of US Criminal Enterprise & China/RICO**



**Coding**

Causes of death are coded according to the International Classification of Diseases, 10th Revision (ICD-10). On January 31, 2020, the World Health Organization (WHO) established a new emergency code for COVID-19: U07.1.

[WHO | Emergency use ICD codes for COVID-19 disease outbreak](#)

**ICD-10 Code**

U07.1 - COVID-19

**Excludes:** Coronavirus infection, unspecified site (B34.2) and Severe acute respiratory syndrome (SARS), unspecified (U04.9)

The WHO has provided a second code, U07.2, for clinical or epidemiological diagnosis of COVID-19 where a laboratory confirmation is inconclusive or not available. Because laboratory test results are not typically reported on death certificates in the United States, NCHS did not implement U07.2 for mortality statistics.

**Guidance for Certifying Deaths Due to Coronavirus Disease 2019 (COVID-19)**

**Key Points**

- If COVID-19 is determined to be a cause of death, it should be reported on the death certificate.
- When reporting COVID-19 as a cause of death, use standard WHO terminology, such as "Coronavirus Disease 2019" or "COVID-19."
- Report pre-existing conditions that contributed to the death in Part II of the death certificate.

[Read Full Reporting Guidance](#)

**NVSS / existing work &**

MERGER

Permits China to steer US infection & mortality data through its proxy - Tedros/WHO

<https://www.cdc.gov/nchs/covid19/index.htm>  
<https://www.cdc.gov/nchs/covid19/coding-and-reporting.htm>

Through the CDC/NVSS/WHO, China has interceded on the formulation of US internal data. The Criminal Enterprise/RICO is leveraging it a mechanism of enterprise fraud to propagate & harvest fraudulently constructed co-morbidity data in a closed loop.





# EDIFY

RESEARCH & CONSULTING

ARBITER



VERITATIS