**Suppl 5. *Subdistribution and cause-specific hazard ratios for gastric cancer-specific mortality***

In all patients undergoing resection, those diagnosed in 2004-2009 had higher risks of gastric cancer-specific mortality (HRSD=1.13, HRCS=1.10). Older age was associated with higher gastric cancer-specific mortality (e.g., ≥80 vs 60-69 years: HRSD=1.49; HRCS=1.79). Relative to white patients, American Indian/Alaska Native ethnicities had higher gastric cancer-specific mortality when using the cause-specific model (HRCS=1.31), while Asians/Pacific Islanders had lower such mortalities in both models (HRSD=0.78, HRCS=0.75). Compared to cancers located at gastric cardia, both those at gastric fundus/body (HRSD=0.70, HRCS=0.70) and at gastric antrum/pylorus (HRSD=0.74, HRCS=0.73) were associated with lower mortality from the underlying cancers. The deeper the tumor local invasion was (e.g., invasion of adjacent structures vs of muscularis propria/subserosa: HRSD=1.94; HRCS=2.07), and the more involved lymph nodes were (e.g., ≥16 vs 0 positive nodes: HRSD=3.69; HRCS=4.15), the higher the cancer-associated mortality was. Better differentiation was associated with decreased cancer-specific mortality (e.g., well-differentiated vs poorly-differentiated/undifferentiated: HRSD=0.67; HRCS=0.65). Relative to patients undergoing partial/subtotal gastrectomy, those receiving total/near-total gastrectomy had higher gastric cancer-specific mortality (HRSD=1.16; HRCS=1.17).

Compared to overall resected cases, in those further receiving chemotherapy the association patterns were mostly similar except for some slight differences in association strengths. For instance, older age (e.g., ≥80 vs 60-69 years: HRSD=1.17; HRCS=1.30), deeper tumor local invasion (e.g., invasion of adjacent structures vs of muscularis propria/subserosa: HRSD=1.80; HRCS=1.87), and more positive lymph nodes (e.g., ≥16 vs 0 positive nodes: HRSD=3.26; HRCS=3.59) were less strongly associated with higher gastric cancer-associated mortality, and the association between better differentiation and lower gastric cancer-associated mortality was also weaker (e.g., well-differentiated vs poorly-differentiated/undifferentiated: HRSD=0.80; HRCS=0.80).