

**PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED**

**PHYSICIAN'S STATEMENT**

The Medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948.  
In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

Full name of deceased		Date of Death (DD/MM/YYYY)	
Residence at death		Place of death	
Age at death or date of birth (DD/MM/YYYY)		If institution or hospital, give name	
Cause of death (enter only one cause for each of a, b and c.) Disease or condition directly leading to death: <i>(This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death).</i>		Interval between onset and death	
(a) _____ Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last).		(a) _____	
Due to (b) _____		(b) _____	
Due to (c) _____		(c) _____	
Other significant conditions: <i>(contributing to the death but not related to the disease or condition causing death).</i>			
Date of first attendance in last illness (DD/MM/YYYY)		Date of last attendance in last illness (DD/MM/YYYY)	
If death was due to accident, suicide or homicide, specify which. Describe briefly:		Was inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Was autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If so, by whom and with what findings?	
Have you treated or advised the deceased during the last five years, prior to the last illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If "Yes" to either question, please furnish the following:</b>			
Name	Address	Nature of Illness or Injury	Approximate Dates (DD/MM/YYYY)

(Print or Stamp)

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature

Date (DD/MM/YYYY)