

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(for non-institutional deaths. Not to be used for still births)
To be sent to Registrar along with Form No 2. Death Report

I hereby certify that the deceased Shri/Smt./Kum _____
 _____ son of/wife of / daughter of _____
 _____ resident of _____
 _____ was under my treatment from _____ to _____ and
 he/she died on _____ at _____ am / pm.

Name of Deceased				For use of Statistical office	
Sex	Age of Death				
1. Male	Age in completed years	If less than 1 year age in months	If less than one month age in days	If less than one day age in hours	
2. Female					
CAUSE OF DEATH				Interval between on-set & Death Apox	
I. Immediate cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia etc		(a)			
		Due to (or as a consequence of)			
Antecedent cause Morbid condition, if any, giving rise to the above cause, stating underlying conditions last		(b)			
		Due to (or as a consequence of)			
II		(b)			
		Due to (or as a consequence of)			

If deceased was female was pregnancy the death associated with ? 1. Yes 2. No
 If yes, was there a delivery ? 1. Yes 2. No

Name and signature of the Medical Practitioner Certifying the cause of death

Date of Certification _____

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt./Kum _____ s/w/d of Shri
 _____ r/o _____ was under my treatment from
 _____ to _____ and he/she expired on _____ at
 _____ am / pm

Doctor _____
 Signature and address of Medical Practitioner
 /Medical Attendant with Registration No

DEATH REPORT

Legal Information

This part to be added to the Death Register

To be filled by the informant

1. **Date of Death :**
(Enter the exact day, month and year the death took place (e.g. 01-01-2000))
 2. **Name of the deceased :**
(Full name as usually written)
2(a) Permanent Address of Deceased
2(a) Address of Deceased at Time of death
 3. **Sex of the deceased :**
(Enter "Male or Female", do not use abbreviation)
 4. **Age of the deceased**
(if the deceased was over 1 year of age, give age in completed years, If the deceased was below 1 year of age, give age in months and if below 1 month give in completed number of days, and if below one day, in hours.)
 5. **Place of death :**
(Tick the appropriate entry 1,2 or 3 below and give the name of the Hospital/Institution or the address of the house where the death took place. If other place, give location)
1. Hospital/Institution Name :
2. House Address :
3. Other place :
 6. **Name of the father/husband :**
6(a) **Name of the Mother of Deceased :**
 7. **Informant's name :**
Address :
(After completing all columns 1 to 18, informant will put date and signature here:)
- Date:** _____ **Signature or left thumb mark of the informant** _____

To be filled by the Registrar

Registration No. :

Registration Date:

Registration Unit :

Town/Village :

District :

Remarks : (If any)

Name and Signature of the Registrar

DEATH REPORT

Statistical information

This part to be detached and sent for statistical processing

To be filled by the informant

8. Town or Village of Residence of the deceased :
(Place where the deceased actually lived. This can be different from the place where the death occurred. The house address is not required to be entered.)

a) Name of Town/Village :

b) Is it a Town or village :

(Tick the appropriate entry below)

(1) Town (2) Village

c) Name of District :

d) Name of State :

9. Religion : (Tick the appropriate entry below)

(1) Hindu (2) Muslim (3) Christian

4. Any other religion :

(Write the name of the religion)

10. Occupation of the deceased :

(If no occupation write 'Nil')

11. Type of medical attention received before death :

(Tick the appropriate entry below)

(1) Institutional

(2) Medical attention other than institution

(3) No medical attention

To be filled by the informant

12. Was the cause of death medically certified?

(Tick the appropriate entry below) :

1. Yes 2. No

13. Name of disease or Actual Cause of Death :

(For all deaths irrespective of whether medically certified or not)

14. In case this is a female death, did the death occur while pregnant, at the time of delivery or within 6 weeks after the end of pregnancy :

(Tick the appropriate entry below)

1. Yes 2. No

15. If to habitually smoke, for how many years?

16. If used to habitually chew tobacco in any form for how many years? :

17. If used to habitually chew arecanut in any form (Including pan masala) - for how many years ?

18. If used to habitually drink alcohol : for how many years?

(Columns to be filled are over. Now put signature at top)

To be filled by the Registrar

Name :

Code No.

Registration No.:

Registration Date:

District :

Date of Death:

Tehsil :

Sex: 1. Male 2. Female

Town / Village :

Age : Years/months/days/hours

Registration Unit :

Place of Death: 1. Hospital/Institution 2. House

Name and Signature of the Registrar