

Doctors Certificate (CL 2)

Form No. 2

Contract No. _____

This statement is to be completed by the doctor in attendance during the deceased's last illness or injury and each question should be fully answered.

1- Full Name of deceased : _____ ID number: _____

Residence at death: _____

Date of Death: _____

Place of death (if Hospital or Institution, give name) _____

2- Cause of death (Enter only one cause for each of a, b and c)

Disease or condition directly leading to death (this does not mean the mode of dying such as heart failure, stroke, etc. It means the disease, injury or complication which caused death.

a) _____

Antecedent causes (morbid Conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)

b) Due to (or as a consequence of) _____

c) Due to (or as a consequence of) _____

Interval Between onset and death

a) _____

b) _____

c) _____

Other significant conditions (Contributing to the death but not related to the disease or condition causing death)

(Please state past medical history and dates of onset of this medical history)

3. Dates of First and last attendance in last illness _____

How long had you known deceased? _____

4- If death was due to accident, suicide or homicide, specify which (Describe briefly)

5- Was an inquest held?

☐ YES..

☐ NO

Was an autopsy performed?

☐ YES.. ☐ NO

If so, by whom and with what findings? _____

6- Have you treated the deceased during the last 5 years prior to last illness? ☐ YES.. ☐ NO

Did the deceased, to your knowledge, receive treatment during the last 5 years from Any other physician, or in any hospital or Institution? ☐ YES.. ☐ NO

If "Yes" to either question, please furnish the following:

Physician or Hospital	Address	Nature of Illness or Injury	Dates / dates of onset of past med. Hx.

Date :

Signature and stamp of clinic :

Address :