



CERTIFICATE OF ATTENDING PHYSICIAN
ALL QUESTIONS MUST BE ANSWERED IN FULL

1. a. Deceased's name in full		b. Occupations: at death	Prior thereto
c. Residence at time of death	No. Street	City or Town	Province
2. a. Age of Deceased at death	b. Sex	c. Height	d. Approximate weight in health
e. Color of hair			
f. Were there any identification marks on the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give particulars			
3. How long had you known the deceased?			
4. a. Date of Death	b. Place of Death (If in hospital/institution, give name)		c. Length of Hospitalization
5. a. When were you first consulted for the condition which either directly or indirectly caused death?		Who consulted you? (Specify if deceased, relative or others)	Date of last visit:
b. What was the immediate cause of death? (see instructions)			
c. How long, in your opinion, did the deceased suffer from this disease or impairment?			
d. What were the contributory causes of death? Give below the duration of each: (see instructions)			
Disease or Impairment		Duration	
e. Was there any special connection (remote or proximate) between the death and the occupation, residence, habits or personal history of the deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state which and give particulars			
6. Give below particulars of each condition for which you treated or advised the deceased prior to last illness:			
Nature of Condition	Dates	Duration	Result of Treatment
7. Give names and addresses of other physicians and other practitioners who to your knowledge attended the deceased during the past three years:			
Name	Address	Disease or Impairment and Date	
8. a. Was death due to suicide, homicide or accident?			
b. Was deceased under the influence of liquor or drugs when suicide/accident/homicide happened? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Was there an official inquiry as to cause of death or post mortem examination on the body of the deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which, by whom and with what result?			
Dated at _____ this _____ day of _____, 20__			
Physician's name in print		Physician's Signature	
License No. (Privilege Tax)	Date	Physician's Address	
Witnessed by		Witness Address	

Form No. D-144-1(0596)

INSTRUCTIONS

All Answers must be Entirely in the Physician's Own Handwriting.

In the interest of accurate vital statistics, please conform to the International List of the causes of death when answering Question 5.

If an injury, describe the accident. If a suicide or homicide, state the means employed

In Surgical cases, state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasms, give type part first involved. Please avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details as seen desirable should be given below