FORM NO. 4

(See Rule 7)

MEDICAL CERTIFICATION OF CAUSE OF DEATH

(Hospital in - patients, Not be used for still births)
To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital _____ I hereby certify that the person whose particulars are given below died in the hospital in Ward No. _____

on _____ at _____ am. / pm.

NAME OF DECEASED					For use of Statistical Office
Sex	Age at Death				
	If 1 year or more, age in 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	
1. Male 2. Female					

CAUSE OF DEATH		Interval between on set & death approx.	
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 consequences of)	_____	_____
Antecedent cause Morbid conditions, if any, giving rise tothe above Cause, stating underlying conditions last.	(b)_____ Due to (or as a consequences of)		_____
II. Other significant conditions contributing to the death but not related to the disease or conditions causing it.	(c) _____ _____ _____		_____ _____ _____

Manner of Death

1. Natural 2. Accident 3. Suicide 4. Homicide
5. Pending investigation

How did the injury occur?

If deceased was a female, was the death associated with pregnncy? 1. Yes 2. No.

If yes, was there a delivery? 1. Yes 2. No.

Name and signature of the Medical Attendant certifying the cause of death

Date of verification _____

SEE REVERSE FOR INSTRUCTIONS

(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 admitted to this hospital on*

_____ *and expired on* _____

Doctor _____
(Medical Supdt.
Name of Hospital)