FORM NO. 4A

(See Rule 7)

MEDICAL CERTIFICATION OF CAUSE OF DEATH

(For non-institutional deaths. Not to be use 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 _____ residing 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				
	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 **I** **Immediate cause** **State the disease**, injury of complication which caused death, not the mode of dying such as heart failure, asthenia, etc. **Antecedent cause** Morbid conditions, if any, giving rise to the above Cause, stating underlying conditions ast. **II.** **Other significant conditions contributing to the death but not related to the disease or conditions causing it.**	(a)_____ Due to (or as a consequences of) (b)_____ Due to (or as a consequences of) (c)_____			Interval between on set & death approx. _____	_____ _____ _____ _____

If deceased was female, was the death associated with pregency ? 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 his hospital on* _____ *and expired on* _____

Doctor _____

(Medical Supdt.
Name of Hospital)