28 - 48 Barbados Avenue, Kingston 5, P.O. Box 439, Kingston Jamaica, WI Phone : (809) 929 - 8920 - 9, Fax No. (809) 929 - 4730

PROOF OF DEATH - PHYSICIAN'S STATEMENT

NOTE : The medical certification follows the recommendations of the World Health Assembly made in Geneva and has been accepted in Canada and the United States.

In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

1. (a) Full name of Deceased ____________________

Residence at death ______________________

____

Age at death ____________________________

(b) Date of Death _______________________

Place of Death _____________________

If Institution or Hospital, give name ______

____

		Interval between onset and death
2	CAUSE OF DEATH (enter only one cause for each of a, b and c).	
(a)	Discase or condition directly leading to death: (This does not mean the mode of dying to death : (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the discease, 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	(b)
(c)	Due to	(c)
(d)	Was death due directly or indirectly to acquired Immune Deficiency Syndrome (A.I.D.S) or A.I.D.S related complex (ARC)? Yes [ ] No [ ] If so, when was the condition first diagnosed?	
	Other significant condition: (contributing to the death but not related to the disease or condition causing death).	

3. (a) Date of first attendance in last ____________

(b) Date of last attendance in the last ____________

(SEE OVER)

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4. (a) If death was due to accident, suicide or homicide, specify which.

(b) If due to suicide, did the deceased to your knowledge have AIDS or ARC at the time of death.

Yes [ ] No [ ]

(c) Was an inquest held? Yes [ ] No [ ]

Was an autopsy performed? Yes [ ] No [ ]

If so, by when and with what findings?
(Please attach copies of report if available).

5 Have you treated or advised the deceased during the last five years, prior to last illness?
Yes [ ] No [ ]

Did the deceased, to your knowledge, receive treatment during the five years from any other physician, or in any hospital or institution? Yes [ ] No [ ]

If yes to aither question, please furnish the following:

Name	Address	Nature of illness or Injury	Approximate Dates
....	....	....	....
....	....	....	....

Space is available below for elaboration.

____________________ M.D.
Please Print

____________________ M.D.
Signature

____________________ 20 ______
Date

____
Address