FORM NO. 4A

(see rule 7)

MEDICAL CERTIFICATION OF CAUSE OF DEATH

(For non-institutional deaths, Not to be used for still births)

To be sent to Registrar along with Form No. 2 (Death Report)

I hereby certify that the deceased Shri/Smt./Km. _____ son of /wife of/ daughter of _____ resident of _____ was under my treatment from _____ to _____ and he/she died on _____ at _____ A.M./ P.M.

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 diseases, 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 to the 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).....				

If deceased was a female, was the death associated with pregnancy? 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_____

(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 _____ at _____ A.M. / P.M.

Doctor _____

Signature and address of Medical Practitioner /

Medical Attendent with Registration No.