FORM NO. 4

(see rule 7)

MEDICAL CERTIFICATION OF CAUSE OF DEATH

(Hospital in-patients. Not to 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 persons whose particulars are given below died in the hospital in Ward No_____ 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 undertying 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 How did the injury occur ?

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

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 _____

Doctor _____
(Medical Supdt. & Name of Hospital)