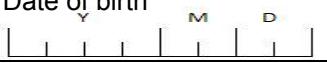
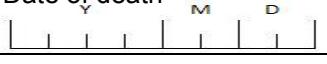
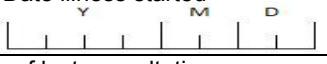


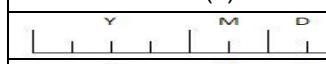
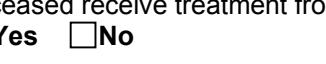
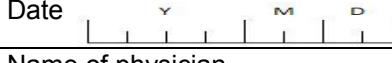
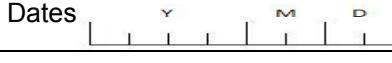
**DEATH CERTIFICATE**

Attending Physician

Last and first name of the deceased	Date of birth  Y M D
Residence at death	Date of death  Y M D
Did the deceased smoke? <input type="checkbox"/> YES <sup>(1)</sup> <input type="checkbox"/> NO <sup>(2)</sup>	
(1) If YES, since when did he/she smoke? _____	
Had he/she already quit smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, during what period? _____	
(2) If NO, did he/she ever smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, during what period? _____	
If death occurred in a hospital or institution, give the name of the establishment	

**CAUSE OF DEATH**

Disease, injury or condition which directly caused death	Date illness started  Y M D
Antecedent causes (morbid conditions having eventually given rise to the above cause)	Date illness started  Y M D
Disease or condition provoked by or resulting from	Date illness started  Y M D
For most recent illness – Date of first consultation  Y M D	For most recent illness – Date of last consultation  Y M D
Specify if death was due to : <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide If yes, describe briefly :	
Was a coroner inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom and with what findings?	

Did you treat the deceased or did he/she consult you during the <b>5 years preceding</b> the most recent illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate the dates	Date(s)  Y M D	Diagnosis (es) then reached:
	 Y M D	
	 Y M D	
To your knowledge, did the deceased receive treatment from any other physician, or in any hospital or other institution <b>during the past 5 years?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of physician	Name of hospital or institution	
Date  Y M D	Diagnosis (es):	
Name of physician	Name of hospital or institution	
Dates  Y M D	Diagnosis (es):	

 Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.  

Signature of attending physician

Name of attending physician (in block letters)

Address of attending physician