



*Apollo Life... for a Better Life*

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PROOF OF DEATH

NO. 2 PHYSICIAN'S STATEMENT

The Medical certification follows the recommendations of the World Health Assembly made in Geneva on July, 2004, 1948. All answers must be in the physician's handwriting.

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

1. Full name deceased	Date of death
2. Residence at death	Place of death (If Hospital or Institution, Give name)
3. Age at death or Date of birth	
4. State the immediate cause of death (Enter Only one Cause for each of a, b, and c) Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia etc. It means the disease, injury or complication which caused death) (a)	Interval between onset and death  (a)
5. Antecedent causes. (Morbid conditions, if any giving rise to the above causes (a) stating the underlying cause last.) Due to (b)	(b)
Due to (c)	
6. Other significant conditions: (Contributing to the death but not related to the disease or condition causing death)	
7. For how long a time was the Deceased confined to the house, or prevented from attending to business?	
8. Date of First Attendance in Last illness What were the general symptoms present, then and afterwards during the progress of the disease?	Date of Last attendance in Last illness
9. How long have you been the Medical attendant or adviser of the deceased and for what illness have you since treated him prior to the last illness?	
10. If death was due to accident, suicide or homicide, specify which and describe briefly	Was an inquest held <input type="checkbox"/> Yes <input type="checkbox"/> No Was an autopsy performed <input type="checkbox"/> Yes <input type="checkbox"/> No If so, by whom and with what findings?
11. Were there any identification marks on the body? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" give particulars	

12. Have you treated or advised the deceased during the last 5 years, prior to last illness?  Yes  No

13. Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any Hospital or Institution?  Yes  No

If Yes to any of the questions, please furnish the following:

Name: Address: Date:

Nature of illness or injury.....  
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14. Was an HIV Test carried out on the deceased?  
If yes, state results.  
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15. Was the deceased's death caused by AIDS - related condition or illness?  
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THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF

.....M.D.  
Signature

.....20.....  
Date

.....  
Address

.....  
Full Name and Rubber Stamp

INSTRUCTIONS  
ALL ANSWERS MUST BE ENTIRELY IN THE PHYSICIAN'S OWN HANDWRITING

In the interest of accurate vital statistics, please confirm to the International list of the causes of death when answering Question 6.  
External causes (Poisons, Violence, e.t.c.)  
If any injury, describe the accident. if a suicide or homicide, state the means employed.

In surgical cases, state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasms, give type and part first involved. Please avoid indefinite terms.  
Describe any unusual features.

Where spaces provided for the answers are too small, details as seem desirable should be given below.

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Signed \_\_\_\_\_  
MEDICAL DEPARTMENT