

FORM NO. 4A

(See Rule 7)

MEDICAL CERTIFICATE 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 Sri/Smt/Kum.....S/D/W of
 resident of Was under my treatment from.....to.....
 and he/she died onatA.M/P.M

Name of the 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		(a)		
State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc.		Due to (or as a consequences of)		
Antecedent Cause		(b)		
Morbid conditions, if any, giving rise to the above Cause, stating underlying conditions last		Due to (or as a consequences of) (c)		
II				
Other significant conditions contributing to the death but not related to the disease or conditions causing it				
If deceased was a female, was pregnancy death associated with? 1. Yes 2. No				
If yes, was there a delivery? 1.Yes 2.No.				
Name and signature of the Medical Practitioner certifying the cause of death Date of Certification.....				
SEE REVERSE FOR INSTRUCTIONS				
(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 under my treatment fromto..... and he/she expired on..... at.....A.M/P.M				
Doctor..... Signature and address of Medical Practitioner/ Medical attendant with Registration No.				

