



CERTIFICATE OF MEDICAL PRACTITIONER

Record No:

I am informed that application is about to be made for the cremation of the body of:

Full Name of Deceased:

Occupation:

Address:

As a medical practitioner who is required or permitted by section 46B or section 46C(1) of the Burial and Cremation Act 1964 to give a doctor's certificate (as defined in section 2(1) of that Act, and who has seen and identified the body after death), I give the following answers to the questions set out below:

1. On what date and at what hour did he or she die?
2. Where did the deceased die? (Give address and say whether own residence, lodgings, hotel, hospital, nursing-home, etc)
3. Are you a relative of the deceased? Yes No
If so, state the relationship:
4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? Yes No
5. Were you the ordinary medical attendant of the deceased? Yes No
If so, for how long? (State how many weeks, months, or years):
6. Did you attend the deceased during his or her last illness? Yes No
If so, for how long? (State how many weeks, months, or years):
7. If you attended the deceased during his or her last illness, when did you last see the deceased alive?
(Say how many hours or days before death)
8. a) How soon after death did you see the body?
b) What steps did you take to satisfy yourself as to the fact of death?
c) How did you establish the identity of the deceased person?
9. What were the causes of death? Period elapsing between onset of each condition and death (years, months, or days)
 - a) Immediate cause – the disease, injury, or complication which caused death?
 - b) Morbid conditions (if any) giving rise to the immediate cause?
(Place the conditions in chronological order beginning with the most recent)
 - c) Other conditions (if any) contributing to death – pregnancy, parturition, over-exertion, dangerous occupation?

State how far your answers as to the causes of death and the duration of such causes are founded on your own observations or on statements made by others. If on statements made by others, give their names and their relationship to the deceased.





10. What was the mode of death? (Say whether syncope, coma, exhaustion, convulsions, etc)

Syncop Coma Exhaustion Convulsions Other

What was its duration? (State number of days, hours, or minutes; and state how far your answer as to the mode of death is founded on your own observations or on statements made by others. If on statements made by others, give their names and their relationship to the deceased).

11. Did the deceased undergo any operation during the final illness or within a year before death; if so, what was its nature, and who performed it?

12. By whom was the deceased nursed during his or her last illness? (If the death occurred in a hospital, this question may be answered by referring generally to the nursing staff in a specified ward, but otherwise give names and say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before death).

13. By what medical attendants (besides yourself, if applicable) was the deceased attended during his or her last illness?

14. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death? Yes No

15. Do you know, or have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to:

a) Violence Yes No b) Poison Yes No
c) Privation or neglect Yes No d) Illegal operation Yes No

16. Have you any reason whatever to suppose a further examination of the body to be desirable? Yes No

17. Have you given the doctor's certificate as defined in section 2(1) of the Burial and Cremation Act 1964? Yes No

CERTIFICATE IN RELATION TO PACEMAKERS AND OTHER BIOMECHANICAL AIDS

I hereby certify that I have examined the body of 'the deceased' and (delete whichever is inapplicable):

I am satisfied that the body does not contain a cardiac pacemaker or any other biomechanical aid.

I have removed from the body a cardiac pacemaker or other biomechanical aid, namely

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief, and that there is no circumstance known to me which can give rise to any suspicion that the death was due wholly or in part to any other cause than disease (or accident) or which makes it desirable that the body should not be cremated.

Signature:

Date:

Address:

Registered Qualifications: