CG | ATLANTIC
MEDICAL & LIFE

PROOF OF DEATH:
PHYSICIAN STATEMENT

Life Choices

Note: The medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948. It has been accepted in Canada and the United States. In the interest of accurate vital statistics, please conform to the International List of Causes of Death.

1. Deceased's Full Name: _____
2. Residence at Death: _____
3. Age at Death: _____ Date of Death (DD/MM/YY): _____

   Place of Death: _____

   If Institution or Hospital provide name: _____
4. Cause of Death (enter only one cause for each of a, b, and c) Interval between Onset and Death

   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) _____ a) _____

   Antecedent causes (Morbid conditions, if any, giving rise to the above cause a) stating the underlying cause last):

   Due to: b) _____ b) _____

   Due to: c) _____ c) _____

   Other significant conditions (contributing to the death but not related to the disease or condition causing death):

   _____

   _____
5. Date of first attendance in last illness (DD/MM/YY): _____
6. Date of last attendance in last illness (DD/MM/YY): _____
7. If death was due to accident, suicide or homicide, specify which and describe briefly: _____

   _____
8. Was an inquest held? ☐ Yes ☐ No
9. Was an autopsy performed? ☐ Yes ☐ No If Yes, by whom and what were the findings? _____

   _____
10. Have you ever treated or advised the deceased in the last three years prior to past illness? ☐ Yes ☐ No
11. Did the deceased, to your knowledge, receive treatment during the last three years from any other physician in any hospital or institution? ☐ Yes ☐ No

If you answered Yes to either question 10 or 11, please furnish the following:

Name of Physician or Hospital	Address	Nature of Illness/Injury	Approximate Dates

These statements are true and complete to the best of my knowledge and belief.

Physician's Signature: _____ Date: _____

Address: _____

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