

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 Shri/Smti./Kum. son of/wife of/daughter of
..... resident of was under my treatment fromto
..... and he/she died on at A.M./P.M.

NAME OF DECEASED				For use of Statistical Office
Sex	Age of Death			
	Age in completed years	If less than 1 year, age in Months	If less than 1 month, age in Days	If less than 1 day, age in Hours
1. Male 2. Female				
<p>I. Immediate cause (a) State the disease, injury or complication due to (or as a consequences of) which caused death, not the mode of dying such as heart failure, asthenia etc.</p> <p>Antecedent cause (b) Morbid conditions, if any, giving rise to the above Cause, stating underlying condition last</p> <p>(c)</p> <p>II. Other significant conditions contributing to the death but not related to the disease or conditions causing it</p>				<p>Interval between onset & death approx.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

If deceased was a female was pregnancy the 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 RESERVE FOR INSTRUCTIONS

(To be detached and handed over to the relative of the deceased)

Certified that Shri./Smti./kum.S/W/D of Shri R/O
..... was under my treatment from to and he/she
expired on at A.M./P.M.

Doctor
Signature and address of Medical
Practitioner/ Medical Attendant with
Registration No.