FORM NO. 4
(See Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(Hospital in-patients. Not to be used for still births)
To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital …….....……..
I hereby certify that the person whose particulars are given below died in the hospital in Ward No. ……. On at ……. AM/PM.

NAME OF DECEASED					
Sex	Age at Death				For use of Statistical Office
	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** State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia etc.	(a)…… ……. Due to (or as a consequences of)				
Antecedent cause Morbid conditions, if any, giving rise to the above Cause, stating underlying condition last	(b)…… …….. Due to (or as a consequences of)				
II Other significant conditions contributing to the death but not related to the disease or conditions causing II	© …… …… ……				

Manner of Death How did the injury occur?
1. Natural 2. Accident 3. Suicide 4. Homicide
5. Pending Investigation

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 Attendant certifying the cause of death
Date of verification ……

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

Certified that Shri/Smt/Km ……S/W/D of Shri. ……
R/O ……was admitted to this hospital on …….. and expired on ……..

Doctor ……
(Medical Supdt.
Name of Hospita1