

FORM NO.2

**DEATH REPORT**  
**Legal information**

This part to be added to the Death Register  
To be filled by the informant

1. **Date of Birth:** (Enter the exact day, month and year the death took place e.g. 1-1-2000)
2. **Name of the deceased:**  
(Full name as usually written)
3. **Sex of the deceased:**  
(Enter "male" or "female" do not use abbreviation)
4. **Age of the deceased:** (If the deceased was over 1 year of age, give age in completed years. If the deceased was below 1 year of age, give age in months, and if below 1 month give age in completed number of days, and if below one day in hours )
5. **Place of Death:** (Tick the appropriate entry 1, 2 or 3 below and give the name of the hospital/Institution or the address of the house where the death took place. If other place, give location ).
  1. Hospital/Institution                      Name
  2. House    Address
  3. Other Place
6. **Informant's name:**  
Address:  
(After completing all columns 1 to 17, informant will put date and signature here ).

Date:      Signature or left thumb mark of the informant

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To be filled by the Registrar

Registration No:    Registration date:

Registration Unit

Town/Village:    District

Remarks. (if any )

Name and Signature of the Registrar



## FORM NO.2

*To be filled by the informant*

11. **Was the cause of death medically certified? :**  
(Tick the appropriate entry below)  
1. Yes 2. No.
12. **Name of Disease or Actual Cause of Death:**  
(For all deaths irrespective of whether medically certified or not)
13. **In case this is a female death, did the death occur  
While pregnant, at the time of delivery or within 6 weeks after the end of  
pregnancy:**  
(Tick the appropriate entry below)  
1. Yes 2. No.
14. **If used to habitually smoke  
for how many years:**
15. **If used to habitually chew tobacco in any  
form for how many years?**
16. **If used to habitually chew arecanut in any  
form (including pan masala)-  
for how many years?**
17. **If used to habitually drink alcohol  
for how many years?**

(Columns to be filled are over. Now put signature at left)

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Registration No:

Registration date:

**Date of Death:**

**Sex:** 1. Male 2. Female

**Age:** Years/months/days/hours

**Place of Birth:** 1. Hospital/Institution 2. House 3. Other place

Name and Signature of the Registrar