Sagicor

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PROOF OF DEATH - PHYSICIAN'S STATEMENT

NOTE : The medical certification follows the recommendations of the World Health Assembly made in Geneva and has been accepted in Canada and the United States.

In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.

1. (a)	Full name of Deceased _____ Residence at death _____ _____ Age at death _____	(b)	Date of Death _____ Place of Death _____ If Institution or Hospital, give name _____ _____
2	CAUSE OF DEATH (enter only one cause for each of a, b and c).		Interval between onset and death
(a)	Discase or condition directly leading to death: (This does not mean the mode of dying to death : (This does not mean the mode of dying such as heart failure, asthenia, etc. It means the discease, injury or complication which caused death).		(a)
	Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last).		(b)
(b)	Due to		
(c)	Due to		(c)
(d)	Was death due directly or indirectly to acquired Immune Deficiency Syndrome (A.I.D.S) or A.I.D.S related complex (ARC)? Yes [ ] No [ ] If so, when was the condition first diagnosed?		
	Other significant condition: (contributing to the death but not related to the disease or condition causing death).		
3. (a)	Date of first attendance in last _____	(b)	Date of last attendance in the last _____

(SEE OVER)

4. (a) If death was due to accident, suicide or homicide, specify which.

(b) If due to suicide, did the deceased to your knowledge have AIDS or ARC at the time of death.

Yes [ ] No [ ]

(c) Was an inquest held? Yes [ ] No [ ]

Was an autopsy performed? Yes [ ] No [ ]

If so, by when and with what findings?
(Please attach copies of report if available).

5 Have you treated or advised the deceased during the last five years, prior to last illness?
Yes [ ] No [ ]

Did the deceased, to your knowledge, receive treatment during the five years from any other physician, or in any hospital or institution? Yes [ ] No [ ]

If yes to aither question, please furnish the following:

Name	Address	Nature of illness or Injury	Approximate Dates
.....	.....	.....	.....
.....	.....	.....	.....

Space is available below for elaboration.

_____ M.D.
Please Print

_____ M.D.
Signature

_____ 20 _____
Date

_____
Address