

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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