



"The Cremation Regulations 1973"

CERTIFICATE of MEDICAL PRACTITIONER

Form B/AB

I am informed that application is about to be made for the cremation of the body of:

SURNAME OF
DECEASED

OTHER NAMES

LAST PERMANENT
ADDRESS

OCCUPATION

Having attended the deceased before, and seen and identified the body after death, I give the following answers to the questions set out below:

| | | | | | |
|---|------------------|---|---|------------------|--------------|
| 1. On what date and at what hour did he (or she) die? | DATE OF DEATH | / | / | HOUR OF DEATH | A.M. P.M. |
|---|------------------|---|---|------------------|--------------|

2. Where did the deceased die? (Give address and say whether own residence, lodgings, hotel, hospital, nursing-home, etc.)

| | |
|--|--------------------------------|
| 3. Are you a relative of the deceased? | If so, state the relationship. |
|--|--------------------------------|

| | |
|--|---------------|
| 4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? | Give details. |
|--|---------------|

| | | | | |
|---|----------------------|-------|--------|-------|
| 5. Were you the ordinary medical attendant of the deceased? | If so, for how long? | years | months | weeks |
|---|----------------------|-------|--------|-------|

| | | | | | |
|---|----------------------|--------|-------|------|-------|
| 6. Did you attend the deceased during his/her last illness? | If so, for how long? | months | weeks | days | hours |
|---|----------------------|--------|-------|------|-------|

| | |
|--|---|
| 7. When did you last see the deceased alive? | (Say how many hours or days before death) |
|--|---|

8. (a) How soon after death did you see the body?

(b) What steps did you take to satisfy yourself as to the fact of death?

(c) How did you establish the identity of the deceased person?

| | | | | |
|-----------------------------------|--|-------|--------|------|
| 9. What were the causes of death? | Period elapsing between onset of each condition and death. | YEARS | MONTHS | DAYS |
|-----------------------------------|--|-------|--------|------|

(a) Immediate cause - the disease, injury or complication which caused death?

(b) Morbid conditions (if any) giving rise to the immediate cause
(Place the conditions in chronological order beginning with the most recent)?

(c) Other conditions (if any) contributing to death - pregnancy, parturition, over exertion, dangerous occupation?

State how far your answers as to the cause of death and the duration of such causes are founded on your own observations or on the statements made by others. If on statements made by others, give their names and their relationship to the deceased.

10. What was the mode of death?
(State whether syncope, coma,
exhaustion, convulsions, etc).

What was its duration? (State number of days, hours or minutes:
and state how far your answer as to the mode of death is
founded on your own observations or on statements made by
others. If on statements made by others, give their names
and their relationship to the deceased).

11. Did the deceased undergo any operation during
the final illness or within one year before death?

Nature of operation:

By whom performed:

12. By whom was the deceased nursed during his (or her) last illness?
(If the death occurred in a hospital, this question may be answered
by referring generally to the nursing staff in a specified ward, but
otherwise give names and say whether professional nurse, relative,
etc. If the illness was a long one, this question should be
answered with reference to the period of four weeks before death).

Answer 'Yes' or 'No' to the following questions - if the answer to any question is 'Yes' give particulars.

13. Was the deceased attended during his (or her)
last illness by any medical attendant besides
yourself?

14. In view of the knowledge of the deceased's habits and
constitution do you feel any doubts whatsoever as to the
character of the disease or the cause of death?

15. Do you know, or have you any reason to suspect, that the
death of the deceased was due, directly or indirectly, to -

a. VIOLENCE
b. POISON

c. PRIVATION OR NEGLECT
d. ILLEGAL OPERATION

16. Have you any reason whatever to suppose a further examination of the body to be desirable?

17. Have you given the certificate required for the registration
of death?

Form AB

CERTIFICATE IN RELATION TO PACEMAKERS AND OTHER BIOMECHANICAL AIDS

I hereby certify that I have examined the body of (Full Name), (Address), (Occupation).

- * I am satisfied that the body does not contain a cardiac pacemaker or any other biomechanical aid.
- * I have removed from the body a cardiac pacemaker or other biomechanical aid, namely

(Delete whichever is inapplicable)

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief, and that there is no circumstance known
to me which can give rise to any suspicion that the death was due wholly or in part to any other cause than disease (or accident) or which makes it
desirable that the body should not be cremated.

SIGNATURE

SURNAME

(Block Letters)

DATE / /

Registered Qualifications

Address

Telephone

NOTE: This certificate must be handed or sent in a closed envelope by the medical practitioner who signs it to a Medical Referee.