FORM NO.4
(see rule 7)
MEDICAL CERTIFICATE OF CAUSE OF DEATH
(Hospital In-patients. Not to be used for still birth)
To be sent to Registrar along with Form No. 2 (Death Report)
A copy of this certificate to be provided to the nearest relative of the deceased

Name of the Hospital ……..

I hereby certify that the person whose particulars are given below died in the hospital in Ward No ……

On | D | D | - | M | M | - | Y | Y | Y | Y | at……A.M./P.M.

NAME OF DECEASED: First Name / Middle Name / Last Name				For use of Statistical Office
Sex	Age at Death			
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours
1. Male 2. Female 3. Transgender Person				

CAUSE OF DEATH

		Interval between onset and 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 conditions last	(b)…… due to (or as a consequences of)	
II Other significant conditions contributing to the death But not related to the disease or condition causing it	(c) …… …… ……	

Manner of death
1. Natural 2. Accident 3. Suicide 4. Homicide
5. Pending investigation

How did the injury occur?

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: | D | D | - | M | M | - | Y | Y | Y | Y |

SEE REVERSE FOR INSTRUCTIONS

FORM NO.4A

(see rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(For non-institutional deaths. Not to be used for still births)

(To be given to the person required under the Registration of Births and Deaths Act, 1969 to give information concerning the death to Registrar along with Form No. 2(Death Report)

I hereby certify that the deceased Shri/Smt./Km…… Son/Wife/Daughter of……resident of ……. was under my treatment from……..to……and he/she died

On | D | D | - | M | M | - | Y | Y | Y | Y | at……A.M./P.M.

NAME OF DECEASED:	First Name	Middle Name	Last Name		For use of Statistical Office
Sex	Age at Death				
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female 3. Transgender Person					

CAUSE OF DEATH		Interval between onset and 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 conditions last	(b)…… due to (or as a consequences of)	
II Other significant conditions contributing to the death But not related to the disease or condition causing it	(c)…… …… ……	

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 Practitioner certifying the cause of death

Date of verification : | D | D | - | M | M | - | Y | Y | Y | Y |

SEE REVERSE FOR INSTRUCTIONS