Proof of Death

Physician's Statement

The Medical Certificate follows the recommendation of The World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all states in the United State and all provinces in Canada. In the interest of accurate vital statistics, please conform to the international list of causes of death.

OTHER THAN WHERE PROHIBITED BY LAW, THE CLAIMANT IS RESPONSIBLE FOR ANY CHARGES INCURRED IN CONNECTION WITH COMPLETION OF THIS FORM.

Part 1 – Deceased Details

Full name of deceased	
Date of death *(mm/dd/yyyy)*	Age at date of death
Residence at death	
Place of death *(if hospital or institution, give name)*	

Part 2 – Information about the Death

1. Cause of death – Enter only for one cause for each of A, B and C.)

A. Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

2. Antecedent causes *(Morbid conditions, if any, giving rise to the above cause A. stating the underlying cause last)*

INTERVAL BETWEEN ONSET AND DEATH

B. Due to:

C. Due to:

3. Other significant conditions *(Contributing to the death but not related to the disease or condition causing death)*

4. If death was due to accident, suicide or homicide, specify which:

5. Was an inquest held? ☐ YES ☐ NO

6. Was an autopsy performed? ☐ YES ☐ NO. If "YES", by whom and with what findings?

Part 3 – Treatment Information

Date of first attendance in last illness *(mm/dd/yyyy)*	Date of last attendance in last illness *(mm/dd/yyyy)*	How long have you known deceased?

1. Have you treated or advised the deceased during the last 3 years, prior to last illness? ☐ YES ☐ NO

2. Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution? ☐ YES ☐ NO

Name	
Address *(include street address, city, province and postal code)*	
Nature of illness or injury	Dates

3. Was the deceased advised of the nature of his illness? ☐ YES ☐ NO

If "YES", when? *(mm/dd/yyyy)*

Part 4 – Physician Information

Signature of physician M.D.	Date *(mm/dd/yyyy)*

Address *(include street address, city, province and postal code)*

CUMIS

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