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 sent to Registrar along with Form No. 2 (Death Report)

I hereby certify that the deceased Shri/Smt/Km. .....
son of/wife of/daughter of .....
resident of ..... was under my treatment from .....
to ..... and he/she died on..... at ..... A.M./P.M.

NAME OF DECEASED					For use of Statistical Office
		Age at Death			
Sex	Age in completed years	If less than 1 year, age in months	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female					

CAUSE OF DEATH		Interval between on set & death approx.	
I. Immediate cause State the disease, injury or complecation 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) (c)		
II. Other significant conditions contributing to the death but not related to the disease or conditions causing it.	....		

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 Pracitioner certifying the cause of death

Date of verification .....

SEE REVERSE FOR INSTRUCTIONS

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Km .....
S/W/D of Shri ..... R/O .....
was under my treatment from..... to ..... and he/she expired on .....
at ..... A.M./P/M.

Doctor .....
Signature and address of Medical Practitioner/
Medical attendant with Registration No.

D/P & S - No. 41/10-10-2011-Medical-50,000-C/24-01-2012.