**PROOF OF DEATH** **MEDISERV** **No. 2 PHYSICIAN'S**

**Submitted to** INTERNATIONAL Ltd. **STATEMENT**

*The Medical certification follows the* recommendations of the World Health Assembly made in Geneva on July 24th, 1948.

**All answers must be in the Physician's handwriting**.

In the interest of accurate vital statistics, Please conform to the International List of the Causes of Death.

| Full name of deceased: | Date of death |
|---|---|
| Residence at death:<br>Age at death or date of birth: | Place of death (If Hospital or Institution, give name) |

| 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 that caused death.)<br>(a) | (a) |
| Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)<br>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.)

| Date of First Attendance in Last Illness: - | Date of Last Attendance in Last Illness: - |
|---|---|
| If death was due to accident, suicide or homicide, specify which and describe briefly. ……<br>……<br>…… | Was an inquest held? Yes ☐ No ☐<br>Was an autopsy performed? Yes ☐ No ☐<br>If so, by whom and with what findings? ……...<br>……... |

Were there any identification marks on the body? Yes ☐ No ☐ If "Yes", give particulars …….
……...

Have you treated or advised the deceased during the last 5 years, prior to last illness? Yes ☐ No ☐

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician, or in any Hospital or Institution? Yes ☐ No ☐

If "yes" to either question, please furnish the following:

| Name | Address | Nature of Illness or Injury | Dates |
|---|---|---|---|

**THESE STATAEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF**

_____M.D.
Signature

_____20_____
Date

_____
Address

Please turn over

## INSTRUCTIONS

### All Answers Must be Entirely in the Physician's Own Handwriting

In the interest of accurate vital statistics, please conform to the International List of the causes of death when answering Question 6. External causes (poisons, violence, etc.)

If an injury, describe the accident. If a suicide or homicide, state the means employed.

In surgical cases, state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasms, give type and part first involved. Please avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details as seem desirable should be given below.

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