

Name and Signature of the Medical Attendant certifying the cause of death
Date of verification

SEE REVERSE FOR INSTRUCTIONS

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

Certified that Shri / Smt, / Kumson/wife /daughter
of Shri..... R/O
..... was under my treatment from
.....to..... and he/she expired onA.M./P.M.
Doctor :
Medical Superintendent:.....
Name of the Hospital

हॉस्पिटलमध्ये मृत्यु झाला तर

**PUNE MUNICIPAL CORPORATION
MEDICAL CERTIFICATION OF CAUSE OF DEATH**

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

FORM NO. 4A (See Rule 7)

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

Name of the Hospital I hereby
certify that the person whose particulars are given below died in the hospital
in Ward No. on at A.M./P.M.

NAME OF DECEASED					
Age at Death					
Sex	If 1 year or more, age in Years	If less than 1 year, age in Months	If less than 1 month, age in Days	If less than 1 day age in Hours	For use of Statistical Office
M F					
CAUSE OF DEATH 1. Immediate cause : (a) Due to (or a State the disease, injury or consequences of) complication which caused death, not the mode of dying such as heart failure, asthenia, etc.				Interval between on Set & death app.	

Antecedent cause : (b) Due to (or a Morbid conditions, if any giving consequences of rise to the above cause, stating underlying conditions last. 2. Other significant conditions (c) contributing to the death but not related to the disease or conditions causing it.		
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Manner of Death : (How did the injury occur?)

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

If deceased was a female; was the death associated with pregnancy ?

1. Yes 2. No

If Yes, was there a delivery ?

1. Yes 2. No

Name and Signature of the Medics' Attendant certifying the cause of death

Date of verification.

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