

INSURANCE CORPORATION
FE MAIN BRANCH
MEDICAL ATTENDANT'S CERTIFICATE

(TO BE COMPLETED BY THE MEDICAL ATTENDANT OF THE DECEASED IN HIS LAST ILLNESS)

- 1) WHAT WAS THE DECESED'S
 - A) CARD NO? _____
 - B) FULL NAME? _____
 - C) ADDRESS? _____

- 2) A) WHAT AS NEARLY AS YOU COULD JUDGE AGE OF THE DECASED AT DEATH?

- B) WAS THE DECEASED RELATED TO YOU? IF YES, HOW?

- C) PLEASE DESCRIBE ANY MARKS OR PHYSICAL PECULARITIES NOTICEABLE FOR PURPOSE OF IDENTIFICATION _____

- 3) WHAT WAS THE TIME AND DATE OF HIS/HER DEATH? AT _____
O'CLOCK ON THE _____ DAY OF _____

- 4) WHERE DID HE/SHE DIE? (GIVE EXACT ADDRESS)

- 5) A) WHAT WAS THE FACT CAUSE OF DEATH, I.E. PRIMARY CAUSE?

- B) BESIDES DEFINING THE DISEASE ON OTHER CAUSE OF DEATH IN SUCH TERMS AS YOU CONSIDER APPROPRIATE, KINDLY ADD THE DISTINCIVE TECHNICAL NAME, INCLUDING SECONDARY CAUSE, IF ANY, _____

- C) WAS THIS ASSCRTAINED BY EXAMINATION AFTER DEATH OF INFERRED FROM SYMPTOMS AND APPEARACE DURING LIFE?

- D) HOW LONG HAD HE/SHE BEEN SUFFERING FROM THIS DISEASE BEFORE HIS DEATH?

- E) WHAT WERE THE SYMPTOMS OF THE ILLNESS? _____

- F) WHEN WERE THE SYMPTOMS FIRST OBSERVED BY THE DECEASED?

- G) WHAT WAS THE DATE ON WHICH YOU WERE FIRST CONSULTED DURING HIS/HER ILLNESS? _____

- H) DID YOU ATTEND HIS/HER DURING THE WHOLE OF ITS COURS

- I) IF NOT, STATE DURING WHAT PERIOD

R & TEMPERATE? _____

B) HAVE YOU ANY REASON TO SUPPOSE OR TO SUSPECT THAT DISEASE WAS IN HIS CASE CAUSED OR AGGRAVATED BY INTEMPERATE HABITS? _____

7) A) WHAT OTHER DISEASE OR ILLNESS PRECEDED THAT WHICH IMMEDIATELY CAUSED DEATH?

B) WHAT OTHER DISEASED OR ILLNESSED CO-EXISTED WITH THAT WHICH IMMEDIATELY CAUSED DEATH? _____

C) GIVE HISTORY OF SUCH DISEASE OR ILLNESS SUSTAINED

I) DATE WHEN FIRST OBSERVED _____

II) BY WHOM TREATED? _____

III) BY WHOM HISTORY REPORTED TO YOU? _____

8) A) WAS THE DESESED TREATED DURING HIS/HER LAST ILLNESS IN ANY OTHER HOSPITAL BEFORE YOU WERE CONGEULTED?

B) DID ANY OTHER MEDICAL PRACTIONERS ATTEND ON HIM/HER IN CONSULATION WITH YOURSELF? _____
IF SO, PLEASE STATE THEIR NAME & ADDRESS _____

9) A) WERE YOU DECEASED'S USUAL MEDICAL ATTENDET? _____

B) IF SO, FOR HOW LONG? _____

C) IF NOT PLEASE STATE NAMES & ADDRESSES OF HIS USUAL MEDICAL ATTENDATS _____

10) WHEN AND FOR WHAT AILMENTS DID YOU TREAT THE DECREASED DURING THE THREE YEAR PRECEDING HIS LAST ILLNESS _____

11) A) WAS, ANY INQUEST OR FORMAL INQUIRY HELD REGARDING THE DEATH OF WAS A PAT MORTEMUM EXAMINATION MADE _____

B) IF SO, BY WHOM AND WHAT WAS THE RESULT OF FINDING _____

12) HAVE YOU ANY OTHER INFORMATION OR REMARKS TO MAKE INCONNECTION WITH DECEASED'S AILMENTS, HABITS, MODE OF LIVING ETC _____

13) I _____ MEDICAL ATTENDAT OF THE DECEASED

_____ DO HEREBY SCLEMNLY DECARE THE FOREGOING STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THAT THE DECEASED DID NOT DIE BY HIS OWN ACT

DATE _____ DATE _____ DATE OF _____ 19 _____

MEDICAL ATTENDANT'S

SIGNATURE _____

QUALIFICATIONS _____

POSTAL ADDRESS _____