FORM NO. 4-A

(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 alone 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
Sex	Age at Death				
	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 complication 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 a there a delivery? 1. Yes 2. No.

Name and signature of the Medical Practitioner 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. / Kum .... 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.