

**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/wife/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			
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	
3. Male 4. Female				
<b>CAUSE OF DEATH</b>				Interval between onset and 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)				
II Other significant conditions contributing to the death but not related to the disease or condition causing it				
(c) .....				

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 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.