Medical certificate

Cremation 4
replacing Form B

01.09

This form can only be completed by a registered medical practitioner.
Please complete this form in full, if a part does not apply enter 'N/A'.

Oak Hill
LAWN CEMETERY & CREMATORIUM

Part 1 Details of the deceased

Full name

Address

Occupation or last occupation if retired or not in work at the date of death

Where a past occupation of the deceased person may suggest that the death was due to industrial disease, you should consider whether to refer the death to a coroner.

Part 2 The report on the deceased

1. What was the date and time of death of the deceased?

Date / / Time

2. Please give the address where the deceased died.

Address

Please state whether it was the residence of the deceased or a hotel, hospital, or nursing home etc.

☐ Their home ☐ Hospital ☐ Other (please specify)

☐ Hotel ☐ Nursing home

3. Are you a relative of the deceased? ☐ Yes ☐ No

If Yes, please give the nature of your relationship.

4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? ☐ Yes ☐ No

If Yes, please give details.

5. Were you the deceased's usual medical practitioner? ☐ Yes ☐ No

If Yes, please state for how long.

If No, please give details of your medical role in relation to the deceased.

6. Please state for how long you attended the deceased during their last illness?

7. Please state the number of days and hours before the deceased's death that you last saw them alive?

Days

Hours

8. Please state the date and time that you saw the body of the deceased and the examination that you made of the body.

Date

/ /

Time

Examination

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9. From your medical notes, and the observations of yourself and others immediately before and at the time of the deceased's death, please describe the symptoms and other conditions which led to your conclusions about the cause of death.

10. If the deceased died in a hospital at which they were an in-patient, has a hospital post-mortem examination been made or supervised by a registered medical practitioner of at least five years' standing who is neither a relative of the deceased nor a relative of yours or a partner or colleague in the same practice or clinical team as you? ☐ Yes ☐ No

If Yes, are the results of that examination known to you? ☐ Yes ☐ No

Note: 'Five years' standing' means a medical practitioner who has been a fully registered person within the meaning of the Medical Act 1983 for at least five years and, if paragraph 10 of Schedule 1 to the Medical Act 1983 (Amendment) Order 2002 (S.I. 2002/3135) has come into force, has held a licence to practice for at least five years or since the coming into force of that paragraph.

11. Please give the cause of death

1. (a) Disease or condition directly leading to death (this does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc.: it means the disease, injury, or complication which caused death)

(b) Other disease or condition, if any, leading to (a)

(c) Other disease or condition, if any, leading to (b)

2. Other significant conditions contributing to the death but not related to the disease or condition causing it.

12. Did the deceased undergo any operation in the year before their death? ☐ Yes ☐ No

If Yes, what was the date and nature of the operation and who performed it.

Date of operation

☐☐ / ☐☐ / ☐☐☐☐

Who performed it

Nature of operation

13. Do you have any reason to believe that the operation(s) shortened the life of the deceased? ☐ Yes ☐ No

If Yes, please give details.

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14. Please give the full name and address details of any person who nursed the deceased during their last illness (Say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before the death.)

15. Were there any persons present at the moment of death? ☐ Yes ☐ No

If Yes, please give the full name and address details of those persons and whether you have spoken to them about the death.

16. If there were persons present at the moment of death, did those persons have any concerns regarding the cause of death? ☐ Yes ☐ No

If Yes, please give details

17. In view of your knowledge of the deceased's habits and constitution do you have any doubts whatever about the character of the disease or condition which led to the death? ☐ Yes ☐ No

18. Have you any reason to suspect that the death of the deceased was

Violent ☐ Yes ☐ No

Unnatural ☐ Yes ☐ No

19. Have you any reason at all to suppose a further examination of the body is desirable? ☐ Yes ☐ No

If you have answered Yes to questions **17**, **18** or **19** please give details below:

20. Has a coroner been informed about the death? ☐ Yes ☐ No

If Yes, please state the outcome.

21. Has there been any discussion with a coroner's office about the death of the deceased? ☐ Yes ☐ No

If Yes, please state the coroner's office that was contacted and the outcome of the discussions.

22. Have you given the certificate required for registration of death? ☐ Yes ☐ No

If No, please give the full name and contact details of the medical practitioner who has

Full name

Address

Telephone number

23. Was any hazardous implant placed in the body (e.g. a pacemaker, radioactive device or 'Fixion' intramedullary nailing system)? ☐ Yes ☐ No

Implants may damage cremation equipment if not removed from the body of the deceased before cremation and some radioactive treatments may endanger the health of crematorium staff.

If Yes, has it been removed? ☐ Yes ☐ No

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Part 3 Statement of truth

I certify that I am a registered medical practitioner.

I certify that the information I have given above is true and accurate to the best of my knowledge and belief and that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or in a place or circumstance which requires an inquest in pursuance of any Act.

I am aware that it is an offence to wilfully make a false statement with a view to procuring the cremation of any human remains.

Your full name

Address

Telephone number

Registered qualifications

GMC reference number

Signed

Dated / /

Once completed, this certificate must be handed or sent in a closed envelope by, or on behalf of, the medical practitioner who signs it to the medical practitioner who is to give the confirmatory medical certificate except in a case where question 10 is answered in the affirmative, in which case the certificate must be so handed or sent to the medical referee at the cremation authority at which the cremation is to take place.