



GROUP DIVISION PROOFS OF DEATH PHYSICIAN'S STATEMENT

POLICY # _____

The Medical Certification follows the recommendation of The World Health Assembly made in Geneva on July 24, 1948. It has been accepted by all states in the United States and all provinces in Canada. In the interest of accurate vital statistics, please conform to the international list of causes of death.

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

FULL NAME OF DECEASED	DATE OF DEATH
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RESIDENCE AT DEATH	PLACE OF DEATH
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AGE AT DEATH OR DATE OF BIRTH	(IF HOSPITAL OR INSTITUTION, GIVE NAME)
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Cause of death (Enter only one cause for each of a, b, and c.) Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury or complication which caused death.) (a)	INTERVAL BETWEEN ONSET AND DEATH (a)
Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)	
Due to (b)	(b)
Due to (c)	(c)
Other significant conditions: (Contributing to the death but not related to the disease or condition causing death.)	

DATE OF FIRST ATTENDANCE IN LAST ILLNESS	DATE OF LAST ATTENDANCE IN LAST ILLNESS
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If death was due to accident, suicide or homicide, specify which. Describe briefly.	Was an inquest held?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Was an autopsy performed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	If so, by whom and with what findings?			

Have you treated or advised the deceased during the last 3 years, prior to last illness?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
If "Yes", to either question, please furnish the following:			
NAME	ADDRESS	NATURE OF ILLNESS OR INJURY	DATES

_____	_____ M.D.
DATE	SIGNATURE
_____	_____
	ADDRESS