

"The Cremation Regulations 1973"

CERTIFICATE of MEDICAL PRACTITIONER

Form B

WHANGANUI
DISTRICT COUNCIL
Te Kaunihera a Rohe o Whanganui

I am informed that application is about to be made for the cremation of the body of:

SURNAME OF
DECEASED

OTHER NAMES

LAST PERMANENT
ADDRESS

(OCCUPATION)-

Where did the deceased die? (Give Address and say whether own
residence, lodgings, hotel, hospital, nursing-home, etc)Having attended the deceased before and seen and identified the body after death I give the following answers to the
questions set out below.

On what date and what hour did he (or she) die?

DATE OF
DEATH

/ /

HOUR OF
DEATHAM.
PM.When did you last see
the deceased alive?(Say how many hours,
or days before death)

How soon after death did you see the body?

What steps did you take to satisfy
yourself as to the fact of death?How did you establish the identity
of the deceased person?

	Period elapsing between onset of each condition.	YEARS	MTHS	DAYS
What was the cause of death?				
Immediate cause – the disease, injury or complication which caused death?				
Morbid conditions (if any) giving rise to the immediate cause (Place the conditions in chronological order beginning with the most recent)?				
Other conditions (if any) contributing to death – pregnancy, parturition, over exertion, dangerous occupation?				

State how far your answers as to the cause of death and the
duration of such causes are founded on your own observations
or on the statements made by others. If on statements made by
others, give their names and relationship to deceased.What was the mode of death?
State whether syncope, coma,
exhaustion, convulsions, etc)What was its duration? (state number of days, hours or minutes:
and state how far your answers as to the mode of death is
founded on your own observations or by the statements made by
others. If on statements made by others, give their names
and their relationship to the deceased).State in
durations

days

hours

minutes

By whom was the deceased nursed during his (or her) last illness?
(If the death occurred in the hospital, this question may be answered
By referring generally to the nursing staff in specified ward, but
Otherwise give names and 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 death).

Answer 'YES' or 'NO' to the following questions – if the answer is 'Yes' give particulars.		
Are you a relative of the deceased? _____	If so, state the relationship. _____	
Have you as far as you are aware any pecuniary interest in the death of the deceased? _____	Give details _____	
Were you the ordinary medical attendant of the deceased? _____	For how long? years months weeks	
Was the deceased attended during his (or her) last illness by any medical attendant besides yourself? _____	_____	

Did you attend the deceased during his/her last illness? _____	For how long? months weeks days hours	
As far as you are aware did the deceased undergo any operation during the final illness or within one year before death? _____	Date & Nature of operation	By whom performed
	_____	_____
In view of the knowledge of the deceased habits and constitution do you feel any doubts whatsoever as to the character of the disease or the cause of death?	_____	

Do you know, or have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to –	<u>VIOLENCE</u> YES <input type="checkbox"/> NO <input type="checkbox"/> <u>PRIVATION OR NEGLECT</u> YES <input type="checkbox"/> NO <input type="checkbox"/> <u>POISON</u> YES <input type="checkbox"/> NO <input type="checkbox"/> <u>ILLEGAL OPERATION</u> YES <input type="checkbox"/> NO <input type="checkbox"/>	
Have you any reason whatever to suppose a further examination of the body to be desirable? _____		
Have you given the certificate required for the registration of death? _____		

Form AB

Certificate in relation to pacemakers and other biomechanical aids

- Delete whichever is inapplicable
- I am satisfied that the body does not contain cardiac pacemaker or any other biomechanical aid.
- I have removed from the body a cardiac pacemaker or other biomechanical aid, namely _____

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief, and that there is no circumstances known to me which can give rise to any suspicion that the death was due wholly or in part to any other cause Than disease (or accident) or which makes it desirable that the body should not be cremated.

Signature _____

SURNAME
(Block Letters) _____ DATE / /

Registered Qualifications _____

Address _____ Telephone _____

NOTE: This certificate must be handed or sent in a closed envelope by the medical practitioner who signs it to a Medical Referee.