DUPLICATE

REGISTER OF DEATH

FORM A2

(For use by Medical Practitioners and in hospitals)

District:

Registrar's Serial No.:

1. Full Name of Deceased	Baptismal or given Name(s)	Middle or Tribal Name	Son or daughter of	Surname or Tribal Name of Father
2. Date Of Death	Date of Month:	Month:	Year:	3.Sex of Deceased Male .. .. 1 ☐ Female .. .. 2 ☐
4. Age Of Deceased	Years(If under one year state in months……... or days……)			5. Occupation of Deceased
Code 6 Exact Place Of Death	No. of house and street Or road, if any	Name of town, if any, or Village/Sub-location and location		If in Institution, name of hospital or medical centre
7. Normal Residence of Deceased Code	If Deceased not normally resident at above place, state District in which he lived.			

8.TO BE COMPLETED BY MEDICAL PRACTITIONER:

Interval between On set and Death

A. Cause of Death– Enter one cause per line :

Code

I. IMMEDIATE CAUSE (A)…… ….

DUE TO (B)……...

DUE TO (C) ……

II.OTHER SIGNIFICANT CONDITIONS…….

B. Certificate

I certify that-

Delete as appropriate

(a) I attended the deceased, or
(b) I examined the body after death, or
(c) I conducted a post mortem examination of the above information is correct to the best of my knowledge.

Signature…… Title……... Date……..

NAME IN BLOCK LETTERS …….. ……...

9. Signature of Local Registrar……. Date record received……. ……...

TO OBTAIN A DISPOSAL PERMIT (BURIAL OR CREMATION) THIS CERTIFICATE IN DUPLICATE (TWO FORMS) MUST BE TAKENT TO THE OFFICE OF THE REGISTRAR OF DEATHS AT:-

On week-days (during office hours); or

On Sundays and Public Holi-days and after office hours on week-days

IMPORTANT– A record must be made for each death. Use a typewriter or ball-point pen or other pen with black or dark blue ink. This is a permanent legal record. Be sure to use the carbon copy is legible.