



MINISTRY OF HEALTH

MANATŪ HAUORA

Burial and Cremation Act 1964

Medical Certificate of Cause of Death

This certificate must be given to the funeral director or other person in charge of the body without delay

The information recorded on this certificate will be used in the compilation of cause-of-death statistics

Please print clearly, and do not use abbreviations

Surname of deceased

First or given name(s) of deceased

Deceased's National Health Index (NHI) number (if available)

Date of birth

Date of death as stated to me

Last seen alive by me

Body seen by me after death

Place of death in full

Post-mortem examination

Sex Female Male

Tick one Discussed with coroner

I consider this death is not reportable under the Coroners Act 2006

I did not see the deceased alive and the doctor who last attended the deceased is unavailable...

Tick any that apply Pregnant at time of death

Not pregnant, but pregnant within 42 days of death (specify below)

Not known if pregnant at time of death or within 42 days of death

Cause of death

Approximate interval between onset and death

Part I Disease or condition directly leading to death* due to (or as a consequence of) Antecedent causes: Morbid conditions, if any, giving rise to the above cause. due to (or as a consequence of) Enter the underlying cause (disease or injury which initiated the train of morbid events leading to death) on the last used line in Part I

*This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury or complication that caused death.

Part II Other significant conditions contributing to the death, but not related to the disease or condition causing death

Accident to Elderly Person

When issuing a certificate under Section 46C of the Burial and Cremation Act 1964 if death was the result of injury provide details about how and where the injury occurred in Cause of death, Part 1 (c) above.

If the deceased was at the time of death suffering from an infectious disease, whether or not covered above, name the disease(s)

I certify that the particulars and causes of death shown above are true to the best of my knowledge and belief, and that no relevant information has been omitted.

Printed name of practitioner Address Qualifications Signature Date Health Practitioner Index - Common Person Number (HPI-CPN)