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DEMERARA MUTUAL

PROOFS OF DEATH

PHYSICIAN'S STATEMENT

CLAIM NO.

FULL NAME OF DECEASED

DATE OF DEATH

RESIDENCE AT DEATH

PLACE OF DEATH (IF HOSPITAL, GIVE NAME)

DATE OF BIRTH

CAUSE OF DEATH:

INTERVAL BETWEEN ONSET AND DEATH

(a) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(a)

ANTECEDENT CAUSES (MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDELYING 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

DID YOU VIEW THE BODY AFTER DEATH AND SIGN THE DEATH CERTIFICATE? ◯ YES ◯ NO

IF DEATH WAS DUE TO ACCIDENT, SUICIDE OR HOMICIDE, SPECIFY WHICH & DESCRIBE BRIEFLY

(a) WAS AN INQUEST HELD? ◯ YES ◯ NO

(b) WAS AN AUTOPSY PERFORMED? ◯ YES ◯ NO

(c) IF SO, BY WHOM AND WITH WHAT FINDINGS?

WERE THERE ANY IDENTIFIICATION MARKS ON THE BODY? IF YES, GIVE PARTICULARS.

HAVE YOU TREATED OR ADVISED THE DECEASED PRIOR TO LAST ILLNESS? ◯ YES ◯ NO

DID THE DECEASED, TO YOUR KNOWLEDGE, RE CEIVE TREATMENT DURING THE LAST 5 YEARS FROM ANY OTHER PHYSICIAN, OR IN ANY HOSPITAL OR INSTITUTION? ◯ YES ◯ NO

IF YES TO EITHER QUESTION, PLEASE FURNISH THE FOLLOWING: -

NAME

ADDRESS

NATURE OF ILLNESS OR INJURY

DATES

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF

DATE

SIGNATURE

ADDRESS