ATTENDING PHYSICIAN'S STATEMENT
DEATH CLAIM

HEALTHIER, LONGER, BETTER LIVES

ALL QUESTIONS MUST BE ANSWERED IN FULL. Read instructions on the reverse side.

1. (a) Deceased's Name in Full		(b) Occupation at the time of death	(c) Prior thereto
(d) Residence at time of death	No. Street	City or Town	Province
2. (a) Age of Deceased at death	(b) Sex (c) Height	(d) Approximate Weight in Health	(e) Color of Hair
(f) Were there any identification marks on the body? [ ] Yes [ ] No If Yes, please give particulars			
3. How long have you known the deceased?			
4. (a) Date of Death	(b) Place of Death (If in hospital/institution, give name)		(c) Length of Hospitalization
5. (a) When were you first consulted for the condition which either directly or indirectly caused death?		Who consulted you? (Specify if deceased, relative or others)	Date of last visit:
(b) What was the immediate cause of death? (see instructions on reverse side)			
(c) How long, in your opinion, did the deceased suffer from this disease or impairment?			
(d) What were the contributory causes of death? Give below the duration of each. Disease or Impairment		Duration	
(e) Was there any special connection (remote or proximate) between the death and the occupation, residence, habits, or personal history of the deceased? [ ] Yes [ ] No If Yes, please state which and give particulars.			

6. Give particulars of each condition for which you treated or advised the deceased prior to last illness:

Nature of Condition	Dates	Duration	Result of Treatment

7. Give names and addresses of other physicians and other practitioners who to your knowledge attended to the deceased during the past three years:

Name	Address	Disease or Impairment and Date

8. (a) Was death due to suicide, homicide or accident?

(b) Was deceased under the influence of liquor or drugs when suicide / accident / homicide happened? [ ] Yes [ ] No

9. Was there an official inquiry as to the cause of death or post mortem examination on the body of the deceased? [ ]Yes [ ] No If Yes, which, by whom and with what was the result?

Dated at _____ this _____ day of _____ , 20_____		
Physician's Name in Print		Physician's Signature
License No. (Privilege Tax)	Date	Physician's Address
Witnessed by:		Witness Address

INSTRUCTIONS

1. All answers must be entirely in the Physician's own handwriting.
2. In the interest of accurate vital statistics, please conform to the International List of the causes of death when answering Question 5.
3. If cause of death is injury, please describe the accident. If cause is suicide or homicide, please state the means employed.
4. In Surgical cases, please state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasms, please give type part first involved. Please avoid indefinite terms. Please describe any unusual features.
5. Where spaces provided for the answers are too small, such details as seen desirable should be given below.