



ROMANS FUNERAL HOME LIMITED
CONFIRMATORY MEDICAL CERTIFICATE

TO BE GIVEN BY A GOVERNMENT OFFICER WHO IS NOT A RELATIVE OF THE DECEASED OR A RELATIVE PARTNER OF THE MEDICAL PRACTITIONER WHO GIVES THE CERTIFICATE FORM C

DECEASED _____

BEING AT MEDICAL OFFICER FOR _____ MEDICAL DISTRICT

AND BEING NEITHER A RELATIVE OF THE DECEASED, NOR A RELATIVE OR PARTNER OF THE MEDICAL PRACTITIONER WHO HAS GIVEN THE FORGOING MEDICAL CERTIFICATE, HAVE EXAMINED IT AND HAVE PERSONAL INQUIRY AS STATED IN MY ANSWERS TO THE QUESTIONS BELOW.

1. HAVE YOU SEEN THE BODY OF THE DECEASED _____
2. HAVE YOU CAREFULLY EXAMINED THE BODY EXTERNALLY? _____
3. HAVE YOU MADE A POST-MORTEM EXAMINATION? _____
4. HAVE YOU SEEN AND QUESTIONED THE MEDICAL PRACTITIONER WHO ATTENDED TO THE DECEASED? _____
5. HAVE YOU SEEN QUESTIONED ANY OTHER MEDICAL PRACTITIONER WHO ATTENDED TO THE DECEASED? _____
6. HAVE YOU SEEN AND QUESTIONED ANY PERSON WHO NURSED THE DECEASED DURING HIS/HER LAST ILLNESS, OR WHO WAS PRESENT AT THE DEATH? _____

7. HAVE YOU SEEN AND QUESTIONED ANY RELATIVES OF THE DECEASED? _____

8. HAVE YOU SEEN AND QUESTIONED ANY OTHER PERSON? _____

(IN THE ANSWER TO QUESTION 5, 6, 7 AND 8 GIVE NAMES AND ADDRESSES OF THE PERSONS SEEN AND SAY WHETHER YOU SAW THEM ALONE)

I AM SATISFIED THAT THE CAUSE OF DEATH WAS _____

AND I CERTIFY THAT I KNOW OF NO REASONABLE CAUSE TO SUSPECT THAT THE DECEASED DIED EITHER A VIOLENT OR UNNATURAL DEATH OF WHICH THE CAUSE BE UNKNOWN OF DIED IN SUCH A PLACE OR CIRCUMSTANCES AS TO REQUIRE IN PURSUANCE OF ANY LAW.

SIGNATURE: _____

ADDRESS: _____

REGISTERED QUALIFICATIONS: _____

OFFICE: _____

DATE: _____

NOTE: THE CERTIFICATES IN FORMS C&D MUST BE HANDLE OR SENT IN AN ENVELOPE TO THE AUTHOURIZED OFFICER BY ONE OR EITHER THE MEDICAL PRACTITIONER BY WHOM THEY ARE GIVEN.