



**FORM C**  
**ROMANS FUNERAL HOME LIMITED**

**(TO BE COMPLETED BY A MEDICAL PRACTITIONER WHO HAS ATTENDED TO THE DECEASED DURING HIS/HER LAST ILLNESS AND WHO CAN CERTIFY DEFINITELY AS TO THE CAUSE OF DEATH)**

**I AM INFORMED THAT APPLICATION IS ABOUT TO BE MADE FOR THE CREMATION OF THE REMAINS OF:**

**(NAME OF DECEASED)** \_\_\_\_\_

**(ADDRESS)** \_\_\_\_\_

**(OCCUPATION)** \_\_\_\_\_

**HAVING ATTENDED TO THE DECEASED BEFORE DEATH, AND SEEN AND IDENTIFIED THE BODY AFTER, I GIVE THE FOLLOWING ANSWERS TO THE QUESTIONS SET OUT BELOW:**

**1. ON WHAT DATE, AND AT WHAT HOUR DID HE OR SHE DIE?** \_\_\_\_\_

**2. WHAT WAS THE PLACE WHERE THE DECEASED DIED?** \_\_\_\_\_

**3. ARE YOU A RELATIVE OF THE DECEASED? STATE RELATIONSHIP IF SO.** \_\_\_\_\_

**4. HAVE YOU, SO FAR, AS YOU ARE AWARE, ANY PECUNIARY INTEREST IN THE DEATH OR THE DECEASED?** \_\_\_\_\_

**5. WERE YOU THE "ORDINARY" MEDICAL ATTENDANT OF THE DECEASED?** \_\_\_\_\_  
**IF SO, FOR HOW LONG?** \_\_\_\_\_

**6. DID YOU ATTEND TO THE DECEASED DURING HIS OR HER LAST ILLNESS? IF SO, FOR HOW LONG?** \_\_\_\_\_

**7. WHEN DID YOU LAST SEE THE DECEASED ALIVE?** \_\_\_\_\_  
**SAY HOW MANY HOURS BEFORE DEATH?** \_\_\_\_\_

**8. HOW SOON AFTER DEATH DID YOU SEE THE BODY?** \_\_\_\_\_  
**AND WHAT EXAMINATION DID YOU MAKE?** \_\_\_\_\_

**9. WHAT WAS THE CAUSE OF DEATH? (1) PRIMARY**  
**(2) SECONDARY**

**(1) IMMEDIATE CAUSE (A)** \_\_\_\_\_

**MORBID CONDITIONS (IF ANY) GIVING RISE TO IMMEDIATE CAUSE (STATE IN ORDER PROCEEDING BACKWARD FROM IMMEDIATE CAUSE)** ) **DUE TO (B)**  
)  
) **DUE TO (C)**

**(2) OTHER MORBID CONDITIONS (IF IMPORTANT) CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE** ) \_\_\_\_\_  
)  
) \_\_\_\_\_

**10. WHAT WAS THE MODE OF DEATH? (STATE WHETHER SYNCOPE, COMA, EXHAUSTION, CONVULSIONS, ETC)** \_\_\_\_\_

**WHAT WAS IT'S DURATION IN DAYS, HOURS, MINUTES?** \_\_\_\_\_

**11. STATE HOW FAR THE ANSWERS TO THE LAST TWO QUESTIONS ARE THE RESULTS OF YOUR OWN OBSERVATION, OR ARE BASED ON STATEMENTS MADE BY OTHERS, SAY BY WHOM**

\_\_\_\_\_  
\_\_\_\_\_

**12. DID THE DECEASED UNDERGO ANY OPERATION DURING THE FINAL ILLNESS OR WITHIN A YEAR BEFORE DEATH? IF SO, WHAT WAS IT'S NATURE AND WHO PERFORMED IT?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**FORM C CONT'D**

13. BY WHOM WAS THE DECEASED NURSED DURING HIS OR HER ILLNESS? (GIVE NAMES AND SAY WHETHER BY A PROFESSIONAL NURSE, RELATIVE, ETC) IF THE ILLNESS WAS A LONG ONE, THIS QUESTION SHOULD BE ANSWERED IN REFERENCE TO THE PERIOD OF FOUR WEEKS BEFORE DEATH. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. WHO WERE THE PERSONS (IF ANY) PRESENT AT THE MOMENT OF DEATH? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. IN VIEW OF THE KNOWLEDGE OF THE DECEASED HABITS AND CONSTITUTION, DO YOU FEEL ANY DOUBT WHATSOEVER AS TO THE CHARACTER OF THE DISEASE OR CAUSE OF DEATH \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. HAVE YOU ANY REASON WHATSOEVER TO SUPPOSE A FURTHER EXAMINATION OF THE BODY TO BE DESIRABLE? \_\_\_\_\_  
\_\_\_\_\_
17. HAVE YOU ANY REASON TO SUSPECT THAT THE DEATH OF THE DECEASED WAS DUE DIRECTLY OR INDIRECTLY TO VOILENCE, POISON, PRIVATION OR NEGLECT? \_\_\_\_\_  
\_\_\_\_\_
18. HAVE YOU GIVEN THE CERTIFICATE REQUIRED FOR REGISTRATION OF DEATH? IF NOT WHO HAS IT? \_\_\_\_\_  
\_\_\_\_\_

**I HEREBY CERTIFY THAT THE ANSWERS GIVEN ABOVE ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND I KNOW OF NO REASONABLE CAUSE TO SUSPECT THAT THE DECEASED DIED EITHER BY A VOILENT OR AN UNNATURAL DEATH OF WHICH THE CAUSE IS UNKNOWN, OR DIED IN SUCH A PLACE OR CIRCUMSTANCES AS TO REQUIRE AN INQUEST IN PURSUANCE OF ANY LAW.**

**SIGNATURE** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**REGISTERED QUALIFICATIONS** \_\_\_\_\_

**DATE** \_\_\_\_\_

**NOTE: THIS CERTIFICATE MUST BE HANDED OR SENT IN A CLOSED ENVELOPE BY THE PRACTITIONERS WHO SIGNS IT, TO THE GOVERNMENT MEDICAL OFFICER WHO IS TO GIVE THE CONFIRMATION CERTIFICATE BELOW (FORM D)**