



PO BOX 4030 SASKATOON SK S7K 3T2
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PROOF OF DEATH PHYSICIAN'S STATEMENT

If there is a charge for completing this form, it is the responsibility of the individual claiming benefit.

Full name of deceased _____ Residence at death _____ Age at death _____ OR Date of birth _____ <div style="text-align: center; font-size: small;">D M Y</div>	Date of Death _____ Place of Death (if Hospital or Institution, give name) _____	
Cause of Death <i>(Enter only one cause for each of a, b and c.)</i> Disease or condition directly leading to death: <i>(This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</i> (a) _____ Antecedent causes. <i>(Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.)</i> Due to or as a consequence of (b) _____ Due to or as a consequence of (c) _____ Other significant conditions: <i>(Contributing to the death but not related to the disease or condition causing death.)</i> _____		Interval between onset and death (a) _____ (b) _____ (c) _____
Date of First Attendance in Last Illness _____ <div style="text-align: center; font-size: small;">D M Y</div>	Date of Last Attendance In Last Illness _____ <div style="text-align: center; font-size: small;">D M Y</div>	
If death was due to accident, homicide, or suicide, specify which. Describe briefly. _____	Was an inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, by whom and with what findings? _____	
Have you treated or advised the deceased during the last 3 years, prior to last illness? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to either question, please furnish the following:		
Name	Address	Nature of Illness or Injury
_____	_____	_____
		Dates _____ <div style="text-align: center; font-size: small;">D M Y</div>
		_____ <div style="text-align: center; font-size: small;">D M Y</div>

Physician's Signature

Date

Address

The Medical certification follows the recommendations of the World Health Assembly, made in Geneva on July 24, 1948. It has been accepted by all states in the United States and all provinces in Canada. In the interest of accurate vital statistics, please conform to the International List of the Causes of Death.