CREMATION Certificate of Medical Practitioner: Form B

CREMATION REGULATIONS 1973: r7(1)(a) – updated January 2009

I am informed that application is about to be made for the cremation of the body of the following:

Full Name of Deceased: ……

Address: ……

Occupation: ……

As a medical practitioner who is required or permitted by section 46B or 46C(1) of the Burial and Cremation Act 1964 to give a doctor's certificate (as defined in section 2(1) of that Act) for the death, and who has seen and identified the body after death, I give the following answers to the questions set out below:

1. On what <u>date</u> and at what <u>hour</u> did he (or she) die? ……

2. Where did the deceased die? ……

   Was this their own residence, lodgings, hospital, nursing-home, etc ……..…….....

3. Are you a relative of the deceased? If so, state the relationship. ……..…….....

4. Do you have any pecuniary (financial) interest in the death of the deceased? ……..…….....

5. Were you the ordinary medical attendant of the deceased? ……..…….....

   - If so, for how long? [State how many weeks, months, or years.] ……..…….....

6. Did you attend the deceased during his (or her) last illness? ……..…….....

   - If so, for how long? [State how many hours, days, weeks, or months] ……..…….....

7. If you attended the deceased during his or her last illness, when did you last see the deceased alive? [Say how many hours or days before death.] ……..…….....

8. (a) How soon after death did you see the body? ……..…….....

   (b) How did you confirm the fact of death? ……..…….

   (c) How did you establish the identity of the deceased person (e.g. by personal knowledge, staff or family)?

   ……..……

9. What were the causes of death?
   Include the period elapsing between onset of each condition and death (in years, months, or days).

   (a) Immediate cause—the disease, injury, or complication which caused death:

   ……..……

   (b) Morbid conditions giving rise to the immediate cause (in chronological order beginning with the most recent)

   ……..……

   ……..……

   (c) Other conditions (if any) contributing to death—e.g. pregnancy, parturition, over-exertion, dangerous occupation?

   ……..……..……..……

State how far your answers as to the causes of death and the duration of such causes are founded on your own observations or on statements made by others *(e.g. family, nursing or medical colleagues, police or ambulance staff)*. If on statements made by others, give their names and their relationship to the deceased.

……..……

……..……

Deceased name: ……

10. What was the mode of death? (e.g. syncope, coma, exhaustion, convulsions, etc.) …….....

What was its duration? (State number of days, hours, or minutes) ..…….....

State how far your answer as to the mode of death is founded on your own observations or on statements made by others. If on statements made by others, give their names and their relationship to the deceased.

……..……

……..……

11. Did the deceased undergo any operation during the final illness or within a year before death? Yes / No

- if YES, what was its nature,? ……..…….....

- who performed it? ……..…….....

Did death occur within 24 hours of any procedure or operation? ……..…….....

12. By whom was the deceased nursed during the last illness? (If the death occurred in a hospital, this may be answered by referring generally to the nursing staff in a specified ward, but otherwise give names and say whether professional nurse, relative, etc. This question should be answered with reference to the period of four weeks before death.)

……..……

13. By what medical attendants (besides yourself, if applicable) was the deceased attended during his (or her) last illness?

……..……

14. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death? Yes / No

15. Do you have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to:

(a) Violence (including accidental force): Yes / No (b) Poison (including overdose): Yes / No
(c) Privation or neglect: Yes / No (d) Illegal operation: Yes / No

16. Do you have any reason whatever to suppose a further examination of the body to be desirable? Yes / No

17. Have you given the doctor's certificate (as defined in section 2(1) of the Burial and Cremation Act 1964) for the death? Yes / No

Has this case been discussed with a coroner for any reason? Yes / No

Form AB (NOTE that Cremation can only proceed if this is answered clearly): Certificate in relation to Pacemakers and Other Biomechanical Aids (i.e <u>any electronic device that is battery operated</u>)

I hereby certify that I have examined the body of the deceased person named above.
* NB: **Please cross out and initial the lines that are incorrect***:

- I am satisfied that the body does not contain a cardiac pacemaker or any other biomechanical aid
- I have removed from the body a pacemaker or relevant biomechanical aids (as defined above)

  namely (*i.e.* ***please describe what was removed***) …….
- A pacemaker or other relevant biomechanical aid is still present and needs to be removed.

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief, and that there is no circumstance known to me which can give rise to any suspicion that the death was due wholly or in part to any other cause than disease (or accident) or which makes it desirable that the body should not be cremated.

Signature: ……..……

Address: ……..……

Urgent contact phone number: ……..……

Registered Medical Qualifications: ……..……

Date: ……..……

This certificate must be handed or sent in a closed envelope by the medical practitioner who signs it to a Medical Referee.