

Certificate of Medical Practitioner



Form B Cremation Regulations 1973 Reg 7(1)(a)

Consecutive cremation number: _____

The medical practitioner completing this certificate must place it in a sealed envelope and hand or send it to a medical referee.

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

Full name of deceased: _____

Address: _____

Occupation: _____

As a medical practitioner who is required or permitted by section 46B or section 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 date and at what hour did he (or she) die? _____

2. Where did the deceased die? (Give address and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)

3. Are you related to the deceased? Yes No If yes, what is the relationship: _____

4. Have you, so far as you are aware, any pecuniary interest in the deceased's death? Yes No

5. Were you the deceased's ordinary medical attendant? Yes No
If yes, for how long? (How many weeks, months or years.) _____

6. Did you attend the deceased during his (or her) last illness? Yes No
If yes, 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) What steps did you take to satisfy yourself as to the fact of death? _____

c) How did you establish the identity of the deceased person? (specify) _____

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

a) Immediate cause - the disease, injury or complication which caused death: _____

b) Morbid conditions (if any) giving rise to the immediate cause (place in chronological order, beginning with the **most** recent):

c) Other conditions (if any) contributing to death - pregnancy, parturition, over-exertion, dangerous occupation:

9. (cont.) 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. If on statements by others, give their names and their relationship to the deceased.

10. What was the mode of death? (say whether syncope, coma, exhaustion, convulsions etc) _____
What was its duration? (State the number of days, hours or minutes; and 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; if so, what was its nature, and who performed it?

12. Who nursed the deceased during his (or her) last illness? (If death occurred in a hospital, this question may be answered by referring generally to the nursing staff in a specified ward, but otherwise give the names and say whether professional nurse, relative etc. If the illness was long, 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 know any reason to suspect that the death of the deceased was due, directly or indirectly to -

a) Violence Yes No b) Poison Yes No

c) Privation or neglect Yes No d) Illegal operation Yes No

16. Have you 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

FORM AB Cremation Regulations 1973 Reg 7(1)

CERTIFICATE IN RELATION TO PACEMAKERS AND OTHER BIOMECHANICAL AIDS

I hereby certify that I have examined the body of the above-named deceased.

* I am satisfied that the body does not contain a cardiac pacemaker or any other biomechanical aid.

* I have removed from the body a cardiac pacemaker or other biomechanical aid, namely _____

* Delete whichever is inapplicable

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: _____ Date: _____

Full name: _____

Address: _____

Registered qualifications: _____

PRIVACY STATEMENT:

The personal information that you provide in this form will be held and protected by Auckland Council in accordance with our privacy policy (available at aucklandcouncil.govt.nz/privacy and at our libraries and service centres) and with the Privacy Act 1993. Our privacy policy explains how we may use and share your personal information in relation to any interaction you have with the council, and how you can access and correct that information. We recommend you familiarise yourself with this policy.