



A Better Place For You™

1920 College Avenue
Regina SK S4P 1C4

PROOF OF DEATH - PHYSICIAN'S STATEMENT

Policy No. _____

The Medical Certification follows the recommendation 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 causes of death.

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

Full name of deceased	Date of Death
Residence at death	Place of Death
Age at death or date of birth	(if hospital or institution, give name)

Cause of death (enter only for one cause for each of a, b, and c.)
Disease or condition directly leading to death: (this does not mean the mode of dying, such as heart failure, asthenia, etc. It means disease, injury or complication which caused death.)

Interval between onset and death

(a) _____ (a)

Antecedent causes. (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)

Due to (b) _____ (b)

Due to (c) _____ (c)

Other significant conditions: (Contributing to the death but not related to the disease or condition causing death.)

Date of first attendance in last illness	Date of last attendance in last illness	How long have you known deceased?												
<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>day</td><td>month</td><td>year</td></tr> </table>				day	month	year	<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>day</td><td>month</td><td>year</td></tr> </table>				day	month	year	_____
day	month	year												
day	month	year												

If death was due to accident, suicide or homicide, specify which. Describe briefly. _____

Was an inquest held? Yes No

Was an autopsy performed? Yes 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? Yes No

Did the deceased, to your knowledge, receive treatment during the last 3 years from any other physician, or in any hospital or institution? Yes No

If "Yes", to either question, please furnish the following:

Name	Address	Nature of illness or injury	Dates

Was the deceased advised of the nature of his illness? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes", when?						
	<table border="1"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>day</td><td>month</td><td>year</td></tr> </table>				day	month	year
day	month	year					

Was the deceased a cigarette/cigarillo smoker? Yes No Unknown

signature

date

please print or stamp

address & phone