Reg. 7 (1) (a)

'The Cremation Regulations 1973'
Form B/AB

Hamilton City Council
Te kaunihera o Kirikiriroa

CERTIFICATE OF MEDICAL PRACTITIONER

Cremation No. .....

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 48B or section 48C(1) of the Burial and Cremation Act 1964 to give a doctor's certificate (as defined in section 2(1) of that Act, 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? Date of Death: / / Hour of Death: am pm

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

   .....

3. Are you a relative of the deceased? Yes ☐ No ☐

   If so, state the relationship:.....

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

   If so, please provide details:.....

5. Were you the ordinary medical attendant of the deceased? Yes ☐ No ☐

   If so, for how long? *(State how many weeks, months, or years)*: Weeks:..... Months: ..... Years: .....

6. Did you attend the deceased during his (or her) last illness? Yes ☐ No ☐

   If so, for how long? Months:.....Weeks: .....Days: ..... Hours:.....

7. If you attended the deceased during his or her last illness, when did you last see the deceased alive?

   (State how many hours, or days before death): Hours:..... or Days: .....

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?.....

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 the death - **years** **months** **days**

   .....

   (b) Morbid conditions (if any) giving rise to the immediate cause (place the conditions in chronological order beginning with the most recent)? - **years** **months** **days**

   .....

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

   .....

   State how far your answers as 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 made by others, give their names and their relationship to the deceased:**

   .....

   .....

NOTE: This Certificate must be handed or sent in a closed envelope, by the medical practitioner who signs, it to a medical referee.

Please Turn Over

10. What was the mode of death? (Say whether syncope, coma, exhaustion, convulsions, etc.)

☐ Syncope ☐ Coma ☐ Exhaustion ☐ Convulsions.....

What was its duration? *(State 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. By whom was the deceased nursed during his (*or* her) last illness? *(If the death occurred in a hospital, this question may be answered by referring generally to the nursing staff in a specific ward, but otherwise give names and say whether professional nurse, relative, etc. If the illness was a long one, 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 whatsoever as to the character of the disease or the cause of death?

Yes ☐ No ☐ .....

15. Do you know, or have you 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 ☐
(c) Illegal operation	Yes ☐	No ☐

16. Have you any reason whatsoever 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? Yes ☐ No ☐

CERTIFICATE IN RELATION TO PACEMAKERS AND OTHER BIOMECHANICAL AIDS

I hereby certify that:

☐ I am satisfied that the body does not contain a cardiac pacemaker, other biomechanical aids, or radioactive materials.

☐ I have removed from the body a cardiac pacemaker or any other biomechanical aid, namely.....

.....

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

Name:.....
(PLEASE PRINT FULL NAME)

(Registered Qualifications)/ No:.....

Address: .....

Signature: .....

Date:.....