



PROOF OF DEATH - PHYSICIAN'S STATEMENT

Note: The Medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24th 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.

Policy Number: _____ Full name of deceased: _____

Date of death: _____ Residence at death: _____

Place of death: _____ Age at death/date of birth: _____
(If Hospital or Institution, give name)

CAUSE OF DEATH (Enter only one cause for each of a, b, c)

Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
a)

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

Due to: b)

Due to: c)

Other significant conditions: (contributing to the death but not related to the disease or condition causing death:

Was the deceased unable to work from the onset of disability?
If not, when did he/she cease working?

Interval between onset and death:

a)

b)

c)

Date of First Attendance in Last Illness:

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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 yes, by whom and what findings?

Have you treated or advised the deceased during the last three years, prior to last illness: Yes No
Did the deceased, to your knowledge, receive treatment during the last three years from any other physician, or any Hospital or Institution: Yes No

If Yes to either question, please furnish the following:

Name: _____ Address: _____ Nature of Illness or Injury: _____ Dates: _____

To your knowledge, was the deceased a smoker? Yes No
If yes, please indicate the length of time (approx.) please check one: Cigarettes pipes cigars

The Company is not responsible for any fee for this information. _____ M.D.

Signature

Date:

Address: