Proof of Death

LIBERTY

LIFE INVESTMENTS HEALTH CORPORATE PROPERTIES ADVICE

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The medical certification follows the recommendations of the World Health Assembly made in Geneva on July 24, 1948, All answers must be in the physician's handwriting.
In the interest of accurate vital statistics, pleas conform to the International List of Causes of Death.

PART 1: PHYSICIAN'S STATEMENT

Full name of deceased

Date of death D D - M M - Y Y Y Y

Age at death or date of birth D D - M M - Y Y Y Y

Residence at death

Place of death (name of hospital or institution)

Cause of death *(Enter only one cause for each of a, b and c)*	Interval between onset and death
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 complications which caused 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 D D - M M - Y Y Y Y

Date of last attendance in last illness D D - M M - Y Y Y Y

If death was due to an accident, suicide or homicide, specify which

Describe briefly

Was an inquest held? Y N

Was an autopsy performed? Y N

If so, by whom and with what findings?

Were there any identification marks on the body? Y N

If "Yes", give particulars

Have you treated or advised the deceased during the last 5 years, prior to last illness? Y N

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician or in any hospital or institution? Y N

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

Name

Address

Nature of illness or injury

Date D D - M M - Y Y Y Y

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Name

Address

Signature

Date D D - M M - Y Y Y Y

PART 2: CONFIDENTIAL MEDICAL REPORT

A review of my medical records reveals the following

PHYSICAL EXAMINATION

Date examined D D - M M - Y Y Y Y Height Weight kg

Blood Pressure Pulse

Appearance

Were any X-rays done? Y N If "Yes", please give details of type(s) and results.

Were any ECG's done? Y N If "Yes", attach copies of results.

Urinalysis results Y N If "Yes", attach copies of results.

Has a HIV-test been done? Y N If "Yes", attach copies of results.

Have other blood studies been done? Y N If "Yes", attach copies of results.

PRIOR MEDICAL HISTORY

(If answer to Question 8 in Part 1 of this statement is "Yes", please complete the questions below.) Include copies of Pathology reports or other special studies.

DATE CONSULTED	COMPLAINTS AND/OR DIAGNOSIS	PHYSICAL OR LABORATORY FINDINGS	TREATMENT

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Doctor's name

Signature Date D D - M M - Y Y Y Y

Stamp