PROOF OF DEATH

Submitted to

NO. 2 PHYSICIAN'S STATEMENT

American Life Insurance Company
(Incorporated in USA, Nepal Regn. No. 6/062/063)
Narayani Complex, Pulchowk
P.O. Box 11590
Kathmandu, Nepal
Tel: +977-1-5555166
Fax: +977-1-5555173

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, please conform to the international list of the Causes of Death.

Full name of deceased: Date of death:

Residence at death: Place of death (If Hospital or Institutions, give name)

Age at death or date of birth:

Cause of death (Enteronly 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, asthma etc. It means the disease, injury or complication which caused death)

Interval between onset and death

Due to (a) ..... (a) .....

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

Due to (b) ..... (b) .....

Due to (c) (c) .....

Date of first diagnosed:

Past Medical History (if any):

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

If death was due to accident, suicide or homicide, specify which and describe brifely

Was an inquest held ? Yes ☐ ☐ No

Was an autopsy performed Yes ☐ ☐ No

Were there any Indentification marks on the body ? Yes No

If so, by whom and with what finding ?

If "Yes", give particulars

Have you treated or advised the deceased during the last 5 years, prior to last illness ? Yes ☐ ☐ No

Did the deceased, to your knowledge, receive treatment during the last 5 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

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

Signature.....

Name .....

Date .....

Address.....

NMC No.....

Official Seal .....

P.T.O

INSTRUCTIONS

All Answers Must be Entirely in the Physician's Own Handwriting

In the interest of accurate vital statistics, please confirm to the International List of the causes of death whom answering Question 6. External causes (Poisions, Violence, etc.)

If any injury, describe the accident. If suicide or homicide, state the means employed.

In surgical cases, state the nature of operation and the disease of condition requiring such procedure. If Females, puerperal states are to be indicated. In neoplasms, give type and part first involved. Please avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details as seem desirable should be given.

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Signature

Name:.............................