

CREMATION Certificate of Medical Practitioner or Nurse Practitioner: Form B
CREMATION REGULATIONS 1973 (updated April 2018)

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 or nurse practitioner who is required or permitted by section 46B or 46C(1) of the Burial and Cremation Act 1964 to give a certificate of cause of death (as defined in section 2(1) of that Act) for the death, 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? (*specify*)

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? (*specify*) 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? (*specify*) Yes / No

5. Were you the ordinary medical attendant of the deceased? (*specify*) Yes / No

- If so, for how long? [*State **how many weeks, months, or years.***]

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

- If so, for how long? [*State **how many hours, days, weeks, or months.***]

7. If you attended the deceased during his or her last illness, when did you last see the deceased alive? [*Say **how many hours or days before death.***]

8. (a) How soon after death did you see the body? (*specify*)

(b) What steps did you take to satisfy yourself as to the **fact of death**? (*specify*)
.....

(c) How did you **establish the identity** of the deceased person? (*specify*)
.....

Period elapsing between onset
of each condition and death
(*years, months, or days*).

(a) Immediate cause—the disease, injury, or complication which caused death: (*specify*)
.....

(b) Morbid conditions (if any) giving rise to the immediate cause (place the conditions in chronological order beginning with the most recent) (*specify*):
.....
.....
.....

(c) Other conditions (if any) contributing to death—e.g. pregnancy, parturition, over-exertion, dangerous occupation?
.....

State how far your answers as to 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.

.....
.....

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

.....

What was its duration? (state number of days, hours or minutes)

.....

State how far your answer as to the mode of death is founded on **your own observations or on statements made by others.**

.....

If based 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? Yes / No

- if YES, what was its nature,?

.....

- who performed it?

.....

12. By whom was the deceased **nursed** during his (or her) last illness? (If the death occurred in a hospital, this may be answered by referring generally to the nursing staff in a specified 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 4 weeks before death.)

.....

13. By what medical practitioners or nurse practitioners (besides yourself, if applicable) was the deceased attended during his (or her) last illness? (specify)

.....

14. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever 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	(d) Illegal operation:	Yes / No

16. Have you any reason whatever to suppose a further examination of the body to be desirable? (specify) Yes / No

17. Have you given a certificate of cause of death (as defined in section 2(1) of the Burial and Cremation Act 1964) for the death? Yes / No

Form AB

Certificate in relation to Pacemakers and Other Biomechanical Aids*

*(a biomechanical aid is defined as a cardiac pacemaker or any electronic device that is battery operated)

I hereby certify that **I have examined the body of the deceased** person with the details above.

- I am satisfied that the body does not contain a cardiac pacemaker or any other biomechanical aid or
- I have removed from the body a cardiac pacemaker or other biomechanical aid, namely:

.....

(Delete whichever is inapplicable)

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

Date:

Signature:

Registered Qualifications:

Address:

This certificate must be handed or sent in a closed envelope by the medical practitioner or nurse practitioner who signs it to a Medical Referee.