

**CREMATION Certificate of Medical Practitioner: Form B**  
**CREMATION REGULATIONS 1973: r7(1)(a) (updated February 2018)**

I am informed that application is about to be made for the cremation of the body of:

Full Name of Deceased: \* FULL name \*

Address: .....

Occupation: \* NB: don't place a sticker here \*

As a medical 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? .....

2. Where did the deceased die? .....

Was this their own residence, lodgings, hospital, nursing-home, etc .....

3. Are you a relative of the deceased? If so, state the relationship. ....

4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? (i.e. financial interest)

5. Were you the ordinary medical attendant of the deceased? (refers to GP)

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

6. Did you attend the deceased during his (or her) last illness? .....

- 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? .....

(b) What steps did you take to satisfy yourself as to the fact of death?  
e.g. "no vital signs on examination" \*

(c) How did you establish the identity of the deceased person?  
by recognition / staff or family. Don't rely solely on the ID bracelet

9. What were the causes of death? Include the period elapsing between onset of each condition and death (in years, months, or days).

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

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

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

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.

(Names of key specialists or specialist services who diagnosed the conditions)

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

i.e. in layman's terms, "how the patient died"

What was its duration? .....

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.

Did you observe that mode of death yourself?  
Otherwise the name and role of whoever informed you.

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. 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?

(if not already mentioned in Q.9)

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? 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

= any battery-powered device that could explode in the cremator.

Form AB  
Certificate in relation to Pacemakers and Other Biomechanical Aids.

Includes:  
- pacemaker  
- ICD  
- nerve stimulator

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
- \* I have removed from the body a cardiac pacemaker or other biomechanical aid, namely:

\* if there is a battery-powered device, note it here so that the funeral director knows to remove it. \*

\* 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.

Signature: .....

Address: .....

Registered Qualifications: your medical degree

Date: .....

(Ideally also leave a contact phone number)

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