



Environmental Health and Housing

Mintlyn Crematorium, Lynn Road,
Bawsey, King's Lynn, Norfolk PE32 1HB
Tel: (01553) 630533
Fax: (01553) 630998

Cremation 4
Replacing Form B

Medical Certificate

This form can only be completed by a registered medical practitioner.
Please complete this form in full, if a part does not apply enter 'N/A'.

Details of the deceased

Full name

Address

.....

.....Postcode.....

Occupation or last occupation if retired or not in work at date of death

.....

Where a past occupation of the deceased person may suggest that the death was due to industrial disease, you should consider whether to refer the death to a coroner.

The report on the deceased

1. What was the date and time of death of the deceased?

Date / / Time.....

2. Please give the address where the deceased died.

Address

.....

.....

.....Postcode.....

Please state whether it was the residence of the deceased or a hotel, hospital, or nursing home etc.

Their home Hospital Hotel Nursing home

Other (please specify)

3. Are you a relative of the deceased? Yes No

If Yes, please give the nature of your relationship.

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4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? Yes No

If Yes, please give details.

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.....



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5. Were you the deceased's usual medical practitioner? Yes No

If Yes, please state for how long.

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If No, please give details of your medical role in relation to the deceased.

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6. Please state for how long you attended the deceased during their last illness?

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7. Please state the number of days and hours before the deceased's death that you last saw them alive?

Days..... Hours.....

8. Please state the date and time that you saw the body of the deceased and the examination that you made of the body.

Date Time.....

Examination

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9. From your medical notes, and the observations of yourself and others immediately before and at the time of the deceased's death, please describe the symptoms and other conditions which led to your conclusions about the cause of death.

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10. If the deceased died in a hospital at which they were an in-patient, has a hospital post-mortem examination been made or supervised by a registered medical practitioner of at least five years' standing who is neither a relative of the deceased nor a relative of yours or a partner or colleague in the same practice or clinical team as you?

Yes No

If Yes, are the results of that examination known to you?

Yes No

Note: 'Five years' standing' means a medical practitioner who has been a fully registered person within the meaning of the Medical Act 1983 for at least five years and, if paragraph 10 of Schedule 1 to the Medical Act 1983 (Amendment) Order 2002 (S.I. 2002/3135) has come into force, has held a licence to practice for at least five years or since the coming into force of that paragraph.

11. Please give the cause of death

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

.....

.....

(b) Other disease or condition, if any, leading to (a)

.....
.....

(c) Other disease or condition, if any, leading to (b)

.....
.....

2. Other significant conditions contributing to the death but not related to the disease or condition causing it.

.....
.....

12. Did the deceased undergo any operation in the year before their death? Yes No

If Yes, what was the date and nature of the operation and who performed it.

Date Who performed it.....

Nature of operation

.....
.....

13. Do you have any reason to believe that the operation(s) shortened the life of the deceased?

Yes No

If Yes, please give details.

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.....

14. Please give the full name and address details of any person who nursed the deceased during their last illness (Say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before the death.)

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15. Were there any persons present at the moment of death?

Yes No

If Yes, please give the full name and address details of those persons and whether you have spoken to them about the death.

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16. If there were persons present at the moment of death, did those persons have any concerns regarding the cause of death?

Yes No

If Yes, please give details

.....
.....

17. In view of your knowledge of the deceased's habits and constitution do you have any doubts whatever about the character of the disease or condition which led to the death?

Yes No

18. Have you any reason to suspect that the death of the deceased was
- | | | |
|-----------|------------------------------|-----------------------------|
| Violent | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unnatural | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

19. Have you any reason at all to suppose a further examination of the body is desirable? Yes No

If you have answered Yes to questions 17, 18 or 19 please give details below:

.....

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20. Has a coroner been informed about the death? Yes No

If Yes, please state the outcome.

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21. Has there been any discussion with a coroner's office about the death of the deceased? Yes No

If Yes, please state the coroner's office that was contacted and the outcome of the discussions.

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22. Have you given the certificate required for registration of death? Yes No

If No, please give the full name and contact details of the medical practitioner who has

Full name.....

Address

Postcode..... Telephone number.....

23. Was any hazardous implant placed in the body (e.g. a pacemaker, radioactive device or 'Fexion' intramedullary nailing system)? Yes No

Implants may damage cremation equipment if not removed from the body of the deceased before cremation and some radioactive treatments may endanger the health of crematorium staff.

If Yes, has it been removed? Yes No

Statement of truth

I certify that I am a registered medical practitioner.

I certify that the information I have given above is true and accurate to the best of my knowledge and belief and that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or in a place or circumstance which requires an inquest in pursuance of any Act.

I am aware that it is an offence to wilfully make a false statement with a view to procuring the cremation of any human remains.

Your full name

Address

Postcode..... Telephone number.....

Registered qualifications

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.....
.....

GMC reference number

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.....

Signed

Dated

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Once completed, this certificate must be handed or sent in a closed envelope by, or on behalf of, the medical practitioner who signs it to the medical practitioner who is to give the confirmatory medical certificate except in a case where question 10 is answered in the affirmative, in which case the certificate must be so handed or sent to the medical referee at the cremation authority at which the cremation is to take place.



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Cremation 5
Replacing Form C

Confirmatory Medical Certificate

This form may only be completed by a registered medical practitioner of at least five years' standing who is not either a relative of the deceased, the medical practitioner who issued the medical certificate (form Cremation 4) or a relative or a partner or colleague in the same practice or clinical team as the medical practitioner who issued that certificate.

'Five years' standing' means a medical practitioner who has been a fully registered person within the meaning of the Medical Act 1983 for at least five years and, if paragraph 10 of Schedule 1 to the Medical Act 1983 (Amendment) Order 2002 (S.I. 2002/3135) has come into force, has held a licence to practice for at least five years or since the coming into force of that paragraph.

Please complete this form in full, if a part does not apply enter 'N/A'.

Details of the deceased

Full name

Address

.....

.....Poscode.....

Occupation or last occupation if retired or not in work at date of death

.....

The report on the deceased

1. Have you questioned the medical practitioner who gave the Medical Certificate (form Cremation 4)? Yes No

If No, please give reasons.

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In answer to questions 2, 3, 4, and 5, please give names and addresses of persons questioned and say whether you spoke to them in person or by telephone. Any failure to answer one of these questions in the affirmative may be treated as an inadequate enquiry.

2. Have you questioned any other medical practitioner who attended the deceased? Yes No

If Yes, please give the full name and address details of the medical practitioner(s).

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3. Have you questioned any person who nursed the deceased during their last illness, or who was present at the death? Yes No

If Yes, please give the full name and address details.

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4. Have you questioned any of the relatives of the deceased? Yes No

If Yes, please give the full name and address details.

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5. Have you questioned any other person? Yes No

If Yes, please give the full name and address details.

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6. Please state the date and time that you saw the body of the deceased and the examination that you made of the body.

Date / / Time.....

Examination

.....
.....

7. Do you agree with the cause of death given in question 11 of Part 2 of the Medical Certificate (form Cremation 4)? Yes No

If No, please give reasons and give the cause of death.

Reason(s) for disagreeing

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

.....
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(b) Other disease or condition, if any, leading to (a)

.....
.....

(c) Other disease or condition, if any, leading to (b)

.....
.....

2. Other significant conditions contributing to the death but not related to the disease or condition causing it.

.....
.....

Statement of truth

I certify that I am a registered medical practitioner of at least five years' standing and I am not a relative of the deceased, or a relative or a partner or colleague in the same practice or clinical team as the medical practitioner who has given the Medical Certificate (form Cremation 4).

I certify that the information I have given above is true and accurate to the best of my knowledge and belief and that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or in a place or circumstance which requires an inquest in pursuance of any Act.

I am aware that it is an offence to wilfully make a false statement with a view to procuring the cremation of any human remains.

Your full name

Address

.....

.....

Postcode.....Telephone number.....

Registered qualifications

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.....

.....

GMC reference number

.....

.....

Signed

Dated

.....

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Once completed, this certificate and the Medical Certificate (form Cremation 4) must be handed or sent in a closed envelope by one of the medical practitioners giving the certificates to the medical referee at the cremation authority at which the cremation is to take place.