UL MUTUAL

DEATH CERTIFICATE
Attending Physician

Last and first name of the deceased	Date of birth Y M D
Residence at death	Date of death Y M D

Did the deceased smoke? ☐ **YES** (1) ☐ **NO** (2)

(1) If YES, since when did he/she smoke? _____

Had he/she already quit smoking? ☐**Yes** ☐**No** If yes, during what period ? _____

(2) If NO, did he/she ever smoke? ☐**Yes** ☐**No** If yes, during what period? _____

If death occurred in a hospital or institution, give the name of the establishment

CAUSE OF DEATH

Disease, injury or condition which directly caused death	Date illness started Y M D
Antecedent causes (morbid conditions having eventually given rise to the above cause)	Date illness started Y M D
Disease or condition provoked by or resulting from	Date illness started Y M D

For most recent illness – Date of first consultation Y M D	For most recent illness – Date of last consultation Y M D

Specify if death was due to : ☐ Accident ☐ Suicide ☐ Homicide
If yes, describe briefly :

Was a coroner inquest held? ☐**Yes** ☐**No** Was an autopsy performed? ☐**Yes** ☐**No**
If yes, by whom and with what findings?

Did you treat the deceased or did he/she consult you during the **5 years preceding** the most recent illness? ☐**Yes** ☐**No** If yes, indicate the dates	Date(s) Y M D	Diagnosis (es) then reached:

To your knowledge, did the deceased receive treatment from any other physician, or in any hospital or other institution **during the past 5 years**? ☐**Yes** ☐**No**

Name of physician	Name of hospital or institution
Date Y M D	Diagnosis (es):
Name of physician	Name of hospital or institution
Dates Y M D	Diagnosis (es):

Signed at _____ this_____ day of _____ 20_____.

_____ _____
Signature of attending physician Name of attending physician (in block letters)

_____
Address of attending physician