**MEADOWREST MEMORIAL GARDENS**

**HEAD OFFICE**

12 Carlton Crescent, Kingston 10

Tel: 876 960-2961-2  Fax: 876 929-2394

**CEMETERY & CREMATORIUM**

Whittakers Mountain, St. Catherine

Email: info@meadowrest.com

Website: www.meadowrest.com

**FORM C**

**MMG No:**

**Date:**

**DD: _____**

**MM: _____**

**YYYY: _____**

**(TO BE GIVEN BY A MEDICAL PRACTITIONER WHO HAS ATTENDED TO THE DECEASED DURING HIS/HER LAST ILLNESS AND WHO CAN CERTIFY DEFINITELY AS TO THE CAUSE OF DEATH)**

**I AM INFORMED THAT APPLICATION IS ABOUT TO BE MADE FOR THE CREMATION OF THE REMAINS OF:**

**NAME OF DECEASED: _____**

**ADDRESS: _____**

**OCCUPATION: _____**

**HAVING ATTENDED TO THE DECEASED BEFORE DEATH, AND SEEN AND IDENTIFIED THE BODY AFTER, 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. **WHAT WAS THE PLACE WHERE THE DECEASED DIED? _____**

3. **ARE YOU A RELATIVE OF THE DECEASED? STATE RELATIONSHIP IF SO._____**
   **_____**

4. **HAVE YOU, SO FAR, AS YOU ARE AWARE, ANY PECUNIARY INTEREST IN THE DEATH OR THE DECEASED? _____**

5. **WERE YOU THE "ORDINARY" MEDICAL ATTENDANT OF THE DECEASED? _____**

   **IF SO, FOR HOW LONG? _____**

6. **DID YOU ATTEND TO THE DECEASED DURING HIS OR HER LAST ILLNESS? IF SO,**

   **FOR HOW LONG? _____**

7. **WHEN DID YOU LAST SEE THE DECEASED ALIVE? _____**

   **SAY HOW MANY HOURS BEFORE DEATH? _____**

8. **HOW SOON AFTER DEATH DID YOU SEE THE BODY? _____**

   **AND WHAT EXAMINATION DID YOU MAKE? _____**

9. **WHAT WAS THE CAUSE OF DEATH?  (1) PRIMARY _____**

   **(2) SECONDARY _____**

   **(1) IMMEDIATE CAUSE (A)_____**

   **MORBID CONDITIONS (IF ANY) GIVING RISE TO IMMEDIATE CAUSE (STATE IN ORDER PROCEEDING BACKWARD FROM IMMEDIATE CAUSE)**

   **DUE TO (B)**
   **DUE TO (C)**

   **(2) OTHER MORBID CONDITIONS (IF IMPORTANT) CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE _____**

10. **WHAT WAS THE MODE OF DEATH? (STATE WHETHER SYNCOPE, COMA, EXHAUSTION,**

    **CONVULSIONS, ETC) _____**

    **WHAT WAS IT'S DURATION IN DAYS, HOURS, MINUTES? _____**

11. **STATE HOW FAR THE ANSWERS TO THE LAST TWO QUESTIONS ARE THE RESULTS OF YOUR OWN OBSERVATION, OR ARE BASED ON STATEMENTS MADE BY OTHERS, SAY BY WHOM**

    **_____**

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**FORM C CONT....**

12. **DID THE DECEASED UNDERGO ANY OPERATION DURING THE FINAL ILLNESS OR WITHIN A YEAR BEFORE DEATH? IF SO, WHAT WAS IT'S NATURE AND WHO PERFORMED IT?**

_____

_____

13. **BY WHOM WAS THE DECEASED NURSED DURING HIS OR HER ILLNESS? (GIVE NAMES AND SAY WHETHER BY A PROFESSIONAL NURSE, RELATIVE, ETC) IF THE ILLNESS WAS A LONG ONE, THIS QUESTION SHOULD BE ANSWERED IN REFERENCE TO THE PERIOD OF FOUR WEEKS BEFORE DEATH.**

_____

_____

14. **WHO WERE THE PERSONS (IF ANY) PRESENT AT THE MOMENT OF DEATH?**

_____

15. **IN VIEW OF THE KNOWLEDGE OF THE DECEASED HABITS AND CONSTITUTION, DO YOU FEEL ANY DOUBT WHATSOEVER AS TO THE CHARACTER OF THE DISEASE OR CAUSE OF DEATH**

_____

16. **HAVE YOU ANY REASON WHATSOEVER TO SUPPOSE A FURTHER EXAMINATION OF THE BODY TO BE DESIRABLE?**

_____

17. **HAVE YOU ANY REASON TO SUSPECT THAT THE DEATH OF THE DECEASED WAS DUE DIRECTLY OR INDIRECTLY TO VOILENCE, POISON, PRIVATION OR NEGLECT?**

_____

18. **HAVE YOU GIVEN THE CERTIFICATE REQUIRED FOR REGISTRATION OF DEATH? IF NOT, WHO HAS IT?**

_____

**I HEREBY CERTIFY THAT THE ANSWERS GIVEN ABOVE ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND I KNOW OF NO REASONABLE CAUSE TO SUSPECT THAT THE DECEASED DIED EITHER BY A VOILENT OR AN UNNATURAL DEATH OF WHICH THE CAUSE IS UNKNOWN, OR DIED IN SUCH A PLACE OR CIRCUMSTANCES AS TO REQUIRE AN INQUEST IN PURSUANCE OF ANY LAW.**

**SIGNATURE**_____

**ADDRESS**_____

**REGISTERED QUALIFICATIONS**_____

**DATE**_____

***NOTE: THIS CERTIFICATE MUST BE HANDED OR SENT IN A CLOSED ENVELOPE BY THE PRACTIONERS WHO SIGNS IT, TO THE GOVERNMENT MEDICAL OFFICER WHO IS TO GIVE THE CONFIRMATION CERTIFICATE BELOW (FORM D).***