



**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](mailto:info@meadowrest.com)  
Website: [www.meadowrest.com](http://www.meadowrest.com)

**FORM D**  
**MMG No:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**DD:** \_\_\_\_\_  
**MM:** \_\_\_\_\_  
**YYYY:** \_\_\_\_\_

**CONFIRMATORY MEDICAL CERTIFICATE**

**TO BE GIVEN BY A GOVERNMENT OFFICER WHO IS NOT A RELATIVE OF THE DECEASED OR A RELATIVE PARTNER OF THE MEDICAL PRACTITIONER WHO GIVES THE CERTIFICATE FORM C**

**NAME OF DECEASED:** \_\_\_\_\_

**I BEING THE MEDICAL OFFICER FOR \_\_\_\_\_ MEDICAL DISTRICT AND BEING NEITHER A RELATIVE OF THE DECEASED, NOR A RELATIVE OR PARTNER OF THE MEDICAL PRACTITIONER WHO HAS GIVEN THE FOREGOING MEDICAL CERTIFICATE, HAVE EXAMINED IT AND HAVE PERSONAL INQUIRY AS STATED IN MY ANSWERS TO THE QUESTIONS BELOW.**

- 1. HAVE YOU SEEN THE BODY OF THE DECEASED** \_\_\_\_\_
- 2. HAVE YOU CAREFULLY EXAMINED THE BODY EXTERNALLY?** \_\_\_\_\_
- 3. HAVE YOU MADE A POST-MORTEM EXAMINATION?** \_\_\_\_\_
- 4. HAVE YOU SEEN AND QUESTIONED THE MEDICAL PRACTITIONER WHO ATTENDED TO THE DECEASED?**  
\_\_\_\_\_
- 5. HAVE YOU SEEN AND QUESTIONED ANY OTHER MEDICAL PRACTITIONER WHO ATTENDED TO THE DECEASED?**  
\_\_\_\_\_
- 6. HAVE YOU SEEN AND QUESTIONED ANY PERSON WHO NURSED THE DECEASED DURING HIS/HER LAST ILLNESS, OR WHO WAS PRESENT AT THE DEATH?**  
\_\_\_\_\_
- 7. HAVE YOU SEEN AND QUESTIONED ANY RELATIVES OF THE DECEASED?**  
\_\_\_\_\_
- 8. HAVE YOU SEEN AND QUESTIONED ANY OTHER PERSON?**  
\_\_\_\_\_

*(IN THE ANSWER TO QUESTION 5, 6, 7 AND 8 GIVE NAMES AND ADDRESSES OF THE PERSONS SEEN AND SAY WHETHER YOU SAW THEM ALONE)*

**I AM SATISFIED THAT THE CAUSE OF DEATH WAS** \_\_\_\_\_  
\_\_\_\_\_

**AND I CERTIFY THAT I KNOW OF NO REASONABLE CAUSE TO SUSPECT THAT THE DECEASED DIED EITHER A VIOLENT OR UNNATURAL DEATH OF WHICH THE CAUSE BE UNKNOWN OR DIED IN SUCH A PLACE OR CIRCUMSTANCES AS TO REQUIRE ANY FUTRTHHER INQUIRY OR EXAMINATIONS.**

**SIGNATURE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_



**FORM D CONT....**

REGISTERED QUALIFICATIONS: \_\_\_\_\_

OFFICE: \_\_\_\_\_

DATE: \_\_\_\_\_

***NOTE: THE CERTIFICATES IN FORMS C&D MUST BE HANDLE OR SENT IN AN ENVELOPE TO THE AUTHOURIZED OFFICER BY ONE OR EITHER THE MEDICAL PRACTITIONER BY WHOM THEY ARE GIVEN.***