THIS CERTIFICATE MUST BE DELIVERED WITH THE DECEASED'S MEDICAL CARD WITHIN FIVE DAYS TO THE REGISTRAR FOR THE DISTRICT IN WHICH THE PERSON (a) DIED OR

(b) WAS ORDINARILY RESIDENT (WITHIN NORTHERN IRELAND) IMMEDIATELY BEFORE DEATH

FOR INSTRUCTIONS TO INFORMANTS SEE OVERLEAF

MEDICAL CERTIFICATE OF CAUSE OF DEATH

Births and Deaths Registration (Northern Ireland) Order 1976, Article 25(3)

To be signed by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the last illness of the deceased person and given to some person required by Statute to give information of the death to the Registrar. (SEE OVERLEAF)

FOR USE OF REGISTRAR

Entry No .....

District .....

Name of Deceased .....

Usual Residence .....

Place of Death .....

Date of Death ..... day of ..... 20.....

Date on which last seen alive and treated by me for the undermentioned conditions ..... day of ..... 20 .....

Whether seen after death by me .....

Whether seen after death by another medical practitioner .....

CAUSE OF DEATH		These particulars not to be entered in Death Register
I		Approximate interval between onset and death (years, months, weeks, days, hours)
Disease or condition directly leading to death*	(a) Cerebral Oedema.	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	due to (or as a consequence of) (b) Status epilepticus.	
	due to (or as a consequence of) (c) meningoencephalitis	
II	SIADH ↓ Sodium II	
Other significant conditions contributing to the death, but not related to the disease or condition causing it.	~~Epilepsy~~ Previous history of epilepsy.	

*This does not mean the mode of dying eg heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

I hereby certify that the above-named person has died as a result of the natural illness or disease for which he has been treated by me within twenty-eight days prior to the date of death, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature JSSlevin *Qualifications as registered by General Medical Council* .....

Residence .....

Date ..... 20.....

The Health Service Number of the deceased should be entered here by the certifying doctor.

[redacted]

[redacted]

[redacted]

TO: [redacted]

P:1/1

4-MAY-2006 09:13 FROM:DR CHAKRAVARTY & PAR