

CROWNHILL CREMATORIUM & CEMETERY OFFICE

Dansteed Way, Crownhill, Milton Keynes MK8 0AH Tel: 01908 568112 Fax: 01908 563358

E-mail: crownhill@milton-keynes.gov.uk www.milton-keynes.gov.uk/crematorium

Medical certificate

Cremation Form 4 (replacing Form B)

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'.

| Pa | rt 1 - Details of the deceased | |
|-------------------|--|---|
| Full | name | |
| | | |
| Add | dress | |
| | | |
| | | |
| Occ | cupation or last occupation if retired or not in work at the d | ate of death |
| | | |
| | ere a past occupation of the deceased person may suggest uld consider whether to refer the death to a coroner. | |
| Pa | rt 2 - The report on the deceased | |
| Pa ı 1. | rt 2 - The report on the deceased What was the date and time of death of the deceased? | |
| | • | Time |
| | What was the date and time of death of the deceased? | Time |
| | What was the date and time of death of the deceased? | Time |
| 1. | What was the date and time of death of the deceased? Date | Time |
| 1. | What was the date and time of death of the deceased? Date Date Please give the address where the deceased died | Time |
| 1. | What was the date and time of death of the deceased? Date Date Please give the address where the deceased died | |
| 1. | What was the date and time of death of the deceased? Date Date Please give the address where the deceased died Address | |
| 1. | What was the date and time of death of the deceased? Date Date Please give the address where the deceased died Address Please state whether it was the residence of the decease | d or a hotel, hospital or nursing home etc. |
| 1. | What was the date and time of death of the deceased? Date Date Please give the address where the deceased died Address Please state whether it was the residence of the decease Their home Hospital | d or a hotel, hospital or nursing home etc. |

| death of the deceas | | | Yes | |
|---|-------------------|-----------------------------------|-------------------------------|--------------|
| If yes, please give d | etails ———— | | | |
| | | | | |
| | | | | |
| Were you the decea | ased's usual med | dical practitioner? | Yes | |
| If Yes, please state f | or how long. | | | |
| f No, please give de | etails of your me | edical role in relation to the de | ceased. | |
| | | | | |
| | | | | |
| | | | | |
| Please state for hov their last illness? | v long you atten | ided the deceased during | | |
| Please state the nu | mber of days an | d hours before the deceased's | death that you last saw the | m alive? |
| | • | | | |
| Days | | Hours | | |
| Days | , | | | |
| · | | Hours | eased and the examination tl | nat vou made |
| Please state the dat | | | eased and the examination tl | nat you made |
| Please state the dat the body? Date | e and time that | Hours | eased and the examination the | nat you made |
| Please state the dat the body? | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| the body? Date ———————————————————————————————————— | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | nat you made |
| Please state the dat the body? Date | e and time that | Hours | | hat you made |

| 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 | Yes | |
| 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? | | |
| coneague in the same practice of cliffical team as you: | | |

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) 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. Did the deceased undergo any operation in the year before their death? Yes No 12. If Yes, what was the date and nature of the operation and who performed it. Date of operation Who performed it Nature of operation 13. Do you have any reason to believe that the operation(s) shortened the life of the deceased? No Yes If Yes, please give details

| Please give the full name and address details of any person who nursed the Say whether professional nurse, relative, etc. If the illness was a long one, with reference to the period of four weeks before the death.) | | |
|--|---------------------|------------|
| | | |
| | | |
| | | |
| | | |
| Were there any persons present at the moment of death? | Yes | |
| f Yes, please give full name and address details of those person and whet the death. | her you have spoker | to them ab |
| | | |
| | | |
| | | |
| f there were persons present at the moment of death, did those persons have any concerns regarding the cause of death? | Yes | |
| f Yes, please give details | | |
| n 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 | |
| Have you any reason to suspect that the death of the deceased was | | |
| Violent | Yes | |
| Unnatural | Yes | |
| Have you any reason at all to suppose a further examination of the body is desirable? | Yes | |
| f you have answered Yes to questions 17, 18 or 19 please give details belo | ow. | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Part 2 - continued 20. Has a coroner been informed about the death? Yes No If Yes, please state the outcome. 21. Has there been any discussion with a coroner's office about the death of the deceased? No Yes If Yes, please state the coroner's office that was contacted and the outcome of the discussions. 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** Telephone Number

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

Part 3 - 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 if 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 | Telephone number |
| | |
| | |
| Registered qualification | |
| | |
| | |
| | |
| GMC Reference number | |
| | |
| Signed | Dated |
| | |

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.



CROWNHILL CREMATORIUM & CEMETERY OFFICE

Dansteed Way, Crownhill, Milton Keynes MK8 0AH Tel: 01908 568112 Fax: 01908 563358

E-mail: crownhill@milton-keynes.gov.uk www.milton-keynes.gov.uk/crematorium

Confirmatory Medical certificate

Cremation Form 5 (replacing Form C)

This form can 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 a lest 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'.

| Par | t 1 - Details of the deceased | | |
|-------|--|-------------|----|
| Full | name | | |
| | | | |
| Add | ress | | |
| | | | |
| | | | |
| | | | |
| Occi | upation or last occupation if retired or not in work at the date of death | | |
| | | | |
| 1. | Have you, questioned the medical practitioner who gave the Medical Certificate (form Cremation 4)? If No, please give reasons. | Yes | No |
| In ar | nswer to questions 2, 3, 4 and 5, please give names and addresses of page to them in person or by telephone. Any failure to answer one of the ted as inadequate enquiry. | = | - |
| - | ted as madequate enquiry. | | |
| - | Have you questioned any other medical practitioner who attended the deceased? | Yes | No |
| trea | Have you questioned any other medical practitioner who attended | | No |

Regulation 16(c)(i) of the Cremation (England and Wales) Regulations 2008

| their last illness, or who was present at the death? | Yes | |
|---|------------------------|---------------|
| If Yes, please give the full name and address details. | | |
| | | |
| | | |
| | | |
| | | |
| Have you questioned any of the relatives of the deceased? | Yes | |
| If Yes, please give the full name and address details. | | |
| | | |
| | | |
| | | |
| Have you questioned any other person? | Yes | |
| If Yes, please give the full name and address details. | | |
| | | |
| | | |
| | | |
| | | |
| Please state the date and time that you saw the body of the decease the body? | ed and the examination | that you made |
| Date | Time | |
| | | |
| | | |
| Examination | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| If NIa is | along aire reason and aire the correspt death | |
|-----------|--|--------|
| π Νο, μ | please give reason and give the cause of death. | |
| Reasor | n(s) for disagreeing | |
| | | |
| | | |
| | | |
| | | |
| | | |
| 4 () | | |
| 1. (a) | Disease or condition directly leading to death (this does not mean the mode of dying, such a failure, asphyxia, asthenia, etc: it means the disease, injury, or complication which caused de | |
| | tailule, aspriyala, astrietila, etc. it means the disease, injury, or complication which caused de | atrij |
| | | |
| | | |
| | | |
| | | |
| | | |
| (b | o) Other disease or condition, if any, leading to (a) | |
| | | |
| | | |
| | | |
| | | |
| | | |
| (c) | 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 conc | lition |
| | causing it. | |
| | | |
| | | |
| 1 | | |

Part 3 - 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 if 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 | Telephone number |
| | |
| | |
| | |
| Registered qualification | |
| | |
| | |
| | |
| | |
| | |
| GMC Reference number | |
| | |
| | |
| Signed | Dated |
| | |

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.



CROWNHILL CREMATORIUM & CEMETERY OFFICE

Dansteed Way, Crownhill, Milton Keynes MK8 0AH Tel: 01908 568112 Fax: 01908 563358

E-mail: crownhill@milton-keynes.gov.uk www.milton-keynes.gov.uk/crematorium

Authorisation of cremation of deceased person by medical referee

Cremation Form 10 (replacing Form F)

| Please complete this form in full, if a part does not apply enter N/A. | |
|--|--------------------|
| Part 1 - Details of the deceased | |
| Full name | |
| | |
| Address | |
| | |
| | |
| | |
| Occupation or last occupation if retired or not in work at date of death | |
| | |
| Part 2 - Authorisation by medical referee | |
| An application has been made for the cremation of the remains of the deceased. | |
| I am satisfied that - | |
| (a) the requirements of the Cremation (England and Wales) Regulations 2008 have been co | • |
| (b) the inquiry/examination made by the persons who gave the relevant certificates has been(c) the fact and cause of death have been definitely ascertained or, if not ascertained, a coninquest. | |
| Accordingly, I authorise the Registrar of the following crematorium to cremate the remains of that crematorium - | he deceased within |
| Name of crematorium | |
| | |
| Print you full name | |
| | |
| Cremation authority | |
| | |
| Signed Dated | |