Province of British Columbia
Ministry of Health and
Ministry Responsible for Seniors
DIVISION OF VITAL STATISTICS

DOCUMENT CONTROL NUMBER (Office Use Only): 200723500

REGISTRATION NUMBER (Office Use Only): 96-008051

PHYSICIAN'S

MEDICAL CERTIFICATION OF DEATH

This is a permanent legal record – Type or print plainly – Complete all Items – Use blue or black ink only

See Reverse for Instructions

Important Notice to Doctors

Issue the Medical Certification of Death promptly to avoid delaying funeral arrangements. If the medical practitioner is for any reason unable to complete the Medical Certificate within 48 hours of death, the funeral director or the physician shall notify a coroner.

Name of Deceased
1. Surname (Print or Type): ROACH
All given names: WILLIAM DAVID LOUIS
2. Sex: ☑ M ☐ F ☐ U/K
Personal Health Number: 9041 129B 17568

Actual Date of Death
3. Month (By Name) / Day / Year: April 08 1996
Approximate Time of Death (24 hour clock): 1356 HRS.
Date of Birth 4. Month (By Name) / Day / Year: Dec 18 1911
If under 1 day: Hours / Minutes

Place of Death
5. Name of Hospital or Institution (Otherwise give exact location where death occurred, eg. address): GEORGE DERBY CENTRE
City, town or other place (by name): BURNABY
Postal code: V3N 3X5
Type of place (e.g. Hospital, Nursing home, Home, Street, Workplace etc.): LONG TERM CARE FACILITY

MEDICAL CAUSE OF DEATH

SHADED AREA - OFFICE USE ONLY

		Approximate Interval Between → Onset/Death
PART I Immediate cause of death.	(a) Pneumonia	
due to, or as a consequence of		
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying causes last.	(b) Squamous Cell Ca Lung	1 year
due to, or as a consequence of		
	(c)	
PART II Other significant conditions contributing to the death.		

Office use: I / / / / / II* — Place of accident or violence: — Reject:

Other Medical Particulars
6. Recent surgery (28 days or less prior to death) ☐ Yes ☑ No — If Yes, date ____ — Surgery & Findings
7. Coronary bypass ☐ Yes ☑ No — Heart valve replaced ☐ Yes ☑ No — Organ transplant recipient ☐ Yes (specify) ☑ No
8. Was deceased pregnant at time of death? ☐ Yes ☑ No — OR — Did death occur within 90 days postpartum? ☐ Yes ☑ No
9. Environmental/occupational/lifestyle (e.g. pesticides, asbestos, abuse of tobacco, alcohol etc.) ☐ Yes (Specify below) ☑ No ☐ Unknown

Autopsy Particulars
10. Autopsy being held? ☐ Yes ☑ No
11. Does cause of death stated above take account of autopsy findings? ☑ Yes ☐ No
12. May further information relating to cause of death be available later? ☐ Yes ☑ No

Manner of Death
13. State if death was ☑ Natural ☐ Suicide ☐ Homicide ☐ Accident ☐ Could not be determined ☐ Pending investigation
If death was NOT from natural causes was the Coroner notified? ☐ Yes ☐ No

Accident or Violence *(if applicable)*
14. Place of Injury (exact location and type of place)
15. Date of Injury Month (By Name) Day Year
16. How did injury occur? (describe circumstances)

Certification by Physician
I viewed the body after death ☑ Yes ☐ No
I attended the deceased for the final illness on: Month (By Name) Day Year: April 08 1996
I certify to the best of my knowledge and belief this person died on the date and from the cause(s) stated herein.
Signature of medical practitioner X [signature]
Date signed. Month (By Name) Day Year
Name of medical practitioner (print or type): K. K. Niki
MSC Personal No: 05112
Phone No.: 524-9 2491
Address: 2006 8th Ave New Westminster
Postal code

Notations *(Office use only)*

Certification of District Registrar
NEW WESTMINSTER
I certify that this was accepted by me on this date at:
Month (By Name) Day Year: APR 12 1996
Signature of District Registrar: [signature]
Registration District Number: 035

IMPORTANT: Any change or correction made in the completion of this form must be initialled by the person certifying the original information.

HLTH 406A REV 92/12