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

DOCUMENT CONTROL NUMBER: 299901868

REGISTRATION No. (Department Use Only): 93-007239

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)*: LEVINGS
All given names: STEPHEN HERBERT ODELL
2. Sex: ☑ M ☐ F
Personal Health Number:

Actual Date of Death

3. Month (By Name) Day Year: MAY 15 1993
Approximate Time of Death (24 hour time): 1430 hrs.

Date of Birth

4. Month (By Name) Day Year: OCT 31 1910
If under 1 day: Hours / Minutes

Place of Death

5. Name of Hospital or Institution *(Otherwise give exact location where death occurred, eg. address)*: GORGE ROAD HOSPITAL
City, town or other place *(by name)*: VICTORIA
Postal code:
Type of place *(e.g. Hospital, Nursing home, Home, Street, Workplace etc.)*: 7
Office Use Only:

MEDICAL CAUSE OF DEATH

SHADED AREA - OFFICE USE ONLY

		Approximate Interval Between → Onset/Death				
PART I Immediate cause of death.	(a) CARDIAC FAILURE	3 DAYS	I	4289		
due to, or as a consequence of						
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the **underlying cause last.**	(b) CHRONIC OBSTRUCTIVE LUNG DISEASE	YRS	/	496		
due to, or as a consequence of						
	(c) EMPHYSEMA	YRS	/	492		
			/			
			/			
PART II Other significant conditions contributing to the death.	BRONCHOPNEUMONIA	2 DAYS	II*	485	4149	
	ISCHAEMIC HEART DISEASE	YRS	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 Office Use Only:	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 Office Use Only:	
Manner of Death	13. State if death was ☑ Natural ☐ Accident ☐ Suicide ☐ Could not be determined ☐ Homicide ☐ 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)*: N/A	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: MAY 11 1993

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: MAY 17 1993
Office Use Only:

Name of medical practitioner *(print or type)*: DR N RAICHURA
MSC Personal No.: 0158173
Phone No.: 811 4355

Address: #14-3170 Tillicum Rd Victoria, BC
Postal code: V9A 7H5

Notations *(Departmental use only)*

Certification of District Registrar

I certify that this was accepted by me on this date at: Victoria

Month (By Name) Day Year: JUN 18 1993
Signature of District Registrar: [signature]
Registration District No.: 046

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