

(See Rule 5 of himachal Pradesh Registration of Births and Death Rules, 2003)

DEATH REPORT FORM

DEATH REPORT

Legal information This part to be added to the death register	Statistical information This part is to be Detached and sent for statistical processing		
To be filled by the informant	To be filled by the informant	To be filled by the informant	
1. Date of death(enter the exact day, month and year the death took place e.g. 1-1-2000 <input type="text"/> <input type="text"/>	9. Town or village of residence of the deceased (place where the deceased actually lived. This can be different from the place where the death occurred. The house address is not required to be entered) a) Name of Town / village <input type="text"/>	13. Was the cause of death medically certified?(tick the appropriate entry below) 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/>	In the case of multiple, birth fill in separate from each child and write "Twin Birth "or triple birth"etc as the case may be, in the remarks column in the box below left <input type="text"/>
2. Name and Deceased(Full name as usually written <input type="text"/> <input type="text"/>	b)is it a town or village(tick the appropriate entry below) 1. Town <input type="checkbox"/> 2. Village <input type="checkbox"/> c)Name of district <input type="text"/> d) Name of state <input type="text"/>		
3. Name of the father /husband(full name is usually written <input type="text"/> <input type="text"/>	10.Religion(Tick the appropriate entry below) 1. Hindu <input type="checkbox"/> 2. Muslim <input type="checkbox"/> 3.christian <input type="checkbox"/> 4. Sikh <input type="checkbox"/> 5.Any other religion (write name of the religion) <input type="text"/>	14. Name the decease or actual cause of death. (For all deaths irrespective of whether medically certified or not) <input type="text"/> <input type="text"/>	
4.Sex of the deceased(Enter ,male or female) do not use abbreviation <input type="text"/> <input type="text"/>	11. occupation of the deceased(if no occupation write nil) <input type="text"/> 12.Type of medical attention received before death(tick the appropriate entry below): 1. institutional <input type="checkbox"/> 2.medical attention other <input type="checkbox"/>	15. in case female death, did the death occur while pregnant at the time of delivery or within 6 weeks after the end of pregnancy(tick the appropriate entry below) 1. While pregnant <input type="checkbox"/> 2. At the time of delivery <input type="checkbox"/>	

	than institution 3. no medical attention <input type="checkbox"/>	3. Within six weeks after the end of delivery
5. Age of deceased (if the deceased was over 1 year of age in completed years. If the deceased was below 1 year of age, give age in months and if below one month give age in completed number of days if below one days in hours)		16. If used to habitually, smoke for how many years?
6 .Permanent Address:		17. If used to habitually chew tobacco in any form for how many years?
7. Place of Death (Tick the appropriate entry 1, 2 and 3 below the give name of the hospital /institution or the address of the house where the death took place. If other place ,give location) 1. Hospital / institution name: <input type="checkbox"/> 2. House address: <input type="checkbox"/> 3. Other place: <input type="checkbox"/>		18. If used to habitually chew area nut in any form (including pan masala) for how many years? 19. if used to habitually drink alcohol for how many years
8. Informants name and address: (after completing all columns 1 to 17,informant will put date and signature here)		(columns to be filled by over now put signature at left)
Date <input type="text"/> Signature or left thumb <input type="text"/>		
Mark of the informant <input type="text"/>		
To be filled by the registrar	To be filled by the registrar	
Registration no: <input type="text"/> Registration date: <input type="text"/> Registration unit: <input type="text"/> Town/ village: <input type="text"/> District: <input type="text"/>	Name: <input type="text"/> Tehsil: <input type="text"/> Town/ village: <input type="text"/> Registration unit: <input type="text"/>	Registration no: <input type="text"/> Registration date: <input type="text"/> Sex 1.male 2. Female <input type="text"/> Date of death: <input type="text"/> Age years/ month/ days/ hours place of the death 1.Hospital/ Institution <input type="checkbox"/>

Remarks(if any)		2) House <input type="checkbox"/>	
		3) other place <input type="checkbox"/>	
Name and signature of registrar		Name and signature of the registrar	
<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	