



# MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA **STATEMENT OF RESULTS OF POST MORTEM EXAMINATIONS**

DATE OF REPORT: 10/11/2010

NAME OF DECEASED: [Name]

AGE: [Age]

SEX: [Sex]

DATE OF DEATH: [Date]

PLACE OF DEATH: [Place]

CAUSE OF DEATH: [Cause]

MANNER OF DEATH: [Manner]

TOXICOLOGICAL REPORT: [Toxicology]

LABORATORY REPORT: [Laboratory]

POST MORTEM REPORT: [Post-mortem]

CONCLUSION: [Conclusion]

SIGNATURE OF PHYSICIAN: [Signature]

DATE: [Date]

PLACE: [Place]

NAME: [Name]

DESIGNATION: [Designation]

INSTITUTION: [Institution]

ADDRESS: [Address]

PHONE: [Phone]

FAX: [Fax]

EMAIL: [Email]

WEBSITE: [Website]

NOTE: [Note]

REFERENCE: [Reference]

REMARKS: [Remarks]

SIGNATURE OF PHYSICIAN: [Signature]

DATE: [Date]

PLACE: [Place]

NAME: [Name]

DESIGNATION: [Designation]

INSTITUTION: [Institution]

ADDRESS: [Address]

PHONE: [Phone]

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DATE: [Date]

PLACE: [Place]

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REMARKS: [Remarks]

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