

Book N° _____		DEATH CERTIFICATE		Certificate N° _____	
1. Name and surname of the decease. Sonia Josefina Torres Villacorta Known by: _____		11. Current place of residence of the decease: State: La Paz City: Zacatecoluca Pa Village: _____		Area Urban: 1 <input type="checkbox"/> Rural: 2 <input type="checkbox"/>	
2. Decease Identification Number: _____ 3. Date of death: Minutes: 45 Hours: 17 p.m Day: 26 Month: 5 Year 2024		12. Name and surname of the mother: Barbara Torres Name and surname of the father: _____			
4. Place of death: State: La Paz City: Zacatecoluca PA Village: _____		13. CAUSE OF DEATH Write only one cause on each line (a), (b), (c), y (d)		Approximate range between the onset of the disease and death	
5. Location of death: National Hospital: 1 <input type="checkbox"/> Hospital Nacional PA Santa Teresa Health Unit : 2 <input type="checkbox"/> Hospital or Private Clinic 3 <input type="checkbox"/> House: 4 <input type="checkbox"/> Street: 5 <input type="checkbox"/> Other: 6 <input type="checkbox"/> Specify _____		(a) 164 – Acute cerebral vascular accident, not specified as hemorrhagic or ischemic. Due to (because of) _____ (b) N17.9- Unspecified acute renal failure Due to (because of) _____ (c) _____ Due to (because of) _____ (d) _____		1 day (s) 1 day (s) _____ 5 year(s)	
6. Gender: Male: 1 <input type="checkbox"/> Female: 2 <input type="checkbox"/> Undetermined: 3 <input type="checkbox"/>		BASIC CAUSA			
7. Marital or familial status: Single: 1 <input type="checkbox"/> Accompanied: 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widower 4 <input type="checkbox"/> Separated: 5 <input type="checkbox"/> Divorced: 6 <input type="checkbox"/> Ignored 7 <input type="checkbox"/> Impuberty 8 <input type="checkbox"/>		II. Other significant pathological states that contributed to death, but not related to the disease or disease state that caused it. _____			
8. For ages over 1 year (years old) 69 Children under 1 year old: Hour: _____ Minutes: _____ Days _____ Months: _____ Complete: Married Mother Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 3 <input type="checkbox"/> Type of childbirth: Vaginal: <input type="checkbox"/> Cesarean 2 <input type="checkbox"/> Don't know 3 <input type="checkbox"/> Mother's age: _____ Duration of pregnancy: _____ Weeks of gestation _____		- This does not mean the way or manner of dying, for example: Heart weakness, asthenia, etc. It. Properly means the illness, trauma or complications of death. 14. If the disease is a woman between 10 -54 years old, investigate if she died during: Pregnant: 1 <input type="checkbox"/> Birth 2 <input type="checkbox"/> Postpartum 3 <input type="checkbox"/> Puerperium <input type="checkbox"/> Mediate puerperium: 5 <input type="checkbox"/> Late Puerperium 6 <input type="checkbox"/>			
If days are between 1 to 28, complete the following information birth. Weight: _____ grams height at birth _____ centimeters Place where the child was born Hospital 1 <input type="checkbox"/> Out-of-hospital: 2 <input type="checkbox"/> How many has the mother had: Pregnancies _____ Abortions _____ Stillborn _____		ACCIDENTAL OR VIOLENT DEATH 15. Accident: 1 <input type="checkbox"/> Suicide: 2 <input type="checkbox"/> Homicide: 3 <input type="checkbox"/> Ignored 4 <input type="checkbox"/>			
9. Deceased last occupation HOUSEWIFE 10. Retired Yes: 1 <input type="checkbox"/> No: 2 <input type="checkbox"/> Ignored: 3 <input type="checkbox"/>		14. Causes of death Firearm: 1 <input type="checkbox"/> White weapon 2 <input type="checkbox"/> Drop 3 <input type="checkbox"/> Drowning: 4 <input type="checkbox"/> Car accident 5 <input type="checkbox"/> Poisoning 6 <input type="checkbox"/> Explosive device 7 <input type="checkbox"/> Hanging or strangulations 8 <input type="checkbox"/> By blunt object: 9 <input type="checkbox"/> Other _____ 10 <input type="checkbox"/>			
18. Registration Date: _____ 19. Signature and seal of Responsible doctor: OLIVIA MARGARITA ALVAREZ QUINTEROS JVPM 20783		Assistance and Medical Certification 17. Had medical assistance during his/her illness: Yes <input type="checkbox"/> No <input type="checkbox"/> Ignored <input type="checkbox"/> Death certified by the doctor: Yes <input type="checkbox"/> No <input type="checkbox"/> Ignored <input type="checkbox"/> Death certified by a coroner's: Yes <input type="checkbox"/> No <input type="checkbox"/> Ignored <input type="checkbox"/>			
20. Name, signature, and seal of the registrar of the family State		<div>Seal of Santa Teresa Hospital</div> <div>Doctor's signature and seal</div>			