TO BE FILLED OUT BY ISSUER

1. DECEDENT'S NAME (*First, Middle, Last)*	**2.** SEX □ Male □ Female	**3.**	**ROC Citizen**	□ **ID No.**	
			Foreign National	□ **Passport No.**	
				□ **Uniform ID No.**	

4. REGISTERED PERMANENT RESIDENCE *(street and number, city, town, country)*

5a. DATE OF BIRTH *(Month, Day, Year)*	**5b. TIME OF BIRTH** *(For death within one day after birth)* **Hour Minutes**
6a. DATE OF DEATH *(Month, Day, Year)*	**6b. TIME OF DEATH** **Hour Minutes**
7a. LOCATION OF DEATH *(street and number, city, town, country)*	**7b. PLACE OF DEATH** □ **Hospital** □ **Clinic** □ **Nursing home/Long term care facility** □ **Own Residence** □ **Others**

8. MANNER OF DEATH

□ **Natural Death(Natural deaths are due solely or nearly totally to disease and/or the aging process)**

□ **Accident** □ **Suicide** □ **Homicide** □ **Could not be Determined**

9a. KIND OF BUSINESS/INDUSTRY	**9b. DECEDENT'S USUAL OCCUPATION**

10. IF FEMALE:

□**Not pregnant within past year** □**Pregnant at time of death**

□**Not pregnant, but pregnant within 42 days of death** □**Not pregnant, but pregnant 43 days to 1 year before death**

□**Unknown if pregnant within the past year**

11. CAUSE OF DEATH *(Enter the diseases, injuries, or complications that caused the death. Do not enter the mode dying, such as heart failure or respiratory arrest.)*

PART I.

		Approximate interval: Onset to death
IMMEDIATE CAUSE *(Final disease or condition resulting in death)*	**a.** _____	_____
	Due to (or as a consequence of):	
	b. _____	_____
Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** *(Disease or injury that initiated events resulting in death)* **LAST**	Due to (or as a consequence of):	
	c. _____	_____
	Due to (or as a consequence of):	
	d. _____	_____

PART II. *Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.* _____ _____

THIS IS TO CERTIFY THAT THE ABOVE STATEMENT IS TRUE.

Name and License Number of Certifying Physician:

Name and Practice License Number of Hospital (Clinic):

Medical Care Institution Code:

Address of Hospital (Clinic):

Date Signed (Month, Day, Year) :

□ Internet transmission (Pursuant to Article 14 of the Household Registration Law and Article 4 of the Regulations for Death Information Notification)