Death Notification Form (D1) v 16.08.18

FORM D1

REPUBLIC OF KENYA

THE BIRTHS AND DEATHS REGISTRATION ACT
(*Cap.* 149)

PERMIT FOR BURIAL

Serial No. DA _____ IP Number _____

1. NAME OF DECEASED _____
First Name Middle Name Father's or husband's name

2. IDENTIFICATION /PASSPORT NUMBER _____

4. SEX: Male ☐ Female ☐ 5. AGE _____ 6. DATE OF DEATH _____
Year s Month s Days Day Month Year

9. USUAL RESIDENCE _____
Sub-location or estate and town District

After making due inquiry as to cause of the death of the above named deceased person. I hereby authorize the interment of the body.

18. DATE: _____ 19. REGISTRATION ASSISTANT FOR: 20. SIGNATURE
Day Month Year

_____ _____

PERMIT ISSUED TO (NAME): _____ ID No. _____ SIGNATURE _____

FORM D1

REGISTER OF DEATH

((for use in health institutions and by Medical Practitioners)

Serial No. DA _____ IP Number _____

1. NAME OF DECEASED _____
First Name Middle Name Father's or husband's name

2. IDENTIFICATION /PASSPORT No. _____ 3. NATIONALITY _____

4. SEX: Male ☐ Female ☐ 5. AGE _____ 6. DATE OF DEATH _____
Years months days Day Month Year

7. MARITAL STATUS: (a) Married ☐ (b) Divorced ☐ (c)Single ☐ (d) Widowed ☐

8. PLACE OF DEATH: _____
Health Institution/Sub-location or estate and town. District

9. USUAL RESIDENCE _____
Sub-location or estate and town District

10. LEVEL OF EDUCATION _____ 11. OCCUPATION _____

12. CAUSE OF DEATH (PRINT IN BLOCK LETTERS, DO NOT ABBREVIATE) _____

IMMEDIATE CAUSE: disease or condition directly leading to death (a) _____
Due to

ANTECEDENT CAUSES: Morbid conditions, if any, which gave rise to immediate cause (a)
(b) _____
Due to stating the underlying condition last
(c) _____

OTHER SIGNIFICANT CONDITIONS: Contributing to death but not related to (a) _____

MEDICAL CERTIFICATION

13. CERTIFICATE: I certify that:
(a) I attended the deceased before death or
(b) I examined the body after death; or
Tick as Appropriate (c) I conducted a post-mortem examination of the body, and that the above information is correct to the best of my knowledge.

14. NAME _____ 15. TITLE _____

16. DATE _____ 17. SIGNATURE _____

REGISTRATION ASSISTANT

18. DATE _____ 19. REGISTRATION ASSISTANT FOR: 20. SIGNATURE _____
Day Month Year (Name of health institution)

_____

REGISTRAR

21. DISTRICT _____ 22. REGISTRATION No. _____

23. DATE _____ 24. NAME _____ 25. SIGNATURE _____