

This form is issued by Glasnevin Crematorium Limited, Finglas Road, Dublin 11. Tel: (01) 882 6500.  
www.dublincemeteriestrust.ie

**This Certificate should reach the relevant office  
NO LATER THAN 3.00PM ON THE DAY PRIOR TO THE CREMATION.**

**PURSUANT TO THE BYE LAWS MADE BY GLASNEVIN CREMATORIUM LIMITED**

Completion of this form is mandatory. **All questions must be answered** to complete the certificate for the purposes of Cremation.

**The doctor completing the certificate must see the body before and after death.**

Must be **FULLY REGISTERED** on The Medical Register of Ireland i.e. **POST INTERN YEAR**

**PART 1: STATEMENT OF TRUTH**

**\*PLEASE PRINT IN BLACK PEN ONLY\***

I certify that I am a registered medical practitioner.

I hereby certify that the answers given below are true and accurate to the best of my knowledge and belief.

Name (Block capitals)	<input type="text"/>	Signature	<input type="text"/>
Practice Address	<input type="text"/>		
Date	<input type="text"/>	REGISTERED NUMBER:	<input type="text"/>
Telephone No	<input type="text"/>		

**PART 2: DETAILS OF THE DECEASED**

I am informed that application is about to be made for the cremation of the remains of:-

Name of deceased	<input type="text"/>
Deceased Address	<input type="text"/>

**PART 3: REPORT ON THE DECEASED**

**HAVING SEEN AND IDENTIFIED THE DECEASED BEFORE AND AFTER DEATH.**

I give the following answers to the questions set out below:-

1.	(a) Were you the regular attending doctor of the Deceased	Y <input type="checkbox"/>	N <input type="checkbox"/>
	(b) If so, for how long?	<input type="text"/>	
2.	(a) Did you attend the Deceased during his or her last illness	Y <input type="checkbox"/>	N <input type="checkbox"/>
	(b) If so, for how long?	<input type="text"/>	
3.	(a) When did you last see the deceased alive?	Date	<input type="text"/>
	(say how many days or hours before death)	Days or Hours	<input type="text"/>
4.	(a) How soon after death did you see the deceased?	<input type="text"/>	
	(b) What examination did you make?	<input type="text"/>	
5.	On what date and at what hour did he or she die?	Date	Hour <input type="text"/>

Medical Certificate Continued

- 6 (a) Address where the deceased died [redacted]  
(b) Please indicate whether answer to 6 (a) above was: Own residence  Hospital  Nursing Home   
Other (please state) [redacted]
7. (a) Are you a relative of the deceased? Y  N   
(b) If yes, state relationship [redacted]
8. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? Y  N
9. Cause of death and duration of last illness: (NO ABBREVIATIONS)
- Disease or condition directly leading to death (a) [redacted]  
due to (or as a consequence of) (b) [redacted]  
Approximate interval between onset and death [redacted]
- Antecedent causes (c) [redacted]  
Morbid conditions, if any, due to (or as a consequence of)  
Giving rise to the above  
Cause, stating the underlying Condition last (d) [redacted]  
Approximate interval between onset and death [redacted]
- Other significant conditions contributing to the death  
but not related to the disease or condition causing it [redacted]  
Approximate interval between onset and death [redacted]

NOTE: IF DEATH IS NOT DUE TO NATURAL CAUSES, THE CORONER SHOULD BE NOTIFIED

10. (a) State how far the answer to the last question  
Is the result of your own observation [redacted]  
(b) If not your own observation, what was the  
Source of your information? [redacted]
11. (a) Has a Post Mortem been carried out? Y  N   
(b) If "YES" state by whom the examination was made [redacted]
12. By whom was the deceased nursed during his or her  
last illness [redacted]  
  
(Give names and say whether professional nurse, Relatives etc. If the illness was a long one this question  
Should be answered with reference to The period of four weeks before the death)  
[redacted]
13. Who were the persons present (if any) at the moment of death? [redacted]

**Medical Certificate Continued**

14. In view of your knowledge of the deceased's habits and constitution, do you feel any doubt whatsoever as to the character of the disease or the cause of death stated in 9, over?

[Blank space for answer]

15. Have you any reason to suspect that the death of the person who has died was violent or unnatural? Y  N

16. Do you have any reason to suspect that the death occurred under or within 24 hours of anaesthetic or medial procedure, or admission to hospital. Y  N

[Blank space for answer]

17. Have you any reason whatever to suppose a further examination of the deceased to be desirable? Y  N

18. Has a coroner been informed or has there been any discussion with the coroner about the death? Y  N

Date and time of enquiry [Blank space]

If yes, please state coroners office that was contacted

[Blank space for coroner's office name]

State the outcome of the discussions

[Blank space for outcome of discussions]

19. (a) Did you sign the Death Notification / Registration Form? Y  N

(b) If No, who has? [Blank space]

20. Has the deceased been fitted with any of the following battery powered and other implants that could cause problems during cremation: **Please indicate either YES Or NO for each device listed (do not leave the box blank).**

- a) Pacemaker Y  N
- b) Implantable Cardioverter Defibrillators (ICDs) Y  N
- c) Cardiac resynchronization therapy devices (CRTDs) Y  N
- d) Implantable loop recorders Y  N
- e) Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices BIVADs Y  N
- f) Implantable drug pumps including intrathecal pumps Y  N
- g) Neurostimulators (including for pain & Functional Electrical Stimulation) Y  N
- h) Bone growth stimulators Y  N
- i) Hydrocephalus programmable shunts Y  N
- j) Fixion nails Y  N
- k) Any other battery powered or pressurised implant Y  N
- l) Radioactive implants Y  N
- l) Radiopharmaceutical treatment (via injection) Y  N

Other prosthesis Y  N

Please state [Blank space]

**If the answer to above is in the affirmative they must be removed**

Please state by whom? [Blank space]

**NOTE: CREMATION MAY BE REFUSED IF CERTAIN PROSTHESIS ARE NOT REMOVED.**