



**DEPARTMENT OF PUBLIC HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA**

NOTIFICATION OF DEATH

Form No. 1

Name: _____ Sex: _____
 Age: _____ Date of Birth: _____
 Place of Birth: _____
 Date of Death: _____

Place of Death: _____
 Cause of Death: _____
 Name of Doctor: _____
 Signature of Doctor: _____

No.	Particulars	Signature of Doctor	Signature of Registrar
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Signature of Registrar: _____
 Date: _____
 Place: _____