

# Medical Statement

I, the undersigner,	
Practising physician Municipal coroner at	

Hereby declare that I have medically attended / examined the body of

Surname and family names	
Date of birth	
Place of birth	
Date of death	
Place of death	

The abovesaid did not die of any contagious disease, but from

Cause of death	
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- Autopsy (examination) has taken place at
- Autopsy has not taken

Signature,