

TO BE FILLED OUT BY ISSUER		
1.DECEDENT'S NAME (First, Middle, Last)	2.SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	3.IDENTIFICATION NUMBER
4.REGISTERED PERMANENT RESIDENCE (number, street, road, town, city, country)		
5a.DATE OF BIRTH (Month, Day, Year)	5b.TIME OF BIRTH (For death within one week after birth) Hour _____ Minutes _____	
6a.DATE OF DEATH (Month, Day, Year)	6b.TIME OF DEATH Hour _____ Minutes _____	
7a.LOCATION OF DEATH (number, street road, town, city, country)	7b.PLACE OF DEATH <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Own Residence <input type="checkbox"/> Others	
8.MANNER OF DEATH <input type="checkbox"/> Natural Death(Natural deaths are due solely or nearly totally to disease and/or the aging process) <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		
9a.KIND OF BUSINESS/INDUSTRY	9b.DECEDENT'S USUAL OCCUPATION	
10.IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year		
11.CAUSE OF DEATH (Enter the diseased, injuries, or complications that caused the death. Do not enter the mode dying, such as heart failure or respiratory arrest.)		Approximate Interval between Onset and Death
PART I.		
IMMEDIATE CAUSE (Final Disease or condition resulting in death)		
a. _____		DUE TO (OR AS A CONSEQUENCE OF) :
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE(Disease or injury that initiated events resulting in death)LAST		
b. _____		DUE TO (OR AS A CONSEQUENCE OF) :
c. _____		
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) :		
Address of Hospital (Clinic) : No.565, Sec.2, Daya Rd.Chiayi City, 600, Taiwan		
Date of Signature (Month, Day, Year) :		