

Municipal Form No. 103
(Revised August 2016)

Republic of the Philippines
OFFICE OF THE CIVIL REGISTRAR GENERAL

CERTIFICATE OF DEATH

(To be accomplished in quadruplicate using black ink)

Province _____		Registry No. _____	
City/Municipality _____			
1. NAME (First) ROBERT (Middle) DUNCAN (Last) PETERSON	2. SEX (Male/Female) MALE		
3. DATE OF DEATH (Day, Month, Year) 16 March 2020	4. DATE OF BIRTH (Day) (Month) (Year) 05 / JANUARY / 1944	5. AGE AT THE TIME OF DEATH (Fill-in below accordg. to age category) a. IF 1 YEAR OR ABOVE [2] Completed years 74 b. IF UNDER 1 YEAR [1] Months [0] Days _____ Hours _____ Mins/Sec _____ c. IF UNDER 24 HOURS _____	
6. PLACE OF DEATH (Name of Hospital/Clinic/Institution/House No., St., Barangay, City/Municipality, Province) EVANG, BIRGY BAGA CAY, TACLOBAN CITY, LEYTE		7. CIVIL STATUS (Single/Married/Widow/ Widower/Annulled/Divorced) DIVORCED	
8. RELIGION/RELIGIOUS SECT Roman Catholic	9. CITIZENSHIP Birgy 110 (LITAW) TACLOBAN CITY	10. RESIDENCE (House No., St., Barangay, City/Municipality, Province, Country)	
11. OCCUPATION Retired teacher	12. NAME OF FATHER (First, Middle, Last) 13. MAIDEN NAME OF MOTHER (First, Middle, Last)		
MEDICAL CERTIFICATE (For ages 0 to 7 days, accomplish items 14-19a at the back)			
19b. CAUSES OF DEATH (If the deceased is aged 8 days and over) Interval Between Onset and Death _____			
I. Immediate cause : a. Brain hemorrhage Antecedent cause : b. increased intracranial pressure Underlying cause : c. intracerebral hemorrhage; left basal ganglia			
II. Other significant conditions contributing to death: _____			
19c. MATERNAL CONDITION (If the deceased is female aged 15-49 years old) a. pregnant, not in labour _____ b. pregnant, in labour _____ c. less than 42 days after delivery _____ d. 42 days to 1 year after delivery _____ e. None of the choices _____			
19d. DEATH BY EXTERNAL CAUSES a. Manner of death (Homicide, Suicide, Accident, Legal intervention, etc.) _____ b. Place of Occurrence of External Cause (e.g. home, farm, factory, street, sea, etc.) _____			
21a. ATTENDANT 1 Private _____ 2 Public _____ 3 Hospital _____ 4 None _____ 5 Others _____ Physician _____ Officer _____ Authority _____ Specify _____		21b. If attended, state duration (mm/dd/yy) From _____ To _____	
20. AUTOPSY (Yes/No) _____			
22. CERTIFICATION OF DEATH <input type="checkbox"/> I hereby certify that the foregoing particulars are correct as near as same can be ascertained and I further certify that I have attended/ <input checked="" type="checkbox"/> have not attended the deceased and that death occurred at 2:00 am/pm on the date of death specified above.			
Signature _____ Name in Print PAUL MICHAEL P. LOAYAGA Title of Position JMD III Address TACLOBAN CITY		REVIEWED BY: Signature Over Printed Name of Health Officer _____ Date _____	
23. CORPSE DISPOSAL (Burial, Cremation, if others, specify) _____		24a. BURIAL/CREMATION PERMIT Number _____ Date Issued _____	
25. NAME AND ADDRESS OF CEMETERY OR CREMATORY _____		24b. TRANSFER PERMIT Number _____ Date Issued _____	
26. CERTIFICATION OF INFORMANT I hereby certify that all information supplied are true and correct to my own knowledge and belief.			
Signature _____ Name in Print _____ Relationship to the Deceased _____ Address _____ Date _____		27. PREPARED BY Signature _____ Name in Print Wesley Keith G. Belizar, RN Title or Position DT Date 3/16/20	
28. RECEIVED BY Signature _____ Name in Print _____ Title or Position _____ Date _____			
29. REGISTERED AT THE OFFICE OF THE CIVIL REGISTRAR Signature _____ Name in Print _____ Title or Position _____ Date _____			
REMARKS/ANNOTATIONS (For LCRO/CRG Use Only)			