

APPLICATION FOR CREMATION

FORM A

1. (Name of Applicant)
 Address
 Occupation

apply to the States of Guernsey to undertake the Cremation of the remains of:—

Name of Deceased
 Address
 Occupation
 Age sex whether married, widow, widower or unmarried

The true answers to the questions set out below are as follows:—

1. Are you an executor or the nearest surviving relative of the deceased?	
2. If not, state (a) Your relationship to the deceased. (b) The reason why the application is made by you and not by an executor or any nearer relative.	(a) (b)
3. Did the deceased leave any written directions as to the mode of disposal of his or her remains? If so, what?	
4. Have the near relatives of the deceased been informed of the proposed cremation?	
5. Has any near relative of the deceased expressed any objection to the proposed cremation? If so, on what ground?	
6. What was the date and hour of the death of the deceased?	
7. What was the place where the deceased died? (Give address and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)	
8. Do you know or have you any reason to suspect that the death of the deceased was due, directly or indirectly, to (a) violence; (b) poison; (c) privation or neglect?	
9. Do you know any reason whatever for supposing that an examination of the remains of the deceased may be desirable?	
10. Give name and address of the ordinary medical attendant of the deceased.	
11. Give names and addresses of the medical practitioners who attended deceased during his or her last illness.	

I declare that to the best of my knowledge and belief the information given in this application is correct and no material particular has been omitted.

Date (Signature)

The applicant is known to me and I have no reason to doubt the truth of any of the information furnished by the applicant.

Date (Signature)

(Capacity in which signatory has signed)

Address

MEDICAL CERTIFICATE

Certificate of Medical Attendant

I am Informed that application is about to be made for the cremation of the remains of:—

Name of Deceased

Address

Occupation

Having attended the Deceased before death, and **seen and identified the body after death**, I give the following answers to the questions set out below:—

1. On what date, and at what hour, did he or she die?	
2. What was the place where the deceased died? <i>(Give address and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)</i>	
3. Are you a relative of the deceased? If so, state the relationship.	
4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased?	
5. Were you the ordinary medical attendant of the deceased? If so, for how long?	
6. Did you attend the deceased during his or her last illness? If so, for how long?	
7. When did you last see the deceased alive? <i>(Say how many days or hours before death.)</i>	
8. How soon after death did you see the body, and what examination of it did you make?	
9. What was the cause of death? <i>(Specify the disease, injury, &c. and if possible distinguish the primary from the secondary cause as in death certificate.)</i>	Primary Secondary
Was there any other cause which contributed to or accelerated death? If so, state it, and if more than one other cause, state them all.	
What was its duration in years, months or days?	
10. What was the mode of death? <i>(Say whether, syncope, coma, exhaustion, convulsions, etc.)</i>	
What was its duration in days, hours, or minutes?	
11. State how far the answers to the last two questions are the results of your own observations, or are based on statements made by others. If on statements made by others, say by whom.	
12. Did the deceased undergo any operation during the final illness or within a year before death? If so, what was its nature and who performed it?	
13. By whom was the deceased nursed during his or her last illness? <i>(Give names, and say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before the death.)</i>	
14. Who were the persons (if any) present at the moment of death?	
15. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death?	

16. Do you know, or have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to (a) violence; (b) poison; (c) privation or neglect?	
17. Have you any reason whatever to suppose a further examination of the body to be desirable?	
18. Have you given the certificate required for registration of death?	

IMPORTANT: Pacemakers can cause an explosion if left in a body which is cremated.

Radio-active implants are a health hazard.

Please answer the following questions:

- (i) Has the deceased been fitted with
- | | | |
|--|--------------------------------------|--------|
| | (a) a cardiac pacemaker? | YES/NO |
| | (b) a radio-active or other implant? | YES/NO |
- (ii) If the answer to (a) or (b) above is in the affirmative:
Has this been removed: YES/NO

NOTE: CREMATION MAY BE REFUSED IF A PACEMAKER IS NOT REMOVED

I Hereby Certify that the answers given above are true and accurate to the best of my knowledge and belief; that there is no circumstance known to me which can give rise to any suspicion that the death was due wholly or in part to any other cause than ^{Disease} _{Accident} and that there is no circumstance of any sort known to me which makes it undesirable that the body should be cremated.

Signature Registered Qualifications

Address Date

FORM C

NAME IN BLOCK LETTERS

Confirmatory Medical Certificate

I, being a medical practitioner of not less than five years standing and authorised to practise in this Island, and being neither a relative of the deceased, nor a relative or partner of the medical practitioner who has given the foregoing medical certificate, have examined it and have made personal inquiry as stated in my answers to the questions below: —

1. Have you seen the body of the deceased?	
2. Have you carefully examined the body externally?	
3. Have you made a post mortem examination?	
4. Have you seen and questioned the medical practitioner who gave the above Certificate?	
5. Have you seen and questioned any other medical practitioner who attended the deceased? <i>(Give names and addresses of persons seen and say whether you saw them alone.)</i>	
6. Have you seen and questioned any person who nursed the deceased during his last illness, or who was present at the death? <i>(Give names and addresses of persons seen and say whether you saw them alone.)</i>	
7. Have you seen and questioned any of the relatives of the deceased? <i>(Give names and addresses of persons seen and say whether you saw them alone.)</i>	
8. Have you seen and questioned any other person? <i>(Give names and addresses of persons seen and say whether you saw them alone.)</i>	

I am satisfied that the cause of death was
and I certify that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or died in such place or circumstances as to require an inquest.

NAME IN BLOCK LETTERS

Signature

Address

Date Registered Qualifications

Office

FORM F

AUTHORITY TO CREMATE

WHEREAS application has been made for the cremation of the remains of:—

Name

Address

Occupation

AND WHEREAS I have satisfied myself that all requirements of the Law relating to Cremation (1928) and of the Ordinance made in pursuance of that Law, have been complied with, that the cause of death has been definitely ascertained, and that there exists no reason for any further inquiry or examination; I hereby authorise the Superintendent of the Crematorium at Guernsey to cremate the said remains.

Signature

H.M. Procureur or H.M. Comptroller.

Date