Proofs of Death
Physician's Statement

American Life Insurance Company
WILMINGTON, DELAWARE, U.S.A., INCORPORATED 1921

GULF OPERATIONS
P.O. Box 371916, Dubai, United Arab Emirates

- All answer must be in Physician's handwriting.
- Please complete all relevant information Completely and Legibly.

1. a) Deceased's Full Name

b) Residence at death

c) Age at death **d) Date of death** D D M M Y Y Y Y **e) Place of death**

f) If died in hospital or institution, please provide name

2. Cause of death (enter only one cause for each of a,b, and c)

Disease or condition directly leading to death

(a)

Due to (b)

Due to (c)

Interval between onset and death

a)

b)

c)

3. Date of first attendance in last illness D D M M Y Y Y Y **4. Date of last attendance in last illness** D D M M Y Y Y Y

5. If death was due to suicide, homicide or accident, specify which. Describe briefly

	Yes	No
6. (a) Was an inquest held?	☐	☐
(b) Was an autopsy performed?	☐	☐
(c) If so, by whom and with what findings?		
7. (a) Were there any identification marks on the body?	☐	☐
(b) If "Yes" give particulars		
8. (a) Have you treated or advised the deceased, prior to last illness?	☐	☐
(b) Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution?	☐	☐

If yes to either question, please furnish the following

Name	Duration	Nature of illness or injury	Date
			D D M M Y Y Y Y
			D D M M Y Y Y Y
			D D M M Y Y Y Y

These statements are true and complete to the best of my knowledge and belief.

Name of Physician

Address of Physician

Signature and Stamp M.D. Date D D M M Y Y Y Y

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