MINISTRY OF HEALTH

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(MCCOD) 0049158

I hereby certify that I have medically attended to GIDEON FUSEINI AZURE

of SUMADURI, that I last saw on 10/09/2023 (DD/MM/YY)

Administrative Data				
Folder No.		COD Certificate No.	Facility code	
			SN	D
Sex	☐ Female	☒ Male	☐ Unknown	
Date of birth	D 1 0 1 0 1 9 7 2	Date of death	1 0 0 9 2 0 2 3	
Estimated age (ONLY if Date of birth is unknown)				
Occupation:				

***Frame A*: Medical data: Part 1 and 2**

1 Report disease or condition directly leading to death on line a Report chain of events in due order (if applicable) State the underlying cause on the lowest used line		Cause of death	Time interval from onset of death	Tick underlying cause of death
	a	Respiratory failure		☐
	b	Due to:		☐
	c	Intra hepatic		☐
	d	Cholangiocarcinoma		☐
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)				

***Frame B*: Other medical data**

Was **surgery** performed within the last 4 weeks?	☐ Yes	☐ Yes	☐ Unknown
If yes please specify date of surgery			
If yes please specify reason for surgery (disease or condition)			
Was an autopsy requested?	☐ Yes	☐ Yes	☐ Unknown
If yes were the findings used in the certification?	☐ Yes	☐ Yes	☐ Unknown

Manner of death:

☒ Disease	☐ Assault	☐ Could not be determined
☐ Accident	☐ Legal intervention	☐ Pending investigation
☐ Intentional self harm	☐ War	☐ Unknown
If external cause or poisoning:	Date of injury	D D M M Y Y Y Y

Please describe how external cause occurred (If poisoning please specify poisoning agent)

Place of occurrence of the external cause:

☐ At home	☐ Residential institution	☐ School, other institution, public administrative area	☐ Sports and athletics area
☐ Street and highway	☐ Trade and service area	☐ Industrial and construction area	☐ Farm
☐ Other place (please specify):			☐ Unknown

Foetal or infant Death

Multiple pregnancy	☐ **Yes**	☐ **No**	☐ **Unknown**
Stillborn?	☐ **Yes**	☐ **No**	☐ **Unknown**
If death within 24h specify number of hours survived		Birth weight (in grams)	
Number of completed weeks of pregnancy		Age of mother (years)	
If death was perinatal, please state conditions of mother that affected the fetus and newborn			

Could not be determined	☐ Yes	☐ No	☐ Unknown
☐ At time of death	☐ Within 42 days before the death		
☐ Between 43 days up to 1 year before death	☐ Unknown		
☐ At time of death	☐ Yes	☐ No	☐ Unknown

Issued to (Full name) AZURE ISSIFU ISAAC

Contact details ______ Mobile 0246456055

Relation to deceased BROTHER

Type of ID (ONLY nationally recognised ID) GHANA CARD ID number GHA-715360920-3

Witness by my hand this day 0 4 1 0 2 0 2 3

Name of Officer DR. SHAIBU YAKUBU AKUTINGA

Medical Qualification: SNR MEDICAL OFFICER

Address ______ Signature:

MEDICAL FORM L SECTION 30 .TO BE CAPTURED IN DHIMS2 WITHIN 5 DAYS OF ISSUING

THIS IS NOT A DEATH CERTIFICATE .YOU ARE TO PRESENT THIS TO BDR FOR DEATH REGISTRATION.

Bangyuri's Family Cemetery