EMPLOYEES' STATE INSURANCE CORPORATION

(In Duplicate)* **REG. FORM -13**

DEATH CERTIFICATE

(For Dependant's Benefit or Funeral Expenses)

(Regulations 79 & 95C)

Book No. . . . . Stamp of Dispensary Sl. No. . . . .

Name of the deceased Insured Person . . . . s/w/d of . . . .
. . . . Insurance No. . . . .

I certify that in my opinion the above named deceased Insured Person died on the . . . . day of . . . . as a result of an injury/ due to* . . . . I **had been attending him/her for providing medical benefit before his/her death and I attended him/her for the last time on the . . . . day of . . . .

Signature . . . .
Insurance Medical Officer/ I.M.P.
Name in block letters and rubber stamp

Any other remarks by the Medical Officer }

Dated: . . . .

*Please indicate the name of the disease.

**May be suitably amended if the Insurance Medical Officer/ I.M.P. has not attended the deceased person before his/her death.