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Enhancing Mortality Data Through Integrating Verbal Autopsy into the Civil Registration System in Tamil Nadu, India

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Speaker biography

Dr. Abishek S is the State Nosologist with the Department of Health and Family Welfare, Government of Tamil Nadu, India. His work focuses on strengthening Civil Registration and Vital Statistics (CRVS) systems, particularly improving the cause-of-death certification and mortality data for state to have better public health planning. He is actively involved in initiatives to enhance the cause of death information of the state in collaboration with various organizations.

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Abstract

Background:

Accurate cause of death information is essential for health policy and planning. In India, the Civil Registration System (CRS) is mandated to register all deaths, of which most occur at home without medical attention and remain uncertified. In 2022, only 22% of registered deaths nationally and 45% in Tamil Nadu had a Medical Certificate of Cause of Death (MCCD). To address this, the Government of Tamil Nadu piloted the integration of World Health Organization (WHO)-recommended Verbal Autopsy (VA) methods into CRS workflows to strengthen cause of death attribution for home deaths.

Objectives:

The initiative aimed to improve completeness and reliability of cause of death data by embedding VA within CRS. Specific objectives were to adapt WHO VA tools to the local context, train health inspectors & physicians to conduct and certify VA and establish sustainable mechanisms to capture causes of home deaths alongside institutional MCCD data.

Work performed:

The pilot was implemented by government staff with public health regulations in 2023 across two districts, —Krishnagiri and Karur, with technical support from national research institutions and WHO. The districts were selected to represent distinct demographic, health service, and geographic profiles of Tamil Nadu. WHO VA tools were translated into Tamil and field-tested.

Data on deaths lacking medical certification and permanent residence were obtained from CRS and other available databases for the year 2023, then mapped to Primary Health Centres (PHC). A total of 15,744 deaths were reviewed through 98 primary health centres (PHCs). A multi-tiered cascade model of training was employed to build institutional capacity. Trained health inspectors conducted VA interviews using tablets with preloaded WHO VA 2022 questionnaires. Medical officers then reviewed cases through a physician-certified verbal autopsy (PCVA) portal, supported by master trainers with regular supervision. Health inspectors were trained on interview techniques, digital data entry, and ethics, and informed to complete three to four cases per week. Medical officers received intensive PCVA and ICD-10 training followed by the task of ascertaining cause of death. The PCVA portal incorporated real-time dashboards, flexible case views, and automated validation checks, allowing supervisors to monitor data quality continuously. A rigorous multi-level monitoring and supervision mechanism was established.

Results:

Integration of VA into CRS significantly improved mortality data quality and increased data completeness from 42% to 98% in Karur and 27% to 98% in Krishnagiri. Ill-defined causes of death

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declined from around 53% to 8% in Karur and 60% to 15% in Krishnagiri. The PCVA system streamlined workflows, enabled consistent certification, and supported rapid, evidence-based validation of causes. Routine internal and external supervision with structured feedback enhanced interview quality, translations, and portal usability.

Conclusions

The Tamil Nadu VA–CRS pilot demonstrated that Verbal Autopsy can be feasibly institutionalized within the CRS framework. The integration of multi-tiered capacity building by various methods, digital innovation, intensive supervision and quality metrics provided measurable improvements in efficiency and data accuracy. District selection diversity supported model testing across different contexts, enhancing replicability. The initiative presents a scalable model for strengthening mortality surveillance and guiding evidence-based policy.

Keywords: Verbal Autopsy ; Civil Registration; Mortality Surveillance; Data Quality Evaluation; India

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Introduction

Reliable and timely information on causes of death remains a cornerstone for effective public health planning and policy formulation. Mortality data disaggregated by age, sex, and cause of death serve as critical input for monitoring disease trends, prioritizing health programs, allocating resources, and assessing the impact of interventions. Availability of district-level mortality data enables more effective allocation and utilization of health system resources, thereby helping to reduce preventable deaths and improve population health at the local level(1). Recognizing the importance of such localized data, The Office of the Registrar General of India (ORGI) has promoted the generation of vital statistics sub nationally by publishing annual Reports on Vital Statistics of India Based on the Civil Registration System, which compile disaggregated data on registered births, deaths, and other demographic indicators to support decentralized health planning and evaluation(2).

In the Civil Registration System (CRS) of India, the documentation of deaths involves two distinct but complementary processes: death registration by Form 2 and medical certification of cause of death (MCCD) by Form 4 or 4A. Form 2 - the Death Report, is completed for all deaths, irrespective of where or how they occur. It captures essential demographic information, the date and place of death, and a lay description of the cause of death as reported by the household informant. In contrast, Form 4 for institutional deaths and 4A for non-institutional deaths is completed by a registered medical practitioner who attended the death during the last illness of the patient. It documents the sequence of morbid events leading to death in accordance with WHO **International Classification of Disease** (ICD) guidelines, listing the immediate, antecedent, underlying, and contributory causes. However, despite being implemented since 2000 in the country, significant gaps persist in cause of death certification. Only 24% of registered deaths nationally were medically certified in 2022(3). In Tamil Nadu where the CRS system is stronger, 45% of registered deaths were medically certified (4). The gap of accurate cause of death information leads to difficulty in understanding the true burden of disease, and health systems risk investing in the wrong priorities. This challenge is especially acute in low- and middle-income countries (LMICs), where vital registration systems often lack full coverage and completeness. The deficit primarily arises from the fact that 77% of the deaths occur at home of which 29% occur outside medical supervision where no attending physician is present to issue a MCCD in the state (5). Consequently, deaths without MCCD are often registered with ill-defined or unspecified causes, undermining the reliability of mortality data.

Tamil Nadu, with its strong administrative framework and nearly universal death registration, recognized this persistent limitation. The state comprises 16,391 vital event registration units serving a population of approximately 76 million (5). The registration units in rural areas account for more than half of total registered deaths, of which less than 5% have MCCD as per 2020

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data from Tamil Nadu (5). This disparity between registration and certification necessitated an innovative approach to bridge the gap in mortality surveillance. The World Health Organization (WHO) has advocated for the use of Verbal Autopsy (VA) as a method to ascertain probable causes of death when no medical record or physician certification is available (6). The VA approach involves structured interviews with relatives or caregivers of the deceased to obtain information on symptoms and circumstances preceding death. This information is then interpreted by trained physicians or automated algorithms to assign the most probable cause of death based on ICD-10 coding (6).

To improve the completeness and quality of mortality data, the Government of Tamil Nadu initiated an ambitious pilot project to integrate VA methodology adapted from the WHO into the routine operations of the CRS. This initiative, implemented by the Directorate of Public Health and Preventive Medicine (DPH&PM) and supported by WHO, Indian Council of Medical Research–National Institute of Epidemiology (ICMR-NIE), and Madras Medical College (MMC), represented the first systematic attempt in India to embed VA processes directly into a government-run registration system. The project received legal approval under Government Order G.O.(D). No.1368.

The initiative aimed to generate reliable cause-specific mortality data at the district level by adapting WHO VA tools to the Tamil Nadu context, training health inspectors as interviewers to collect and medical officers to certify VA data. The aim was to create a sustainable framework for the routine integration of home-death causes with institutional MCCD data. The design was implemented entirely by government staff, supported by government orders from the state, to evaluate feasibility, efficiency, and quality improvement outcomes.

Work performed:

In Tamil Nadu, Form 2 is received manually by the registrar from the relatives of the deceased. Information is then entered into the online CRS software followed by MCCD which is linked to the corresponding Form 2 record in CRS software. A death certificate is issued only after these steps are completed. For institutions the Form 2 and Form 4 is mandatory while for home deaths, registration units verify events, and medical certificates (Form 4A) are added when available for providing death certificate. Medicolegal deaths are handled through police investigation and forensic confirmation before registration. These processes ensure that the CRS database captures all deaths statewide, though uncertified home deaths rely only on lay-reported causes. Figure 1 illustrates the existing system and planned intervention.

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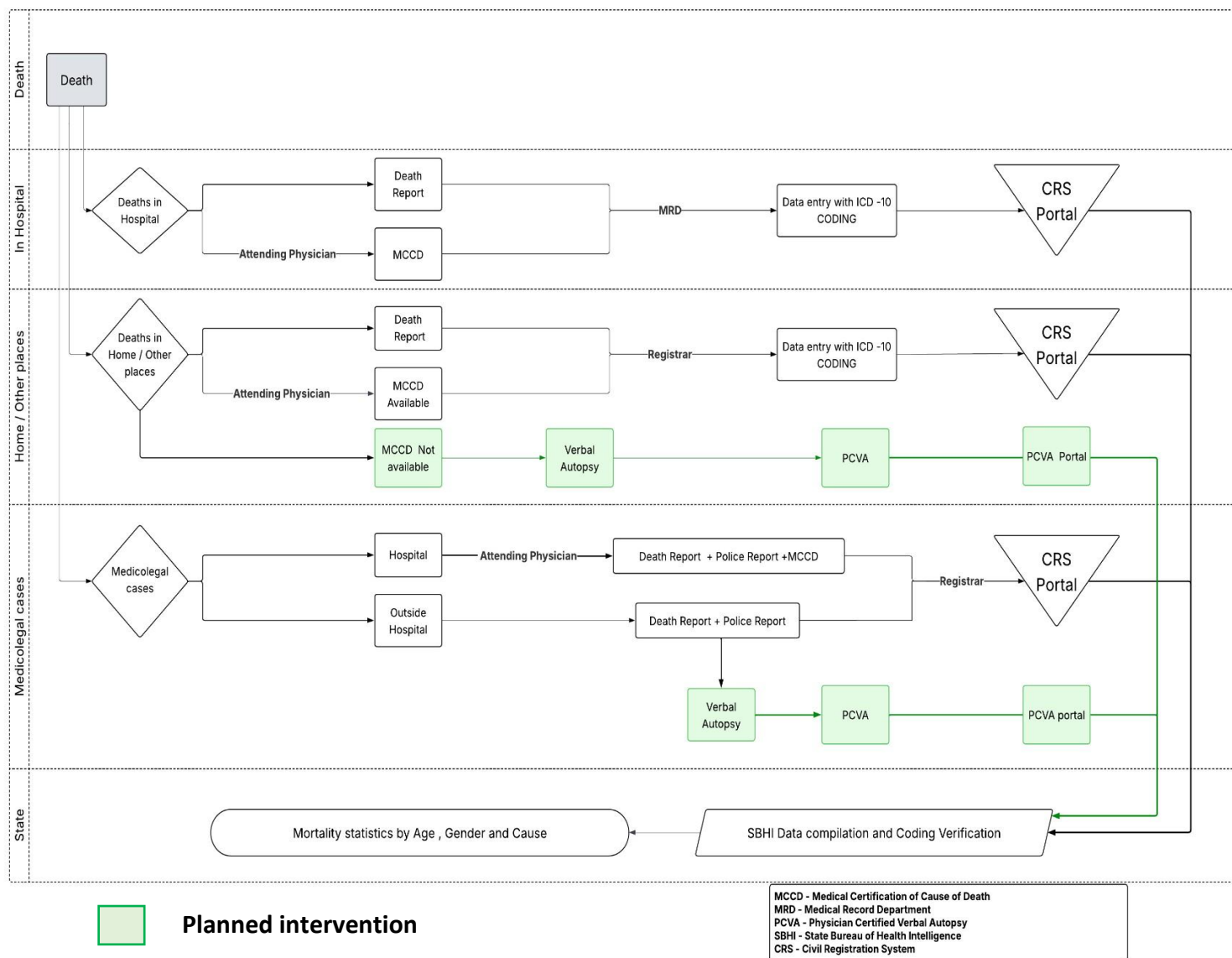


Figure 1: Processes for death recording and data flow of information in the Tamil Nadu Civil Registration System

A small pre-pilot was first conducted in four blocks of Krishnagiri, a district in the northwestern part of Tamil Nadu, selected to represent a variety of geographic and demographic contexts. This pre-pilot included 100 deaths registered in CRS portal without MCCD and tested the operational feasibility of conducting VA interviews using WHO tools translated into Tamil. Feedback from this exercise informed refinements to the interview protocols, data capture methods, and supervision structures. Based on these lessons, the full-scale pilot was conducted in Krishnagiri and Karur districts in Tamil Nadu throughout 2023, representing a rural-hilly and semi-urban district respectively. These districts provided an ideal testing ground to evaluate whether the integration of VA within CRS could

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function effectively across varying health system capacities and community settings. The cause of death from Form 2, based on household lay reporting, was coded and named as CRS data. The MCCD coded data was taken for deaths with MCCD and merged with cause of death data from Form 2 and named as baseline data for comparison as a part of evaluation. This data was saved in CRS database.

The intervention covered all registered deaths from CRS and a certain number of unregistered deaths from the maternal and infant deaths database during the calendar year 2023 who had their residence in Krishnagiri and Karur districts. Deaths without medical certification were extracted from the CRS database and mapped to corresponding primary health centres (PHCs) based on the permanent address of the deceased by district. The maternal death and infant death database, which is not linked to CRS, was used to identify unregistered deaths, and those found were also mapped. Health Inspectors were connected with eligible respondents through Village Health Nurses (VHN) and conducted household interviews using WHO 2022 VA questionnaires, translated into local language and refined through pre-testing. Data were collected electronically using tablets with Open Data Kita (ODK) software. Each Health Inspector was expected to complete three to four interviews per week. ODK data were transmitted to the central server and accessed by PHC Medical Officers via the Physician Certified Verbal Autopsy (PCVA) portal for physician certification (Figure 2).

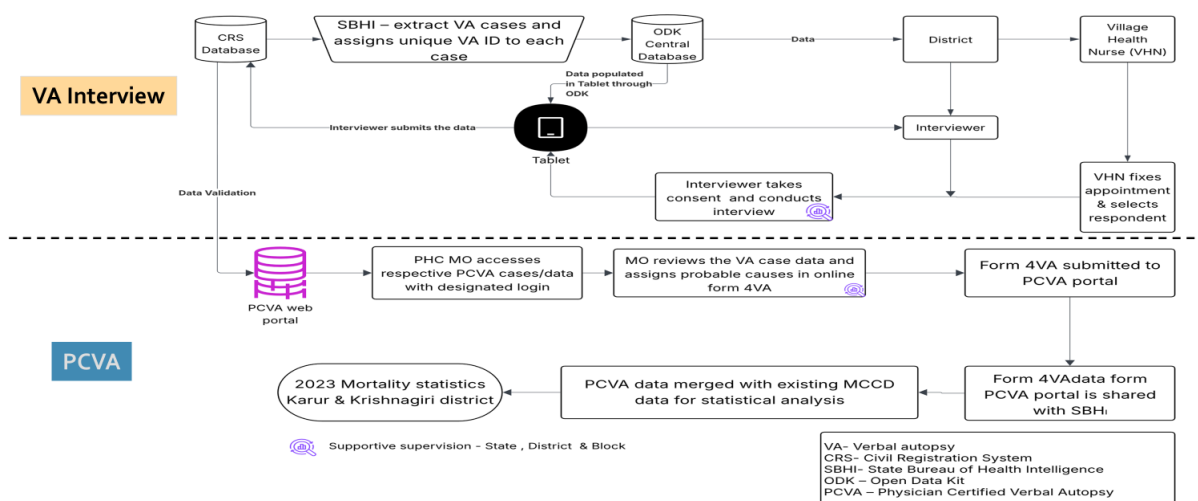


Figure 2: Process followed for VA case identification, field VA data collection and supervision, VA data submission, physician review of VA data for assigning causes of death and for data submission

The PCVA portal was developed with financial and technical support from the WHO and managed through a third-party software development team. The portal was designed to facilitate secure data flow between health inspectors/ sanitary inspectors and medical officers, with built-in mechanisms for real-time data monitoring and quality control. It provided dashboards displaying completion rates, case progress, and error logs, and allowed flexible viewing of case histories by

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symptom section or positive responses. Physicians could easily navigate between open narratives and structured data, improving diagnostic accuracy. The system automatically flagged incomplete or inconsistent data and generated analytical reports for district and state-level monitoring. Complex or ambiguous cases were referred to 131 master trainers for adjudication. Data collection began in October 2023, while physician review activities commenced in August 2024.

A rigorous multi-level monitoring mechanism was established. Supervision occurred internally through state officials, district-level officers & block level officers and externally through WHO, ICM-MMC and ICMR–NIE field teams. The Operational Network for Quality Assurance in Verbal Autopsy (ONQAT) tool was deployed for periodic quality audits, assessing data completeness, logical consistency, and timeliness. Weekly review meetings were held to track performance indicators, address technical issues, and review field experiences.

Qualitative data collection was integrated into the study to assess operational feasibility and capture insights from stakeholders. Structured interviews and focus group discussions were conducted with Health Inspectors, Medical Officers, and district officials to document challenges, perceptions, and process improvements. This qualitative feedback informed iterative refinements to the VA instruments, training curriculum, and supervision processes.

A multi-tiered cascade model of training was employed to build institutional capacity. Training was provided to master trainers, which included one medical officer from each block of both districts, faculty from local medical colleges, regional training institutes, officials from district and state headquarters office and doctors from external agencies WHO, ICMR-NIE and MMC. These trainers in turn were used to train health inspectors, sanitary inspectors and medical officers. Training sessions were standardized to three days, combining lectures, demonstrations, and role-playing exercises. The sessions focused on communication skills, interview techniques, digital data entry using (ODK) software, and ethical engagement with bereaved families. Medical officers were trained in ICD-10 coding, data interpretation, and use of the digital PCVA portal. Sensitization sessions were also organized for (VHN), Sector Health Nurses (SHN), and Village Administrative Officers (VAO) to support field-level implementation and community engagement.

Results

A total of 80 master trainers were trained for VA and 51 for PCVA (physician-certified verbal autopsy) to conduct training sessions and supervise the activity in their areas. At the district level, 87 health inspectors in Karur and 155 in Krishnagiri were trained as VA interviewers, while 44 medical officers in Karur and 66 in Krishnagiri were trained to perform physician certification. For the PCVA master trainers provided to medical officers, a specific pre-test and post-test evaluation comprising 12 questions (total 20 marks) was conducted. Among 47 participants (4 of whom joined

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late), the mean pre-test score was 11.8/20, while the mean post-test score increased to 16.17/20, a statistically significant improvement.

Table 1 presents an overview of the results from the cause of death investigation conducted in this study. In 2023, a total of 24,145 deaths occurred across Karur (10,094) and Krishnagiri (14,051) districts. Among these, 7,960 deaths (33%) were medically certified, while 16,185 deaths (67%) lacked medical certification. VA was successfully conducted for 15,744 deaths, covering nearly all uncertified cases. Only 39 respondents refused participation, and 403 cases could not be traced. Following the integration of MCCD and VA data, cause of death was available for 98% of all registered deaths in both districts—9,904 in Karur and 13,807 in Krishnagiri.

Table 1: Overview of results from field data collection

Variables	Karur	Krishnagiri	Total
Total deaths	10094	14051	24145
Deaths with MCCDs	4107(42%)	3852(27%)	7960(33%)
Deaths without MCCD (including unregistered deaths)	5987 (58%)	10199(73%)	16185(67%)
Cause of death ascertained by VA (% of those w/o MCCD)	5797(97%)	9947(98%)	15744(97%)
Respondent refused participation	8(0.1%)	31(0.3%)	39(0.2%)
Not traceable	182(3%)	221(2%)	403(3%)
Final Cause of death availability (MCCD & VA)	9904(98%)	13807(98%)	23742(98%)

Figure 3 illustrates trends in data quality across different stages of data collection and processing of cause of death data from Krishnagiri and Karur. The CRS data showed that around 60% of deaths were coded as non-specific. Merging the (MCCD) data (named as baseline in the figure) slightly reduced this proportion. A substantial improvement occurred after integrating PCVA results, which lowered non-specific causes to 26% in Krishnagiri and 21% in Karur. Further data validation identified 15% invalid ICD-10 codes in Krishnagiri and 8% in Karur, which were corrected using WHO mortality coding rules. Additional field verification for ill-defined cardiovascular and injury deaths produced the final validated dataset used for cause-specific mortality analysis.

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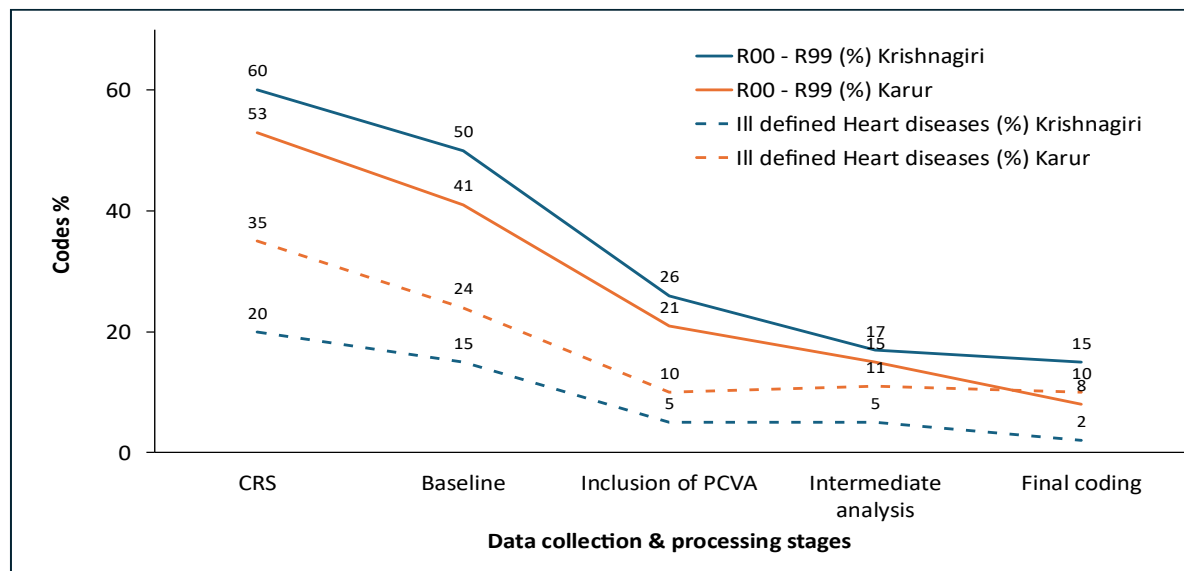


Figure 3: Trends in data quality across different stages of data collection and processing of cause of death data from Krishnagiri and Karur

Qualitative findings through focussed group discussion was received. Interviewers, doctors ascertaining cause of death and district second level officers from both the intervention districts participated separately in the Focussed group discussion and provided their views on the entire process and their feedback were collated. revealed strong ownership and motivation among field staff. Health Inspectors appreciated the structured training and found role-play exercises particularly helpful in navigating sensitive interviews with grieving families. The digital tools were seen as user-friendly and efficient, reducing paperwork and delays. The PCVA digital platform proved instrumental in improving data management. Its dashboards enabled real-time monitoring of interview completion rates, physician workloads, and data quality indicators. Automated checks for missing data and inconsistent coding minimized manual errors and improved timeliness of certification. Medical Officers reported increased confidence in assigning causes of death and improved understanding of ICD-10 coding principles. District-level officials also noted that the VA process had secondary benefits: it strengthened Health Inspectors' participation in death registration and increased Medical Officers' awareness of local disease burdens.

At the same time, several operational challenges were identified. Locating respondents in remote areas was sometimes difficult, particularly when addresses were incomplete. At the PHC level, constraints included limited medical records available with respondents, difficulty cross-referencing with hospital data, and time pressures on physicians managing routine workloads. The sheer volume of ICD codes posed occasional difficulties for consistent assignment. District-level

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officials emphasized the need for more manpower, simultaneous initiation of VA and PCVA, and regular refresher training to sustain quality.

Discussion:

The Tamil Nadu VA–CRS integration pilot offers a pioneering model for strengthening mortality statistics through institutional innovation. By embedding VA within the official registration system, Tamil Nadu demonstrated that government-owned civil registration and vital statistics (CRVS) systems can effectively generate reliable cause of death data without reliance on external parallel mechanisms.

The results show significant improvements in data completeness and quality, far exceeding pre-pilot benchmarks. The availability of cause of death information improved from 42% in Karur and 27% in Krishnagiri to 98% in both districts. Ill-defined causes also reduced from approximately 60% to below 15%. The increased quantity and quality of cause of death data align with WHO-recommended standards for high-quality mortality data (7). Such enhancement reflects the combined effect of systematic training, strong supervision, and the integration of digital platforms for data collection and review. Similar patterns of improvement have been observed in other low- and middle-income settings where VA has been institutionalized within national CRVS systems (8)(9)(10).

A key innovation in this pilot was the PCVA portal, which streamlined data management and physician review through a centralized, digital platform. The PCVA system enabled real-time monitoring, facilitated consistency in coding, and improved accountability. Digital dashboards supported multi-level supervision and feedback loops, aligning with global best practices in CRVS digitization (11)(12). Importantly, the portal's adaptability—such as allowing physicians to view cases in customized formats—enhanced usability and reduced cognitive load during certification.

The cascade model of training not only equipped staff with technical skills but also fostered a sense of professional ownership. The same module was subsequently rolled out to all medical officers at district level trainings. Continuous supervision and refresher sessions created a sustainable framework for skill retention and quality assurance. These findings reinforce evidence from prior CRVS strengthening programs that emphasize workforce capacity as the primary determinant of system sustainability (13).

The inclusion of two demographically distinct districts—Krishnagiri and Karur—enhanced the generalizability of findings. The success in both a hilly, rural region and a semi-urban district shows that the model is adaptable to varied contexts. Similar cross-context validation approaches have been recommended in CRVS system-strengthening literature to ensure replicability and context sensitivity (14)(15). Furthermore, the project demonstrated that when verbal autopsy is institutionalized as a government function rather than an external research exercise, its sustainability and scalability

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increase substantially. Nevertheless, challenges remain. Staff turnover, high workloads, and occasional data quality issues highlight the need for continuous supervision and refresher training. Public awareness campaigns could also improve cooperation during interviews. Ensuring integration with other health information systems, such as hospital records, could further enhance data utility and reduce duplication.

The Tamil Nadu experience contributes valuable evidence to the global discourse on CRVS strengthening. It highlights that digital integration, systematic training, and strong administrative stewardship can transform routine civil registration systems into robust platforms for mortality intelligence. Several recommendations emerged from the field. It was proposed that unnatural deaths with police reports or post-mortem documentation be excluded from the VA load to reduce case burden. Interviewers suggested that VAs be conducted within 21 days of death to minimize recall bias. Refresher training sessions, provision of skeletal templates for open narratives, and additional instruction in ICD-10 coding were recommended.

Enhancements to the PCVA portal were also proposed. Users advocated for a Tamil-language interface to improve accessibility, an option to edit Form 4VA entries once submitted, and the inclusion of garbage-code distributions on dashboards for quality monitoring.

Conclusion & Recommendations:

The Tamil Nadu VA–CRS integration pilot demonstrates that embedding verbal autopsy within an existing civil registration system is both operationally feasible and administratively sustainable. By combining digital tools, systematic training, and strong government stewardship, the project achieved near-complete cause of death ascertainment across two demographically distinct districts within a single year—an outcome rarely achieved in routine CRVS settings. The initiative not only improved the completeness and quality of mortality data but also strengthened institutional capacity and created an enabling environment for high-quality public health surveillance. Field experiences highlighted opportunities for refinement, including adjustments to workload, earlier timing of interviews, enhanced training, and user-driven improvements to the PCVA portal. Scaling this model across Tamil Nadu, and ultimately to other Indian states, has the potential to substantially improve the accuracy and utility of India’s mortality statistics. Continued investment in digital innovation, workforce development, and public engagement will be essential for sustaining data quality and supporting national and global health monitoring, including progress toward the Sustainable Development Goals.

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Annexures:

Form 2

FORM NO. 2 (See Rule 5)		
Form No.2 Death Report Legal Information This part to be added to the Death Register	Form No.2 This part to be detached and sent for statistical processing Death Report (Statistical Information)	Form No.2
To be filled by the informant 1. Date of Death: _____ (Enter the exact day, month and year the death took place) (e.g.1.1.2000) 2. Name of the Deceased: _____ (Full name as usually written) UID No of deceased (if any) _____ 3. Sex of the deceased: _____ Male/Female/Transgender (do not use abbreviation) 4. Name of the Mother: _____ UID No of mother (if any) _____ 5. Name of the Father: _____ UID No of Father (if any) _____ 5.a. Name of Husband/Wife: _____ (Full name as usually written) UID No of Husband/Wife (if any) _____ 5.b. Age of Husband/Wife : _____ 5.c. Contact details of Husband/Wife : _____ 6. Age of the deceased: _____ (If the deceased was over 1 year of age, give age in completed years. If the deceased was below 1 year of age, give age in months, and if below 1 month give age in completed number of days, and if below one day, in hours) 7. Address of the deceased at the time of death: _____ 8. Permanent address of the deceased: _____ 9. Place of death: _____ (Tick the appropriate entry 1,2, or 3 below and give the name of the Hospital / Institution or the address of the house where the death took place. If other place, give location) 1. Hospital / Institution Name: _____ & Address : _____ 2. House Address: _____ 3. Other place _____ 10. Informant's name: _____ Address: _____ (After completing all columns 1 to 21, informant will put date and signature here:) Date: _____ Signature or left thumb mark of the informant	To be filled by the informant 11. Town or Village of Residence of the deceased: _____ (Place where the deceased actually lived. This can be different from the place where the death occurred. The house address is not required to be entered.) a) Name of Town / Village: _____ b) Is it a town or village: _____ (Tick the appropriate entry below) 1. Town 2. Village c) Name of District: _____ d) Name of State: _____ 12. Religion: (Tick the appropriate entry below) 1. Hindu 2. Muslim 3. Christian 4. Any other religion: (Write the name of the religion) 13. Occupation of the deceased: _____ (If no occupation write 'Nil') 14. Type of medical attention received before death: _____ (Tick the appropriate entry below) 1. Institutional 2. Medical attention other than institution 3. No Medical attention	To be filled by the informant 15. Was the cause of death medically certified? (Tick the appropriate entry below) 1. Yes 2. No 16. Name of Deceased or Actual Cause of Death: (for all deaths irrespective of whether medically certified or not) 17. In case this is a female death, did the death occur while pregnant, at the time of delivery or within 6 weeks after the end of pregnancy: (Tick the appropriate entry below) 1. Yes 2. No. 18. If used to habitually smoke – for how many years? 19. If used to habitually chew tobacco in any form – For how many years? 20. If used to habitually chew arecanut in any form (including pan masala)- for how many years? 21. If used to habitually drink alcohol- for how many years? (Column to be filled are over, Now put signature at left)
Registration No: _____ Registration Unit: _____ Town/Village: _____ Remarks: (If any) Name and Signature of the Registrar	To be filled by the Registrar Name _____ District: _____ Taluk: _____ Town/Village: _____ Registration Unit: _____	Registration No: _____ Registration Date: _____ Date of Death: _____ Age: _____ Years/months/days/hours Sex: 1. Male 2. Female 3. Transgender Place of Death: 1. Hospital/Institution 2. House 3. Other place Name and Signature of the Registrar

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Form 4

FORM NO.4
(See Rule 7)
MEDICAL CERTIFICATE OF CAUSE OF DEATH
(Hospital in patients. Not to be used for stillbirths)
To be sent to Registrar along with Form No.2 (Death Report)

Name of the Hospital:

I hereby certify that the person whose particulars are given below died in the hospital in ward No..... on at A.M./P.M

NAME OF DECEASED				For use of Statistical Office
Sex	Age at Death			
	If 1 year or more, age in years	If less than 1 year, age in Months	If less than one month, age in days	If less than one day, age in Hours
1. Male				
2. Female				

CAUSE OF DEATH		Interval between onset & death Approx	
I. Immediate cause State the disease, injury or complication which Caused death, not the mode of dying such as Hear failure, asthenia, etc. Antecedent cause Morbid conditions, if any, giving rise to the above Cause, stating underlying conditions last II. Other Significant conditions contributing to the Death but not related to the diseases or conditions causing it.	(a) due to (or as consequences of) (b) due to (or as consequences of) (c)		

Manner of Death	
1. Natural 2. Accident 3. Suicide 4. Homicide 5. Pending Investigation If deceased was a female, was pregnancy the death associated with? If yes, was there a delivery? 1. Yes 2. No	How did they injury occur? 1. Yes 2. No

Name and Signature of the Medical Attendant certifying the Cause of Death.

Date of Verification:.....

SEE REVERSE FOR INSTRUCTIONS

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum..... S/W/D of Shri.....
R/O..... was admitted to this hospital on.....
and expired on

Doctor:.....
(Medical Supdt.Name of Hospital)

