SOLOMON ISLANDS GOVERNMENT

MINISTRY OF HEALTH AND MEDICAL SERVICES

Death Notice Request Form

Deceased Information

First name:	**Surname:**
Sex : (Tick Box) ☐ Male ☐ Female	**Date of Death:** _____ /____ /_____ Day Month Year
Place of Death: (Name of Clinic/Health Facility) (Name of Village) (Name of Province)	

Applicant Information

First name:	**Surname:**
Sex : (Tick Box) ☐ Male ☐ Female	**Age:**
	Relationship to Decease:
Signature:	**Date:** ____ /_____ /_____ Day Month Year