

Republic of the Philippines
OFFICE OF THE CIVIL REGISTRAR GENERAL
CERTIFICATE OF DEATH

Province <u>IFUGAO</u>			Registry No. <u>2023-115</u>		
City/Municipality <u>LAMUT</u>					
1. NAME (First) (Middle) (Last) BUTCH GAMBOL MARTINEZ			2. SEX (Male/Female) MALE		
3. DATE OF DEATH (Day, Month, Year) 20 AUGUST 2023		4. DATE OF BIRTH (Day) (Month) (Year) 15 JULY 1973		5. AGE AT THE TIME OF DEATH (Fill-in below accordg. to age category) a. IF 1 YEAR OR ABOVE [2] Completed years 50 b. IF UNDER 1 YEAR [1] Months [0] Days [] Hours [] Min/Sec	
6. PLACE OF DEATH (Name of Hospital/Clinic/Institution/House No., St., Barangay, City/Municipality, Province) PANOPDOPAN DISTRICT HOSPITAL LAMUT IFUGAO			7. CIVIL STATUS (Single/Married/Widow/Widower/Annulled/Divorced) MARRIED		
8. RELIGION/RELIGIOUS SECT BAPTIST		9. CITIZENSHIP FILIPINO		10. RESIDENCE (House No., St., Barangay, City/Municipality, Province, Country) BALIDBID, MUNGAYANG, KIANGAN, IFUGAO, PHILIPPINES	
11. OCCUPATION PNP (RETIRED)		12. NAME OF FATHER (First, Middle, Last) FRANCISCO OSORIO MARTINEZ		13. MAIDEN NAME OF MOTHER (First, Middle, Last) VIRGINIA GAMBOL	

MEDICAL CERTIFICATE

(For ages 0 to 7 days, accomplish items 14-19a at the back)

19b. CAUSES OF DEATH (If the deceased is aged 8 days and over) Interval Between Onset and Death

I. Immediate cause : a. **CARDIOGENIC SHOCK**

Antecedent cause : b. **ISCHEMIC HEART DISEASE**

Underlying cause : c. **ACUTE MYOCARDIAL INFARCTION**

II. Other significant conditions contributing to death: **CHF - HYPERTENSION, LIVER ENLARGEMENT**

19c. MATERNAL CONDITION (If the deceased is female aged 15-49 years old)

a. pregnant, b. pregnant, in c. less than 42 days after d. 42 days to 1 year after e. None of the choices

not in labour labour delivery delivery

19d. DEATH BY EXTERNAL CAUSES

a. Manner of death (Homicide, Suicide, Accident, Legal intervention, etc.)

b. Place of Occurrence of External Cause (e.g. home, farm, factory, street, sea, etc.)

20. AUTOPSY (Yes / No)

21a. ATTENDANT

1 Private Physician 2 Public Health Officer 3 Hospital Authority 4 None 5 Others (Specify)

21b. If attended, state duration (mm/dd/yy) From _____ To _____

22. CERTIFICATION OF DEATH

I hereby certify that the foregoing particulars are correct as near as same can be ascertained and I further certify that I have attended/
 have not attended the deceased and that death occurred at **03:45 PM** am/pm on the date of death specified above.

Signature _____

Name in Print **JOHANNA MICHELLE S. TIU, MD**

Title or Position **MEDICAL OFFICER III**

Address **PDH - LAMUT, IFUGAO**

Date **AUGUST 20, 2023**

REVIEWED BY: _____

MAE G. DIAZ, MD, FPOGS

Signature Over Printed Name of Health Officer

AUGUST 20, 2023

Date

23. CORPSE DISPOSAL (Burial, Cremation, if others, specify) BURIAL	24a. BURIAL/CREMATION PERMIT Number _____ Date Issued _____	24b. TRANSFER PERMIT Number _____ Date Issued _____
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25. NAME AND ADDRESS OF CEMETERY OR CREMATORY
PRIVATE LOT MUNGAYANG KIANGAN, IFUGAO

26. CERTIFICATION OF INFORMANT
I hereby certify that all information supplied are true and correct to my own knowledge and belief.

Signature _____

Name in Print **MARY JESUSA D. MARTINEZ**

Relationship to the Deceased **WIFE**

Address **BALIDBID, MUNGAYANG, KIANGAN, IFUGAO**

Date **AUGUST 20, 2023**

27. PREPARED BY

Signature _____

Name in Print **MERILYN B. GALICE**

Title or Position **ASSISTANT REGISTRATION OFFICER**

Date **AUGUST 23, 2023**

28. RECEIVED BY

Signature _____

Name in Print **MERILYN B. GALICE**

Title or Position **ASSISTANT REGISTRATION OFFICER**

Date **AUGUST 23, 2023**

29. REGISTERED AT THE OFFICE OF THE CIVIL REGISTRAR

Signature _____

Name in Print **MERILYN B. GALICE**

Title or Position **ASSISTANT REGISTRATION OFFICER**

Date **AUGUST 23, 2023**

REMARKS/ANNOTATIONS (For LCRO/OCRG Use Only)

TO BE FILLED-UP AT THE OFFICE OF THE CIVIL REGISTRAR

5	8	9	10	11	19a(a)/19b	19a(c)
2	5	0	9	9	0	1
6	0	8	0	2	7	0
3	5	1	6	2		

FOR CHILDREN AGED 0 TO 7 DAYS

14. AGE OF MOTHER _____	15. METHOD OF DELIVERY (Normal spontaneous vertex, if others, specify) _____	16. LENGTH OF PREGNANCY: (in completed weeks) _____
17. TYPE OF BIRTH (Single, Twin, Triplet, etc) _____		18. IF MULTIPLE BIRTH, CHILD WAS (First, Second, Third, etc) _____

MEDICAL CERTIFICATE

19a. CAUSES OF DEATH

a. Main disease/condition of infant _____

b. Other diseases/conditions of infant _____

c. Main maternal disease/condition affecting infant _____

d. Other maternal disease/condition affecting infant _____

e. Other relevant circumstances _____

CONTINUE TO FILL UP ITEM 20

POSTMORTEM CERTIFICATE OF DEATH

I HEREBY CERTIFY that I have performed an autopsy upon the body of the deceased and that the cause of death was _____

Signature _____ Title/Designation _____

Name in Print _____ Address _____

Date _____

CERTIFICATION OF EMBALMER

I HEREBY CERTIFY that I have embalmed BUTCH G. MARTINEZ following all the regulations prescribed by the Department of Health.

Signature _____ Title/Designation L.E.

Name in Print WILHE A. ARGELIANA License No. 3-98-2656

Address BAMBANG, NUEVA VIZCAYA Issued on 3-10-98 at CHD-CMI

Expiry Date 8/2/2025

AFFIDAVIT FOR DELAYED REGISTRATION OF DEATH

I, _____, of legal age, single/married/divorced/widow/widower, with residence and postal address _____

_____ after being duly sworn in accordance with law, do hereby depose and say:

1. That _____ died on _____ in _____ and was buried/cremated in _____ on _____.
2. That the deceased at the time of his/her death:
 - was attended by _____.
 - was not attended.
3. That the cause of death of the deceased was _____.
4. That the reason for the delay in registering this death was due to _____.
5. That I am executing this affidavit to attest to the truthfulness of the foregoing statements for all legal intents and purposes.

In truth whereof, I have affixed my signature below this _____ day of _____, at _____, Philippines.

(Signature Over Printed Name of Affiant)

SUBSCRIBED AND SWORN to before me this _____ day of _____, _____ at _____, Philippines, affiant who exhibited to me his/her CTC/valid ID _____ issued on _____ at _____.

Signature of the Administering Officer _____

Position / Title / Designation _____

Name in Print _____

Address _____