UNOFFICIAL TRANSLATION

Medical Certificate of Cause of Death (SMPK)

1. Date of SMPK form completion: _____/ _____/ _____(DD/MM/YYYY)

2. a. Name of the health facility reporting the death: _____

   b. Health facility code number: ☐☐☐☐☐☐☐☐☐☐

3. Medical record number: _____

4. Full name: _____

5. National ID number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

6. Gender: ☐ Female ☐ Male ☐ Unknown

7. Place (District/City), date of birth: _____, _____/ _____ / _____ ☐ Unknown
   HH BB TTTT

   Age at death: _ _ _ days/weeks/months/years
   (circle one)

8. Place (District/City), date and time of death: _____
   _____/ _____ / _____ ____/ ____
   HH Weight TTTT

9. Address as stated on ID card: _____
   Province: _____ District: _____ Neighborhood/Community: _____/ City/Regency: _____ Village: __

10. Current residential address: _____ Province: _____
    District: _____ Neighborhood Unit/Community
    Unit: _____/ City/Regency: _____ Village: __

11. Cause of death (*select one)*

    ☐ Illness ☐ Violence ☐ Undetermined
    ☐ Accident ☐ Legal decision ☐ Investigation ongoing
    ☐ Suicide ☐ War/Conflict ☐ Unknown

12. If the cause is external or poison (not due to illness),
    a. State the date of the incident: ___/ _____ / _____ (HH/MM/YYYY)
    b. Describe how the external cause occurred (not due to illness). If due to poison, specify the type of poison: _____
    c. Location of the external cause (not due to illness):

    ☐ Home ☐ Sports area ☐ Industrial or construction area
    ☐ Dormitory/nursing home ☐ Schools, offices, institutions, or public service facilities
    ☐ Agricultural area ☐ Highway/toll road ☐ Commercial or service areas
    ☐ Other places (please provide details) _____

13. If fetal or infant death

    a. Multiple pregnancy *(select one)* ☐ Yes ☐ No ☐ Unknown
    b. Stillbirth *(select one)* ☐ Yes ☐ No ☐ Unknown
    c. If death occurred within the first 24 hours, state how many hours the baby survived _____hours
    d. Time of birth (hour: minute): _____: _____ e. Birth weight: _____gram
    f. Gestational age: _____weeks g. Maternal age: ___ years
    h. If perinatal death, specify maternal conditions/diseases affecting the fetus/newborn (select one):

    ☐M1: placental, umbilical cord, and amniotic membrane complications
    ☐M2: maternal pregnancy complications
    ☐M3: Complications during labor and delivery
    ☐M4: maternal medical conditions and surgeries
    ☐M5: No maternal complications
    ☐M6: Other conditions/diseases (specify) _____

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14. Female mortality
   a. Was the deceased pregnant or had she been pregnant within the last year? *(select one)*

   ☐ Yes* ☐ No ☐ Unknown

   b. *If Yes, select one of the conditions at the time of death: (*select one)*

   ☐ Pregnant ☐ Within 42 days before death (postpartum period)

   ☐ 43 days - 1 year before death (late maternal death) ☐ Unknown

   c * If Yes, did the pregnancy contribute to the death? *(select one)*

   ☐ Yes ☐ No ☐ Unknown

15. Medical Data		
Enter the sequence of events—illness, injury, or complications that led to death. DO NOT include terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without indicating the etiology. DO NOT USE ABBREVIATIONS. Enter only one cause per line. Add additional lines if necessary.		
Disease or condition causing	**Cause of death**	**Time interval from the onset of the disease until death. Write the time interval (number) with the time specification (year/month/week/ day/hour/minute)**
Section 1 Report the disease or condition that directly caused death in **row a** If applicable, report the sequence of events leading to death **in order** on the following lines (b, c, d). Record the underlying cause of death in the bottom row used	a)	
	b) *caused by:*	
	c) *caused by:*	
	d) *caused by:*	
Section 2. Other conditions/diagnoses contributing to death and duration of event. The duration of the event is written in parentheses after the name of the condition.		

Other Medical Data

16. In the 4 weeks prior to death, was any surgical procedure performed?

☐ Yes** ☐ No ☐ Unknown

**If Yes:

Please specify the date the surgery was performed: __/ _____ / _____ (DD/MM/YYYY)

Explain the reason for the surgery (specific illness or condition): _____

_____

17. Was an autopsy performed: ☐ Yes*** ☐ No ☐ Unknown

***If Yes, was the autopsy result used for SMPK:

☐ Yes ☐ No ☐ Unknown

Doctor who explained

Name: _____

SIP No.: _____