


Appendix B1: Death notification form (DHA-1663A)

G.P.-S. 09/09



REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HOME AFFAIRS

NOTICE OF DEATH / STILL BIRTH

[Births and Deaths Registration Act 51 of 1992]
[Regulations 11 and 14]

DHA-1663 A
Page 1 of 3

BARCODE

To be completed in full and submitted at the Department of Home Affairs' office by the informant or authorised funeral undertaker. The form to be completed in black ink with BLOCK LETTERS. Please mark with ☑ the CORRECT box, where required. All fields are COMPULSORY. Incomplete applications and applications that are not legible may be considered invalid. (Note: The fingerprints of the deceased, the informant and the undertaker must be taken by the undertaker)

Serial number _____

A. PARTICULARS OF THE DECEASED

Instructions: Section A to be filled out by **Authorised Medical Practitioner / Professional Nurse**, who is responsible for examining the body to determine the cause of death. The Informant must verify, and where necessary, complete in full the personal particulars and other information of the deceased below.

1. Was this a death or a still birth? ☐ 1.1 Death ☐ 1.2 Still birth

2. Identification of the deceased (tick one box):

<input type="checkbox"/> 2.1 The deceased was identified with an ID document / passport (if foreigner) produced by the family	Left thumbprint of deceased
<input type="checkbox"/> 2.2 Still born child	
<input type="checkbox"/> 2.3 The features of the deceased do not seem to match the features on the ID document or passport of deceased	Right thumbprint of deceased
<input type="checkbox"/> 2.4 ID document or passport of the deceased was not presented. The deceased was identified through word of mouth	
<input type="checkbox"/> 2.5 The deceased was already buried prior to the completion of this form	
<input type="checkbox"/> 2.6 The deceased was unidentifiable:	
<input type="checkbox"/> 2.6.1 Burnt <input type="checkbox"/> 2.6.2 Decomposed <input type="checkbox"/> 2.6.3 Other (specify) _____	
<input type="checkbox"/> 2.6.4 DNA samples retrieved for identification purposes <input type="checkbox"/> 2.6.5 Dental records taken for identification purposes	

3. Date of Death / still birth

Y	Y	Y	Y	M	M	D	D
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4.1 Place of Death/still birth (City/Town/Village)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4.2 Province of Death/still birth

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5. Place of Registration of Death / still birth

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6. If death occurred within 24 hours after birth, number of hours alive

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 7. Home telephone no.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

8. Identity No. (Passport No. if foreigner)

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 9. Age at last birthday if DOB is unknown

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10. Date of Birth if there is no ID number

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

 11. Gender ☐ 11.1 Male ☐ 11.2 Female ☐ 11.3 Indeterminable

12. Surname

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

13. Previous / Maiden Surname

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14. Forenames

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

15. Usual* Residential Address: Street

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Town

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Province

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Postal code

--	--	--	--	--	--	--	--

16. Citizenship

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16.1 Place of Birth (City / Town / Village) or Country of Birth, if abroad

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

16.2 Province of Birth

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

17. Marital Status of the deceased ☐ 17.1 Single ☐ 17.2 Married ☐ 17.3 Widowed ☐ 17.4 Divorced

18. Education level of deceased, (Specify only the highest class completed) (mark with a ☑)

Non e	Gr R	Gr 1	Gr 2	Gr 3	Gr 4	Gr 5	Gr 6	Gr 7	Gr 8 Form 1	Gr 9 Form 2	Gr 10 Form 3 NTC 1	Gr 11 Form 4 NTC 2	Gr 12 Form 5 NTC 3	Univ Tech	Unk now n

19. Usual occupation of deceased (type of work done during most of working life)

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20. Type of business / industry: (mark with a ☑)

1. Agriculture, hunting, forestry and fishing	2. Mining and quarrying	3. Manufacturing	4. Electricity, gas and water supply	5. Construction	6. Wholesale and retail trade; repair of motor vehicles, motor cycles and personal and household goods; hotels and restaurants	7. Transport, storage and communication	8. Financial intermediation, insurance, real estate and business services	9. Community, social and personal services	10. Private households, extritorial organisations, representatives of foreign governments & other activities not adequately defined

21. Was the deceased a regular** smoker five years ago? (mark with a ☑) ☐ 21.1 Yes ☐ 21.2 No ☐ 21.3 Do not know ☐ 21.4 Not applicable (minor)


* Where the deceased lived on most days. **Smoking tobacco on most days.

Appendix B1: Death notification form (DHA-1663A) – page 2 of 3

G.P.-S. 0909		REPUBLIC OF SOUTH AFRICA DEPARTMENT OF HOME AFFAIRS			DHA-1663 A Page 2 of 3			
		NOTICE OF DEATH / STILL BIRTH					BARCODE	
		[Births and Deaths Registration Act 51 of 1992]						
		[Regulations 11 and 14]						
To be completed in full and submitted at the Department of Home Affairs' office by the informant or authorised funeral undertaker. The form to be completed in black ink with BLOCK LETTERS. Please mark with <input type="checkbox"/> the CORRECT box, where required. All fields are COMPULSORY. Incomplete applications and applications that are not legible may be considered invalid. (Note: The fingerprints of the deceased, the informant and the undertaker must be taken by the undertaker)							Serial number	
B. CERTIFICATE BY ATTENDING MEDICAL PRACTITIONER / PROFESSIONAL NURSE								
Instructions: Section B to be filled out by the same Medical Practitioner / Professional Nurse who completed Section A.								
<input type="checkbox"/> 22.1 I, the undersigned, hereby certify that the deceased named in Section A, to the best of my knowledge and belief, died solely and exclusively due to Natural Causes								
<input type="checkbox"/> 22.2 I, the undersigned, am not in a position to certify that the deceased died exclusively due to Natural Causes								
Particulars of the Medical Practitioner / Professional Nurse who filled out the form:						23. HPCSA Registration No. _____		
24. Surname		_____						
25. Forenames		_____						
26. Name of Health Facility / Practice				27. Facility / Practice No. _____				
28. Business Address: Street		_____						
Town		_____				Province _____		
Telephone No. (Office)		_____				Postal Code _____		
I, the undersigned, hereby certify that I examined the body of the deceased named in section A and declare that the deceased, to the best of my knowledge and belief, died solely and exclusively due to natural or unnatural causes as indicated on paragraph 22 and in case this is not true, I shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment (Section 31(1)(b) of the Act 51 of 1992.)							Office stamp of health facility or practice	
Place signed		_____						
Date signed		<input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D		Signature _____				
C. CERTIFICATE BY MEDICAL PRACTITIONER/ FORENSIC PATHOLOGIST								
Instructions: Section C to be filled out by Medical Practitioner or Forensic Pathologist, who is conducting medico-legal investigation of death.								
29. I, the undersigned, hereby certify that a medico-legal investigation of death has been conducted on the body of the person whose particulars are given in Section A and that the body is no longer required for the purpose of the Inquest Act, 1959 (Act No. 58 of 1959) and the cause of death is:								
<input type="checkbox"/> 30.1 Natural		<input type="checkbox"/> 30.2 Unnatural		<input type="checkbox"/> 30.3 Under investigation				
31. Date of Post-mortem		<input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D						
32. Name of Medico-legal Mortuary / Mortuary		_____						
33. Mortuary No.		_____						
34. Mortuary Reference Number of Deceased		_____						
35. SAPS Case No.		_____				36. Name of Police Station _____		
Particulars of the Medical Practitioner / Forensic Pathologist who filled out the form:						HPCSA Registration No. _____		
37. Surname		_____						
38. Forenames		_____						
39. Business Address: Street		_____						
Town		_____				Province _____		
Telephone No. (Office)		_____				Postal Code _____		
I, the undersigned, hereby certify that I examined the body of the deceased named in section A and the deceased, to the best of my knowledge and belief, died solely and exclusively due to natural or unnatural causes as indicated on paragraph 29 and in case this is not true, I shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment (Section 31(1)(b) of the Act 51 of 1992.)							Office stamp of mortuary	
Place signed		_____						
Date signed		<input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D		Signature _____				
D. PARTICULARS OF INFORMANT								
Instructions: Section D to be completed by informant. Informant is responsible for certifying the identity of the deceased.								
40. Identity No. (Passport No. if foreigner)		_____				41. Date of Birth		
42. Citizenship		_____						
43. Surname		_____						
44. Forenames		_____						
45. Residential Address: Street		_____						
Town		_____				Province _____		
Telephone No. (Home)		_____				Postal Code _____		
Cellphone No.		_____						
46. The Deceased is my:		<input type="checkbox"/> 46.1 Parent		<input type="checkbox"/> 46.2 Spouse		<input type="checkbox"/> 46.3 Child		
		<input type="checkbox"/> 46.4 Other, Specify _____						
I, the undersigned, hereby certify that the identity of the deceased mentioned in section A is to the best of my knowledge and belief true and correct in case it is not true, I shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment (Section 31(1)(b) of the Act 51 of 1992.)							Left thumb print of informant	
Signature _____		Date signed		<input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D		Place signed _____		

Appendix B1: Death notification form (DHA-1663A) – page 3 of 3

G.P.-S. 09/09



REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HOME AFFAIRS

NOTICE OF DEATH / STILL BIRTH

[Births and Deaths Registration Act 51 of 1992]
[Regulations 11 and 14]

DHA-1663 A
Page 3 of 3

BARCODE

To be completed in full and submitted at the Department of Home Affairs' office by the informant or authorised funeral undertaker. The form to be completed in black ink with BLOCK LETTERS. Please mark with the CORRECT box, where required. All fields are COMPULSORY. Incomplete applications and applications that are not legible may be considered invalid. (Note: The fingerprints of the deceased, the informant and the undertaker must be taken by the undertaker)

Serial number

E. PARTICULARS OF FUNERAL UNDERTAKER

Instructions: Section E to be completed by Funeral Undertaker. The undertaker must take his or her finger print, the finger print of the deceased and the informant. **Authorised Funeral Undertaker or Informant** may submit the completed form to the nearest Home Affairs office.

47. Name of Funeral Parlour

48. DHA Designation No. 49. Company Reg. No.

50. SARS Reg. No. (Income tax reference no.)

Details of Funeral Undertaker or Authorised Representative

51. Identity No. (Passport No. if foreigner)

52. Surname

53. Forenames

54. Business Address

Street

Town

Province Postal Code

Telephone No. (Office) Cellphone No.

55. Date of collection of corpse Y Y Y Y M M D D 56. Date of Cremation (if applicable) Y Y Y Y M M D D

57. Place of Burial (City / Town / Village) Province

58. Date of Burial Y Y Y Y M M D D 59. Grave No. (if available)

Name of person who collected the deceased:

60. Identity No. (Passport No. if foreigner)

61. Surname

62. Forenames

Place signed _____

Date signed Y Y Y Y M M D D Signature _____

Office stamp of funeral undertaker

F. FOR OFFICIAL USE ONLY

Registration of death approved, DHA-1663 received by (particulars of DHA official):

63. Identity No.

64. Surname

65. Forenames

66. Peral No.

Documents included with this notice:

Copy of the deceased's ID Copy of ID document of the informant

DHA - 6 (if applicable) DHA - 1880 (if applicable)

DHA-1663 was submitted by:

Informant Funeral Undertaker

Office stamp of DHA

Appendix B2: Death notification form (DHA-1663B)

NOTICE OF DEATH / STILL BIRTH

Confirmation for Medical and Health use Only
(After completion seal to ensure confidentiality)

DHA-1663 B
Page 1 of 1

To be completed in full and submitted at the Department of Home Affairs' office by the informant or authorised party. The form to be completed in black ink with **BLOCK LETTERS**. Please mark with the CORRECT box, where required.
All fields are COMPULSORY. Incomplete applications and applications that are not legible may be considered invalid.

File no _____ Date _____

G. MEDICAL CERTIFICATE OF CAUSE OF DEATH
Instructions: Section G is to be filled out by Medical Practitioner /Professional Nurse / Forensic Pathologist, who has determined the cause of death

PARTICULARS OF DECEASED

67. Identity No. (Passport No. if foreigner) _____

68. Gender 68.1 Male 68.2 Female 68.3 Indeterminable

69. Surname _____

70. Forenames _____

71. Population Group 71.1 African 71.2 White 71.3 Indian/Asian 71.4 Coloured 71.5 Other (specify) _____

72. Place of Death 72.1 Hospital/Inpatient 72.2 ER/Outpatient 72.3 DOA 72.4 Nursing Home 72.5 At Home 72.6 Other (specify) _____

73. Name of Health Facility/Practice _____

74. Facility Contact Telephone No. incl. Area Code _____

75. Patient File No. _____

76. Contact Person at Facility: Surname _____
Forenames _____
Role/Rank _____

G.1 FOR DEATHS OCCURRING AFTER ONE WEEK OF BIRTH
Instructions: Section G.1 is to be completed for all deaths that occurred after one week of birth

77. CAUSES OF DEATH

<p>Part 1 Enter the disease, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line</p> <p>IMMEDIATE CAUSE (final disease or condition resulting in death) a) _____ Due to (or as a consequence of) _____</p> <p>Sequentially list conditions, if any, leading to immediate cause. b) _____ Due to (or as a consequence of) _____</p> <p>Enter UNDERLYING CAUSE last (Disease or injury that initiated events resulting in death) c) _____ Due to (or as a consequence of) _____</p> <p>d) _____</p> <p>Part 2 Other significant conditions contributing to death but not resulting in underlying cause given in Part 1 _____</p>	<p style="text-align: center;">Approximate interval between onset and death (Days / Months / Years)</p> <table border="1" style="width: 100%; text-align: center;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table> <p style="text-align: center;">ICD-10</p>																																																																																																				

78. If a female, was she pregnant at the time of death or up to 42 days prior to death? () 82.1 Yes 82.2 No

79. Method used to ascertain the cause of death (tick all that apply):
 79.1 Autopsy 79.2 Post mortem examination 79.3 Opinion of attending medical practitioner 79.4 Opinion of attending medical practitioner on duty
 79.5 Opinion of registered professional nurse 79.6 Interview of family member 79.7 Other (specify) _____

G.2 FOR STILL BIRTHS AND DEATHS OCCURRING WITHIN ONE WEEK OF BIRTH (PERINATAL DEATHS)
Instructions: Section G.2 is to be completed for all still births and deaths that occurred within one week of birth (perinatal deaths)

<p style="text-align: center;">Mother</p> <p>80. Identity Number _____</p> <p>81. Date Of Birth Y Y Y Y M M D D _____</p> <p>82. Age of last birthday/ DoB known _____</p> <p>83. Number of previous pregnancies resulting in: <input type="checkbox"/> 83.1 Live births <input type="checkbox"/> 83.2 Still births <input type="checkbox"/> 83.3 Abortions</p> <p>84. Outcome of last previous pregnancy (tick one): <input type="checkbox"/> 84.1 Live birth <input type="checkbox"/> 84.2 Still birth <input type="checkbox"/> 84.3 Abortion</p> <p>85. Date of last previous delivery Y Y Y Y M M D D _____</p> <p>86. First day of last menstrual period Y Y Y Y M M D D _____ Or, if unknown, estimated duration of pregnancy (in completed weeks) _____</p> <p>87. Method of delivery: <input type="checkbox"/> 87.1 Spontaneous <input type="checkbox"/> 87.4 Vacuum extractor <input type="checkbox"/> 87.2 Forceps delivery <input type="checkbox"/> 87.5 Caesarean section <input type="checkbox"/> 87.3 Forceps and rotation <input type="checkbox"/> 87.6 Other (specify) _____</p> <p>88. Antenatal care two or more visits: <input type="checkbox"/> 88.1 Yes <input type="checkbox"/> 88.2 No <input type="checkbox"/> 88.3 Unknown</p>	<p style="text-align: center;">Child</p> <p>89. Type of death: <input type="checkbox"/> 89.1 Still birth <input type="checkbox"/> 89.2 Live birth</p> <p>90. Birth weight (in grams) _____</p> <p>91. This birth was: <input type="checkbox"/> 91.1 Single birth <input type="checkbox"/> 91.2 First twin <input type="checkbox"/> 91.3 Second twin <input type="checkbox"/> 91.4 Other multiple</p> <p>92. If still born, heartbeat ceased: <input type="checkbox"/> 92.1 Before labour <input type="checkbox"/> 92.2 During labour but before delivery <input type="checkbox"/> 92.3 Before delivery but not known whether before or during labour</p> <p>93. If death occurred within 24 hours after birth, number of hours alive _____</p> <p>94. Attendant at birth: <input type="checkbox"/> 94.1 Physician <input type="checkbox"/> 94.2 Trained midwife <input type="checkbox"/> 94.3 Other trained person (specify) _____ <input type="checkbox"/> 94.4 Other (specify) _____</p>
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95. CAUSES OF DEATH

a. Main disease or conditions in foetus or infant _____

b. Other diseases or conditions in foetus or infant _____

c. Main maternal disease or condition affecting foetus or infant _____

d. Other maternal diseases or conditions affecting foetus or infant _____

e. Other relevant circumstances _____

96. Autopsy information ()
 96.1 Certified causes of death has been confirmed by autopsy 96.2 Autopsy information may be available later 96.3 Autopsy not performed