[all handwriting is presented in italics]

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| Please transfer this notice in a sealed envelope | **State of Israel – Ministry of Interior**  **Death Notice** |  |

Pursuant to Section 7 of the Population Registry Law, 5725 – 1965, I hereby give notice of the details of the deceased

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Personal details of the deceased** | | Surname: | | Given Name: | | | | | | Father’s Given Name: | | | | | | | ⮽ ID □ Passport | | | | | | | Sex:  M □F ⮽ |
| Marital status  □ S ⮽ M □ D □ W | | Religion: | | | | | Date of Birth Month Day Year | | | | | | | | Place of Birth: | | | | | | | |
|  | | Hebrew Date of Death  *November 30, 2019* | | | | | Time  *8:30 a.m.* | | | | Gregorian Date of death Midnight  November 30, 2019 | | | | | | | | Place of Death  *Beth Hadar Ashdod* | | | | | |
| If the deceased was married  Spouse’s Name: | | | | | Spouse’s Identity: | | | | | | Address:  City Street/Neighborhood House No | | | | | | | | | | | |
| **Details of the informer supervisor of the institution, physician who determined the death or someone who was present** | | Surname:  *Elkatsatsi* | | | | | Given Name  *Talel* | | | | | | Address:  *Beth Hadar3 Ort St Ashdod* | | | | | | | Date of the Notice  *November 30, 2019* | | | | |
| Signature of the informer: [signature]  [stamp] Dr. Talel Elkatsatsi  L.N. 14712 | | | | | | | | | | | | | | | | | | | | | | |
| **Medical Authorization and details of the authorizing physician** | To the best of my knowledge, death occurred  at hour min month day year  *8:30 a.m. November 30, 2019* | | | | | | | | | | I saw the corpse on:  *November 30, 2019* | | | | | Physician’s Name  TALEL  ELKATSATSI | | | | | | Work Place  *Beth Hadar* | | |
|  | | | Function  *Physician* | | | | | Address:  *Beth Hadar Ashdod* | | | | | | | | Date:  *November 30, 2019* | | | | | | Signature:  [stamp] Dr. Talel Elkatsatsi  L.N. 14712 | | |
| **Diagnosis of the cause of death determined by the physician** | | | | | | | | | | | | | | | | | | | | | |
| **Reason for Death to be completed by the physician who saw the corpse** | | | Immediate cause, injury or disease that caused the death directly, id the reason is unknown | | | | | | | | | 1a *INFRACTION* | | | | | | | | | | | | |
|  | | | Disease or conditions that led to the immediate cause of death. Specify the chain of events that caused the death | | | | | | | | | 1b | | | | | | | | | | | | |
| 1c | | | | | | | | | | | | |
|  | | | Diseases or other conditions that contributed to the death, but are not directly linked to diagnoses 1a - c | | | | | | | | | 2 | | | | | | | | | | | | |
|  | | |
| Circumstances of the Death | | | □ Suspicion of murder □ Work accident □ Other accident  □ Suspicion of suicide □ Road accident | | | | | | | | | | | | Was the deceased pregnant close to death?  □ Yes □ No Did she abort? □ Yes □ No  Did she give birth? □ Yes □ No | | | | | | | | | |
| Description of external injuries | | | | | | | | | | | | | | | | | | | | | |
| Post Mortem | | | Date:  | | | | | | | | | | | | | | Name of Facility: | | | | | | Temporary diagnosis 1:  [signature] | | | | | | |
| Temporary Diagnosis 2: | | | | | | | | | Final Diagnosis: | | | | | | | | | Pathologist’s Signature: | | | |
| **Health Office** | | | Date of Notice:  | | | | | | | Issue of burial license No:  | | | | | | | | | | | | | | | Name of burial company | | | | | | | | | Burial Site: | |
| Place of Birth  City Country | | | Immigration Date: | | | | | | | | Identity Document No: \_\_\_\_\_\_\_\_\_ attached | | | | | | | Office physician’s signature: | | | |
| Regional office of the Population Administration at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | The notice was received and registered on  \_ \_/\_ \_/\_ \_ \_ \_ | | | | | | | | | | | | | | | Clerk's Signature | | | |

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