TAB

CERTIFICATE OF DEATH

For use of this form, see AR 190-8; the proponent agency is PMG.

INTERNMENT SERIAL NUMBER

FROM:

TO:

NAME *(Last, first, MI)*	GRADE	SERVICE NUMBER

NATIONALITY	POWER SERVED	PLACE OF CAPTURE/INTERNMENT AND DATE

PLACE OF BIRTH	DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN	FIRST NAME OF FATHER

PLACE OF DEATH	DATE OF DEATH	CAUSE OF DEATH

PLACE OF BURIAL	DATE OF BURIAL

IDENTIFICATION OF GRAVE

PERSONAL EFFECTS *(To be filled in by Office of Deputy Chief of Staff for Personnel)*

____ RETAINED BY DETAINING POWER

____ FORWARDED WITH DEATH CERTIFICATE TO *(Specify)*

____ FORWARDED SEPARATELY TO *(Specify)*

BRIEF DETAILS OF DEATH/BURIAL BY PERSON WHO CARED FOR THE DECEASED DURING ILLNESS OR DURING LAST MOMENTS *(Doctor, Nurse, Minister of Religion, Fellow Internee)*. IF CREMATED, GIVE REASON. *(If more space is required, continue on reverse side)*.

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE

SIGNATURE OF MEDICAL OFFICER

SIGNATURE OF COMMANDING OFFICER

WITNESSES

SIGNATURE	ADDRESS
SIGNATURE	ADDRESS