



1. Application details

FORM A

Consecutive number (Council officer to complete)

1a. Full name of applicant

First name(s)

Surname

Address

Occupation

I, the above-named, hereby apply to the crematorium authority of the Taranaki Crematorium to undertake the cremation of the body of:

1b. Full name of deceased

First name(s)

Surname

Last address

Occupation

Age

Gender

Relationship status

(i.e. whether the deceased was or had been married, in a civil union, or in a de facto relationship, or was the surviving spouse or partner of a marriage, civil union, or de facto relationship, or had never been married, in a civil union or in a de facto relationship.)

2. The true answers to the questions set out below are as follows:

2a. Are you an executor of the deceased?

Yes

No

2b. Are you a relative of the deceased?

Yes

No

If so, state the relationship

If you are not an executor or a near relative, please state why this application is being made by you and not an executor or near relative:

2c. Have the near relatives of the deceased been informed of the proposed cremation?

Yes

No

2d. If the application is not made by an executor, is there an executor of the deceased?

Yes

No

If there is an executor, has he/she been informed of the proposed cremation?

Yes

No

2e. To the best of your knowledge and belief, has any near relative or executor of the deceased expressed any objection to the proposed cremation?

Yes

No

If so, on what ground?

2f. To the best of your knowledge and belief, what was the date

and time

of the death of the deceased?

2g. Where did the deceased die? Give address, and say whether own residence, lodgings, hotel, hospital, nursing home etc.

Note: The term 'near relative' as used in this form means the spouse, civil union partner, or de facto partner of the deceased, but only if the spouse, civil union partner, or de facto partner was living together with the deceased immediately before his or her death and a parent of the deceased and any child of the deceased who is aged 16 years or over, and any other relative who usually resided with him or her.

Full name of the deceased

First name(s)

Surname

2. The true answers to the questions set out below are as follows - continued

2h. Do you know or have any reason to suspect that the death of the deceased was due, directly or indirectly to:

Violence?	Yes	No	Privation or neglect?	Yes	No
Poison?	Yes	No	Illegal operation?	Yes	No

2i. Do you know any reason whatsoever for supposing that an examination of the body of the deceased may be desirable? Yes No

2j. Do you know or have you any reason to suspect that the body of the deceased contains a cardiac pacemaker or other biomechanical aid? Yes No

2k. Please give the name and address of the ordinary medical attendant of the deceased

Full name

Address

2l. Please give the names and addresses of all the medical practitioners who attended the deceased during his/hers last illness

Full name

Address

Full name

Address

2m. Who were the persons (if any) present at the time of the death?

2n. Was the deceased a member of a religious denomination whose tenets require the burning of the body to be carried out as a religious rite elsewhere than in an approved crematorium? Yes No

If so, give the name by which that religious denomination is known.

3. Declaration - applicant and witness

I have been given a list of items prohibited for cremation at the Taranaki Crematorium and agree to make sure none of the items are included within the casket, or that they can be easily removed from the casket before cremation.

I hereby certify, with a view to procuring the cremation of the body of the above-named deceased, that all the particulars stated above are true, and that to the best of my knowledge and belief no material particular has been omitted.

Signature of applicant

Date

Applicant's first name(s)

Surname

Signature of witness

Date

Witness first name(s)

Surname

Witness address

Witness occupation



1. Deceased details

FORM B

I am informed that application is about to be made for the cremation of the body of:

1a. Full name of the deceased

First name(s)

Surname

1b. Last address

1c. Occupation

1d. Age

1e. Gender

2. Declaration of medical practitioner

As a medical practitioner who is required or permitted by section 46B or 46C(1) of the Burial and Cremation Act 1964 to give a doctor's certificate (as defined in section 2(1) of that Act) for the death, and who has seen and identified the body after death, I give the following answers to the questions set out below:

2a. On what date and at what hour did he/she die?

Date

Hour

2b. Where did the deceased die? (Please give an address, and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)

2c. Are you a relative of the deceased?

Yes

No

If so, state the relationship

2d. Have you, so far as you are aware, any pecuniary interest in the death of the deceased?

Yes

No

2e. Were you the ordinary medical attendant of the deceased?

Yes

No

If so, for how long? (Please state how many weeks, months or years)

2f. Did you attend the deceased during his/her last illness?

Yes

No

If so, for how long? (Please state how many hours, days, weeks or months.)

2g. If you attended the deceased during his or her last illness, when did you last see the deceased alive? (Please state how many hours or days before death.)

2h. (i) How soon after death did you see the body?

(ii) What steps did you take to satisfy yourself as to the fact of death?

(iii) How did you establish the identity of the deceased person?

2i. What were the causes of death? Please state the period elapsing between onset of each condition and death (years, months or days).

(i) Immediate cause - the disease, injury or complication which caused death?

Please turn over

Certificate of medical practitioner - page 2

Full name of the deceased

First name(s)

Surname

2. Declaration of medical practitioner - continued

- (ii) Morbid conditions (if any) giving rise to the immediate cause (place the conditions in chronological order beginning with the most recent)?

- (iii) Other conditions (if any) contributing to death - pregnancy, parturition, over-exertion, dangerous occupation?

- (iv) Please state how far your answers as to the causes of death and the duration of such causes are founded on your own observations or on statements by others. If on statements made by others, give their names and their relationship to the deceased.

- 2j. (i) What was the mode of death? (Please state whether syncope, coma, exhaustion, convulsions, etc.)

- (ii) What was the duration? (Please state number of days, hours or minutes, and state how far your answer as to the mode of death is founded on your own observations or on statements made by others. If on statements made by others, give their names and their relationship to the deceased.)

- 2k. Did the deceased undergo any operation during the final illness or within a year before death? If so, what was its nature and who performed it?

- 2l. By whom was the deceased nursed during his/her last illness? (If the death occurred in a hospital, this question may be answered by referring generally to the nursing staff in a specified ward, but otherwise give names and say whether professional nurse, relative etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before death.)

- 2m. By what medical attendants (besides yourself, if applicable) was the deceased attended during his/her last illness?

- 2n. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death?

Yes No

- 2o. Do you know, or have any reason to suspect, that the death of the deceased was due, directly or indirectly to:

Violence?	Yes	No	Privation or neglect?	Yes	No
Poison?	Yes	No	Illegal operation?	Yes	No

- 2p. Have you any reason to suppose a further examination of the body to be desirable?

Yes No

- 2q. Have you given the doctor's certificate as defined in section 2(1) of the Burial and Cremation Act 1964 for the death?

Yes No

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief and that there is no circumstance known to me which can give rise to any suspicion that the death was due wholly or in part to any other cause than disease (or accident) or which makes it desirable that the body should not be cremated.

Signature

Date

First name(s)

Surname

Address

Registered qualifications

Note: this certificate must be handed, or sent in a closed envelope by the medical practitioner who signs it to a Medical Referee.



Te Kaunihera-ā-Rohe o Ngāmotu

New Plymouth
District Council



FORM
Certificate in relation to
pacemakers and other
biomechanical aids

The Cremation Regulations 1973

Please note: Complete either Form AB or Form BA, not both.

1. Deceased details

FORM AB

Consecutive number (Council officer to complete)

I hereby certify that I have examined the body of

1a. Full name of the
deceased

First name(s)

Surname

1b. Last address

1c. Occupation

1d. Age

1e. Gender

2. Medical practitioner's declaration

2a. Tick one:

I am satisfied that the body does not contain a cardiac pacemaker or any other biomechanical aid.

I have removed from the body a cardiac pacemaker or other biomechanical aid, namely:

2b. Full name of medical
practitioner

First name(s)

Surname

Signature

Date

Address

Registered qualifications



Te Kaunihera-ā-Rohe o Ngāmotu

New Plymouth
District Council



FORM

**Certificate of medical practitioner
or nurse practitioner**

(Deaths from natural causes in long-term residential care
or specialist palliative care if medical practitioner or nurse
practitioner has not seen and identified body)

The Cremation Regulations 1973

Please note: Complete either Form AB or Form BA, not both.

1. Deceased details

FORM BA

I have been informed that an application will be made for the cremation of the body of:

Full name of the deceased

First name(s)

Surname

Address

Occupation

2. Declaration of medical practitioner or nurse practitioner

As a medical practitioner or nurse practitioner who is required or permitted by section 46B(2) of the Burial and Cremation Act 1964 to give a certificate of cause of death (as defined in section 2(1) of that Act) for the death, I give the following answers to the questions set out below:

On what date and at what hour did the deceased die?
(specify)

Date

Hour

Where did the deceased die? (Please give address and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)

Are you a relative of the deceased?

Yes

No

If yes, state the relationship

Have you, so far as you are aware, any pecuniary interest in the death of the deceased?

Yes

No

If yes, specify the nature of
the interest

Were you the ordinary medical practitioner or nurse practitioner of the deceased?

Yes

No

If yes, for how long? (Please state how many weeks, months or years)

For how long did you attend the deceased before the deceased's death? (Please state how many weeks, months, or years)

When did you last see the deceased alive? (Please state how many hours or days before death)

Has a health practitioner identified the body?

Yes

No

If yes, answer the following questions:

(a) Who was it? (Specify the name, profession, registration number, and contact details of the health practitioner)

(b) Did the health practitioner verify that the deceased is dead?

Yes

No

(c) Did the health practitioner consider that the circumstances of the death
were consistent with the deceased dying from natural causes?

Yes

No

(d) What enquiries did you make to determine that the health practitioner identified the body, verified the death of the deceased, and assessed that the circumstances of the death were consistent with the deceased dying from natural causes? (specify)

Please turn over

2. Declaration of medical practitioner or nurse practitioner – continued

What was the direct cause of death? (specify the injury or condition that directly caused the death or assisted dying and the time interval between the onset of the condition and death in years, months, or days)

Period elapsing between onset of each condition and death (years, months, or days).

Interval

What was the antecedent cause of death (if any)? (specify any morbid condition(s) that gave rise to the direct cause of death (from most recent to oldest) and the time interval between the onset of the condition and death in years, months, or days)

Interval

Did another condition contribute to death, e.g., another acute or chronic disease, substance use or abuse, or a dangerous occupation?

Yes

No

If yes, which condition and what was the time interval between the onset of the condition and death in years, months, or days?

Interval

In relation to the causes of death and the duration of such causes, state to what extent your answers are founded on your own observations or on statements made by others. If on statements made by others, give their names and their relationship to the deceased (specify)

What was the mode of death? (specify)

Did the deceased undergo any operation during the final illness or within a year before death?

Yes

No

If yes, what was its nature, when was it performed, and who performed it?

Who nursed the deceased during their last illness? (If the death occurred in a hospital, rest home, or hospice facility, this question may be answered by referring generally to the nursing staff in a specified ward, rest home, or hospice facility, but otherwise give names and say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before death.)

Besides yourself, which other medical practitioners or nurse practitioners (if any) attended the deceased during their last illness? (specify)

In view of your knowledge of the deceased's habits and constitution, do you feel any doubt as to the cause of the deceased's death? (specify)

Do you know, or have any reason to suspect, that the death of the deceased was due, directly or indirectly to –

- | | | | | | |
|---------------|-----|----|---------------------------|-----|----|
| (a) Violence? | Yes | No | (c) Privation or neglect? | Yes | No |
| (b) Poison? | Yes | No | (d) An illegal operation? | Yes | No |

If you answered yes to any of paragraphs (a) to (d), give reasons.

Have you any reason to think that there should be a further examination of the body? (specify)

Have you given the certificate of cause of death (as defined in section 2(1) of the Burial and Cremation Act 1964) for the death? (specify)

Please turn over

2. Declaration of medical practitioner or nurse practitioner – continued

I certify that –

- (a) The answers given above are true and accurate to the best of my knowledge and belief; and
- (b) In my opinion the death was not unexpected; and
- (c) I am not aware of any circumstances that give rise to a suspicion that the death was due wholly or partly to any cause other than that stated that would mean it is undesirable to cremate the body.

Signature

Date

Registered qualifications

Address

Note: this certificate must be handed, or sent in a closed envelope by the medical practitioner or nurse practitioner who signs it to a Medical Referee.



1. Deceased details

FORM F

Consecutive number (Council officer to complete)

Whereas application has been made for the cremation of the body of:

1a. Full name of the deceased

First name(s)

Surname

1b. Last address

1c. Occupation

1d. Age

1e. Gender

2. Declaration

Whereas I have satisfied myself:

- 2a. That all the requirements of the Burial and Cremation Act 1964 and The Cremation Regulations 1973 have been complied with, and
- 2b. *That the cause of death has been definitely ascertained (or that a certificate in form C has been given by a coroner), and
- 2c. That no reason exists for any further inquiry or examination.

Now therefore, I hereby permit the cremation authority of the Taranaki Crematorium to cremate the said body.

Signature

Date

First name(s)

Surname

*Medical Referee (or Deputy Medical Referee or Second Deputy Medical Referee or Medical Officer of Health).

- Note:
1. Delete all inappropriate alternatives in both places where an asterisk appears.
 2. This permission should be signed in duplicate, one copy to be retained with the application papers and the other sent by the Medical Referee to the attendant at the crematorium.
The Medical Referee should attach to the application papers a statement of any special inquiries which he may have seen fit to make before issuing the permission to cremate.



1. Cremation details

FORM H

Consecutive number (Council officer to complete)

1a. Full name of the deceased

First name(s)

Surname

1b. Last address

1c. Occupation

1d. Age

1e. Gender

1f. Date of death

1g. Place of death

1h. Date of Medical Referee's permission or other authority

1i. Date of cremation

1j. Casket size - including handles

1k. Funeral director

1l. Name of person or solicitor responsible for payment of fees

1m. Postal address

2. Authority for disposal of ashes

2a. I*, (full name)

First name(s)

Surname

authorise the cremation authority of the Taranaki Crematorium to dispose of the ashes of the deceased named above, as follows (applicant for cremation to select whichever is applicable):

Interred in the Garden of Remembrance at the Taranaki Crematorium

Taken away by (name of company, courier agent or person)

Signature

Date

*Please state relationship to the deceased (e.g. spouse, executor, near relation, defacto partner, civil union partner, etc).

3. Confirmation of disposal of ashes

3a. Crematorium attendant to select whichever is applicable:

Date ashes interred in the Garden of Remembrance

Signature of person receiving ashes

Signature

Date

3b. Ground of recipient's claim for taking ashes (i.e. applicant for cremation, funeral director, courier or agent acting on behalf of the funeral director or family, relative of the deceased - relationship to be stated, etc).