

B. Death Registration Form (BMD-2)

SWAZILAND GOVERNMENT
DEPARTMENT OF THE REGISTRAR GENERAL

Form BMD 2 No 625597*

PERMIT FOR BURIAL

Cross the appropriate box thus

1. NAME OF DECEASED: (First Name) (Other Name) (Surname) 2. SEX M F

3. DATE OF DEATH: Day Month Year 4. AGE: Day Month Year

5. USUAL PLACE OF RESIDENCE: Name of Area Region (District)

After making due inquiry as to the cause of the death of the above named deceased person, I hereby authorize the interment of his * * her body.

6. DATE: Day Month Year 7. Chief/Registration Information Officer 8. Signature: _____

PERMIT ISSUED TO (Name) (Name of informant) Signature or Thumb print of informant

SWAZILAND GOVERNMENT
DEPARTMENT OF THE REGISTRAR GENERAL

Form BMD 2 No 625597*

REGISTER OF DEATH

	1. NAME AND SURNAME (in block letters)	First Name	Other Names	Surname		For office use only			
	2. DATE OF DEATH	DAY MONTH YEAR							
	3. PLACE OF DEATH (Geographic)	Name of Area Region (District)							
	4. SEX	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>							
	5. MARITAL STATUS	MARRIED <input type="checkbox"/> SINGLE * <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW <input type="checkbox"/> SEPARATED <input type="checkbox"/>							
	6. DATE OF BIRTH	DAY	MONTH	YEAR					
	7. PLACE OF BIRTH (Geographic)	Name of Area Region (District)							
	8. NATIONALITY								
	9. OCCUPATION								
	10. USUAL PLACE OF RESIDENCE								
	11. (a) CAUSE OF DEATH	11. (a) Was cause of death certified by medical practitioner?			Yes <input type="checkbox"/> No <input type="checkbox"/>				
DECEASED	12. CAPACITY OF INFORMANT: Relative <input type="checkbox"/> Other specify <input type="checkbox"/>								
	13. CERTIFICATION: To the best of my knowledge, the information given above is correct. 14. DATE: Day Month Year								
	15. SIGNATURE OR THUMB PRINT 16. Residential Address: _____								
INFORMANT	17. I am satisfied after inquiry that the above-mentioned death is not one to which Section 3 of the Inquest Act No. 59 of 1954 apply. An external examination of the body has * * / has not been made a medical practitioner.								
	18. DATE: Day Month Year 19. STATE CENTRE: _____								
	20. NAME: _____ 21. SIGNATURE: _____								
REGISTRATION INFORMATION OFFICER	22. REGION (DISTRICT): _____ 23. REGISTRATION NO. _____								
	24. DATE: _____ 25. SIGNATURE: _____								

*If the deceased was a married woman, husband's name could be written. ** Delete inapplicable