Form A

SHANNON CREMATORIUM

Illaunmanagh, Shannon, Co. Clare
Tel: 065 671 3088
Email: info@shannoncrematorium.com
Web: www.shannoncrematorium.com

FUNERAL DIRECTOR CONFIRMATORY ORDER FORM

PLEASE TICK WHETHER FORM C ☐ OR FORM D ☐ TO FOLLOW

Funeral Director ..... Telephone: .....
Address ..... Email: .....

Age ..... Sex .....
Religion .....Date of death.....
Name of Deceased ..... Married ☐ Single ☐ Separated ☐
Address..... Divorced ☐ Widow/er ☐
Place of Death (if different from above) .....
Occupation .....
Cremation to take place: Day ..... Date ..... Time .....

Mode of disposal of cremated remains:

(a) Private Disposal: Urn ☐ Casket ☐ Supplied Urn ☐ Interment in Columbarium wall ☐

NB! ASHES OF DECEASED ARE NORMALLY AVAILABLE FOR COLLECTION 3/4 WORKING DAYS AFTER THE CREMATION SERVICE

(b) Memorial Option: State which option: .....
How many spaces (max 3): .....
Confirm inscription: .....

If the deceased has any of the below implants, these must be removed as they will damage the Cremator whilst Cremating.

(a) Heart Pacemaker (b) Heart Defribulator (c) Radio active implant (d)Artificial arms or legs (e) Fixion Implant (f) Baclofen pump

NOTE: CREMATION MAY BE REFUSED IF ANY OF THE ABOVE IMPLANTS ARE NOT REMOVED

No batteries, bottles, alcohol, electronic devices or glass permitted in the coffin as these will also damage the cremator whilst cremating.

If the coffin is longer than 7½ft, wider than 3ft or more than 2ft in height, please contact the crematorium to see if coffin is suitable for cremating.

No cardboard coffins are accepted for cremation or coffins with pitch inside.

I hereby certify that I have complied with all regulations laid down by Shannon Crematorium

Signature of Funeral Director .....

THIS FORM WHEN COMPLETED SHOULD BE SENT TO SHANNON CREMATORIUM, ILLAUNMANAGH, SHANNON, CO. CLARE.
TEL: 065 671 3088 - EMAIL: INFO@SHANNONCREMATORIUM.COM

This form is issued by Shannon Crematorium, Illaunmanagh, Shannon, Co. Clare. Tel: 065 671 3088 Form B

APPLICATION FOR CREMATION BY EXECUTOR OR NEAREST NEXT OF KIN

ALL QUESTIONS MUST BE ANSWERED
PURSUANT TO THE BYE LAWS MADE BY SHANNON CREMATORIUM

This application should be made preferably by an executor and witnessed by a third party at bottom of this page. If not, then by the nearest surviving relative (NSR). This application CANNOT be made by a Common Law partner or a friend.

(Name of Applicant)..... Mr./Mrs./Miss
ie Next of Kin or Executor
(Address) .....
.....
(Occupation or Description) .....
apply to Shannon Crematorium Company to undertake the cremation of the remains of:-
(Name of Deceased).....
First Name in full
(Address) .....
(Occupation).....

Age ..... Sex ..... Religion ..... Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow/er ☐
at SHANNON CREMATORIUM. on.....

The answers must be completed by the applicant (Executor or NSR only!).

1. Are you an executor or the nearest surviving relative (NSR) of the deceased?, Please state which. If you are the NSR, please state your relationship to the deceased. .....

2. If answer to 1 is "No".
   (a) Your relationship to the deceased (a) .....
   (b) The reasons why the application is made by you and not an executor or nearest surviving relative. (b) .....

3. Has the nearest surviving relative of the Deceased been informed of the proposed cremation?

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

(a) Violence or misadventure	Y ☐	N ☐
(b) Unfair means	Y ☐	N ☐
(c) Negligence	Y ☐	N ☐
(d) Malpractice on the part of others	Y ☐	N ☐
(e) Poison / Alcohol / Drug related	Y ☐	N ☐

5. Has the deceased been fitted with any artificial implant?
   Is Yes, Please state what form below and in form your funeral director as he/she has a list of implants that will damage the cremator on Form A of the Cremation Forms. .....
   NB! No batteries, bottles, alcohol, electronic devices or glass permitted in the coffin as these items will also damage the cremator whilst cremating. Any residual metals (i.e. coffin nails, body implants) following cremation are recycled. Monies received from this recycling programme are donated to Truck Run for Katie in support of The Cystic Fibrosis Unit in University Hospital Limerick.

NOTE: CREMATION MAY BE REFUSED IF ANY DAMAGING IMPLANT IS NOT REMOVED

NB! THE CREMATION ASHES OF DECEASED MUST BE COLLECTED NO LATER THAN 1 MONTH AFTER THE CREMATION SERVICE.

I declare that to the best of my knowledge and belief the information given in this, is correct and no material in particular has been omitted.

Date: ..... *(Signature of Applicant) i.e. Executor or NSR* .....

The applicant is known to me and I have no reason to doubt the truth of any of the information furnished by the applicant.

Date: ..... *(Signature of Witness)*.....

(Address).....

Please Print Name ..... Date .....

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This form is issued by Shannon Crematorium, Illaunmanagh, Shannon, Co. Clare. Tel: 065 671 3088 Form C

These Certificates are to be returned to the Funeral Director or Crematorium **AS SOON AS POSSIBLE**

DEAR DOCTOR, PLEASE READ BELOW VERY CAREFULLY !!!

Before you begin to answer this form, please note that you must fulfil all the criteria below first:
(a) You must have at least some knowledge of the deceased's medical history.
(b) You must have seen the deceased before death, within 4 weeks of death.
(c) You must have seen the deceased after death.
(d) You must be fully registered on the Medical Register of Ireland i.e. Post-Intern year
(e) You must report the death to your Coroner, if applicable.
If you do not fulfil ALL of the above criteria, then STOP!
You cannot continue. Please contact the Funeral Director immediately

FORM C **MEDICAL CERTIFICATE**

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

(Name of Deceased) .....

(Address) .....

(Occupation of Deceased) ..... (Age) .....

HAVING SEEN AND IDENTIFIED THE BODY BEFORE AND AFTER DEATH

I give the following answers to the questions set out below:-

1. (a) Were you the regular attending doctor of the Deceased) (a) .....
   (b) If so, for how long?) (b) .....

2. (a) Did you attend the Deceased during his or her last illness) (a) .....
   (b) If so, for how long?) (b) .....

3. (a) When did you last see the Deceased alive?) (Date) .....
   (say how many days or hours before death)) (Days or Hours) .....

4. (a) How soon after death did you see the body? and) (a) .....
   (b) What examination did you make?) (b) .....

5. (a) On what date and at what hour did he or she die?) Date ..... Hour .....

6. (a) What was the place where the Deceased died?) (a) .....
   Give address and .....
   (b) Say whether Deceased's own residence, lodging, hotel
   hospital, nursing home etc.) (b) .....

7. (a) Are you a relative of the Deceased?) (a) .....
   (b) If yes, state relationship) (b) .....

8. Have you, so far as you are aware, any financial interest
   in the death of the Deceased.) .....

9. Cause of death and duration of last illness: **NO ABBREVIATIONS**

			Approximate interval between onset and death
. I		**. I**	
Disease or condition directly leading to death	(a)	.....	.....
		due to (or as a consequence of)	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)	.....	.....
		due to (or as a consequence of)	
	(c)	.....	.....
. II		**. II**	
Other significant conditions contributing to the death but not related to the disease or condition causing it.		.....	.....

NOTE: IF DEATH IS NOT DUE TO NATURAL CAUSES, (IE FALL, FRACTURE, ALCOHOL / DRUG RELATED) YOU MUST REPORT THE DEATH TO YOUR CORONER

10. (a) State how far the answer to the last question is the result of your own observation. .....

(b) If not your own observation, what was the source of your information? .....

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11. (a) Have you or any other doctor performed an Autopsy on the body?) (a).....

(b) If "Yes" state by whom the examination was made.) (b).....

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12. By whom was the Deceased nursed during his or her last illness.) .....

(Give names and say whether professional nurse, relative etc. If the illness was a long one this question should be answered with reference to period of four weeks before the death).) .....

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13. Who were the persons present (if any) at the moment of death.) .....

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14. In view of your 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 stated in 9. above?) .....

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15. Have you any reason to suspect that the Deceased person died either directly or indirectly as a result of:

(a) Violence or misadventure — (a) Yes / No.....

(b) Unfair means — (b) Yes / No.....

(c) Negligence or misconduct — (c) Yes / No.....

(d) Malpractice on the part of others — (d) Yes / No.....

(e) Poison / Alcohol / Drug related — (e) Yes / No.....

(f) Falls / Fractures — (f) Yes / No.....

(g) Any other than natural illness — (g) Yes / No.....

or disease for which he/she had been seen and treated by a registered medical practitioner within one month before his/her death:

IF YOU ARE IN ANY DOUBT ABOUT ANY OF THE ABOVE ANSWERS , PLEASE DISCUSS WITH YOUR CORONER.

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16. Do you know or have you any reason to suspect that the death occurred under or within 24 hours of an anaesthetic or Medical Procedure .....

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17. (a) Have you any reason to suspect that the death of the Deceased should properly be reported to the Coroner?) (a).....

(b) If so have you or anybody else done so) (b).....

What was the outcome of the discussion .....

.....

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18. Have you any reason whatever to suppose a further examination of the body to be desirable?) .....

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19. (a) Did you sign the medical Certificate of the Cause of Death?) (a).....

(b) If not who has?) (b).....

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20. (1) Has the Deceased been fitted with?

(a) A Cardiac Pacemaker / Defribulator) (1.) (a)Yes / No.....

(b) A Radioactive Implant) (b)Yes / No.....

(e) Other Prosthesis) (e)Yes / No.....

(2) If the answer to any of the above is in the affirmative, has this implant been removed?) (2.) Yes / No .....

NOTE: CREMATION MAY BE REFUSED IF ANY ARTIFICIAL IMPLANT IS NOT REMOVED AS THEY WILL DAMAGE THE CREMATOR

YOUR COMPLETION OF THIS FORM C WILL BE DEEMED VOID IF YOU ARE NOT FULLY REGISTERED ON THE MEDICAL REGISTER OF IRELAND I.E. POST INTERN YEAR

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief.

Name ..... (Signature) .....

(please insert name here in block capitals). Date: .....

Telephone No..... (Address) .....

.....

Registered Qualification.....

Year & Month of Full Registration on The Medical Register of Ireland .....
(not provisional)

Medical Registration No .....

Form D

CORONER'S CERTIFICATE FOR CREMATION

I Certify that:-

I am satisfied that there are no circumstances likely to call for further examination of the body.

PARTICULARS OF DECEASED PERSON

Full Names .....

Sex .....

Age .....

Date of Death .....

Place of Death .....

(Please insert name here in block capitals) .....

Signature .....

Coroner for the of

Date .....

If the deceased has any of the below implants, these must be removed as they will damage the Cremator whilst Cremating.

(a) Heart Pacemaker (b) Heart Defribulator (c) Radio active implant (d) Artificial arms or legs (e) Fixion Implant (f) Baclofen pump

NOTE: CREMATION MAY BE REFUSED IF ANY ARTIFICIAL IMPLANT LISTED ABOVE IS NOT REMOVED.

NOTE: This Certificate is issued for the purpose of cremation only and must be delivered to the Funeral Director or Shannon Crematorium as soon as possible. The Cremation cannot be proceeded with unless this Certificate is so delivered.

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