

## Additional file 1 The former TURKSTAT Death Certificate

COUNTERFOIL	REPUBLIC OF TURKEY PRIME MINISTRY STATE INSTITUTE OF STATISTICS	REPUBLIC OF TURKEY MINISTRY OF HEALTH AND SOCIAL WELFARE												
<p>Note: To be retained in responsible institution</p> <p style="text-align: right;">No:.....</p> <p><b>I. Place where the form in filled out:</b></p> <p>a) Province: .....</p> <p>b) District: .....</p> <p><b>II. Deceased:</b></p> <p>a) Name: .....</p> <p>b) Surname: .....</p> <p>c) Father's name: .....</p> <p>d) Mother's name: .....</p> <p>e) Age (Completed): .....</p> <p>f) Sex: .....</p> <p>g) House address: .....</p> <p>h) Cause of death (the main cause): .....</p> <p>i) Date of death: ...../...../.....</p> <p><b>III. Doctor verifying death:</b></p> <p>a) Name: .....</p> <p>b) Surname: .....</p> <p>Burial of deceased, name and identity written above, is permitted.</p> <p style="text-align: right;">...../...../.....</p> <p style="text-align: right;"><b>Official seal and signature</b></p>	<p>To be send to the State Institute of Statistics through Health Directorate in the province centres and Health Clinic in the district centres</p> <p><b>DEATH STATISTICS FORM</b></p> <p><b>I. Place of death</b></p> <p>a) Name of province: .....</p> <p>b) Name of district: .....</p> <p><b>II. Deceased:</b></p> <p>a) Name and surname: .....</p> <p>b) Age (completed): .....years old</p> <p>c) Under one years old: .....month old</p> <p>d) Under one month old: .....days old</p> <p>e) Sex <span style="margin-left: 100px;"><input type="checkbox"/> Male</span> <span style="margin-left: 50px;"><input type="checkbox"/> Female</span></p> <p>f) Permanent residence: .....</p> <p style="text-align: center;"><input type="checkbox"/> Province centres    <input type="checkbox"/> District centres    <input type="checkbox"/> Sub district or village</p> <p>g) Marital status</p> <p style="text-align: center;"><input type="checkbox"/> Never married    <input type="checkbox"/> Married    <input type="checkbox"/> Widowed    <input type="checkbox"/> Divorced</p> <p>h) Education level:</p> <p style="text-align: center;"><input type="checkbox"/> Illiterate    <input type="checkbox"/> Literate without a diploma    <input type="checkbox"/> Primary school</p> <p style="text-align: center;"><input type="checkbox"/> Secondary school and equivalent    <input type="checkbox"/> High school    <input type="checkbox"/> University</p> <p>i) Occupation or job: .....</p> <p style="text-align: center;"><input type="checkbox"/> House wife    <input type="checkbox"/> Retired    <input type="checkbox"/> Student    <input type="checkbox"/> Income owner    <input type="checkbox"/> Other</p> <p>k) The month in which death occurred</p> <table style="width: 100%; text-align: center;"> <tr> <td><input type="checkbox"/> January</td> <td><input type="checkbox"/> February</td> <td><input type="checkbox"/> March</td> <td><input type="checkbox"/> April</td> </tr> <tr> <td><input type="checkbox"/> May</td> <td><input type="checkbox"/> June</td> <td><input type="checkbox"/> July</td> <td><input type="checkbox"/> August</td> </tr> <tr> <td><input type="checkbox"/> September</td> <td><input type="checkbox"/> October</td> <td><input type="checkbox"/> November</td> <td><input type="checkbox"/> December</td> </tr> </table> <p>l) Underlying cause of death: .....</p> <p>m) Autopsy <span style="margin-left: 100px;"><input type="checkbox"/> is done</span> <span style="margin-left: 50px;"><input type="checkbox"/> is not done</span></p> <p><b>III. Death verified by</b></p> <p style="text-align: center;"><input type="checkbox"/> Hospital or health directorate    <input type="checkbox"/> Health centre physician    <input type="checkbox"/> Municipality physician</p> <p style="text-align: right;">...../...../.....</p> <p style="text-align: right;"><b>Official seal and signature</b></p>	<input type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March	<input type="checkbox"/> April	<input type="checkbox"/> May	<input type="checkbox"/> June	<input type="checkbox"/> July	<input type="checkbox"/> August	<input type="checkbox"/> September	<input type="checkbox"/> October	<input type="checkbox"/> November	<input type="checkbox"/> December	<p>To be given to the relatives of dead</p> <p style="text-align: center;"><b>BURIAL LICENCE</b></p> <p>No of counterfoil: .....</p> <p><b>I. Place where the form in filled out:</b></p> <p>a) Province: .....</p> <p>b) District: .....</p> <p><b>II. Deceased:</b></p> <p>a) Name: .....</p> <p>b) Surname: .....</p> <p>c) Father's name: .....</p> <p>d) Mother's name: .....</p> <p>e) Age (Completed): .....</p> <p>f) Sex: .....</p> <p>g) House address: .....</p> <p>h) Cause of death (the main cause): .....</p> <p>i) Date of death: ...../...../.....</p> <p><b>III. Doctor verifying death:</b></p> <p>a) Name: .....</p> <p>b) Surname: .....</p> <p>Burial of deceased, name and identity written above, is permitted.</p>
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