

DEATH INVESTIGATION REPORT



Investigator/Sheriff/Deputy	Date of Death
Local ME (On-Call)	Case Number

Primary Rationale for Medical Examiner Activity (choose one):

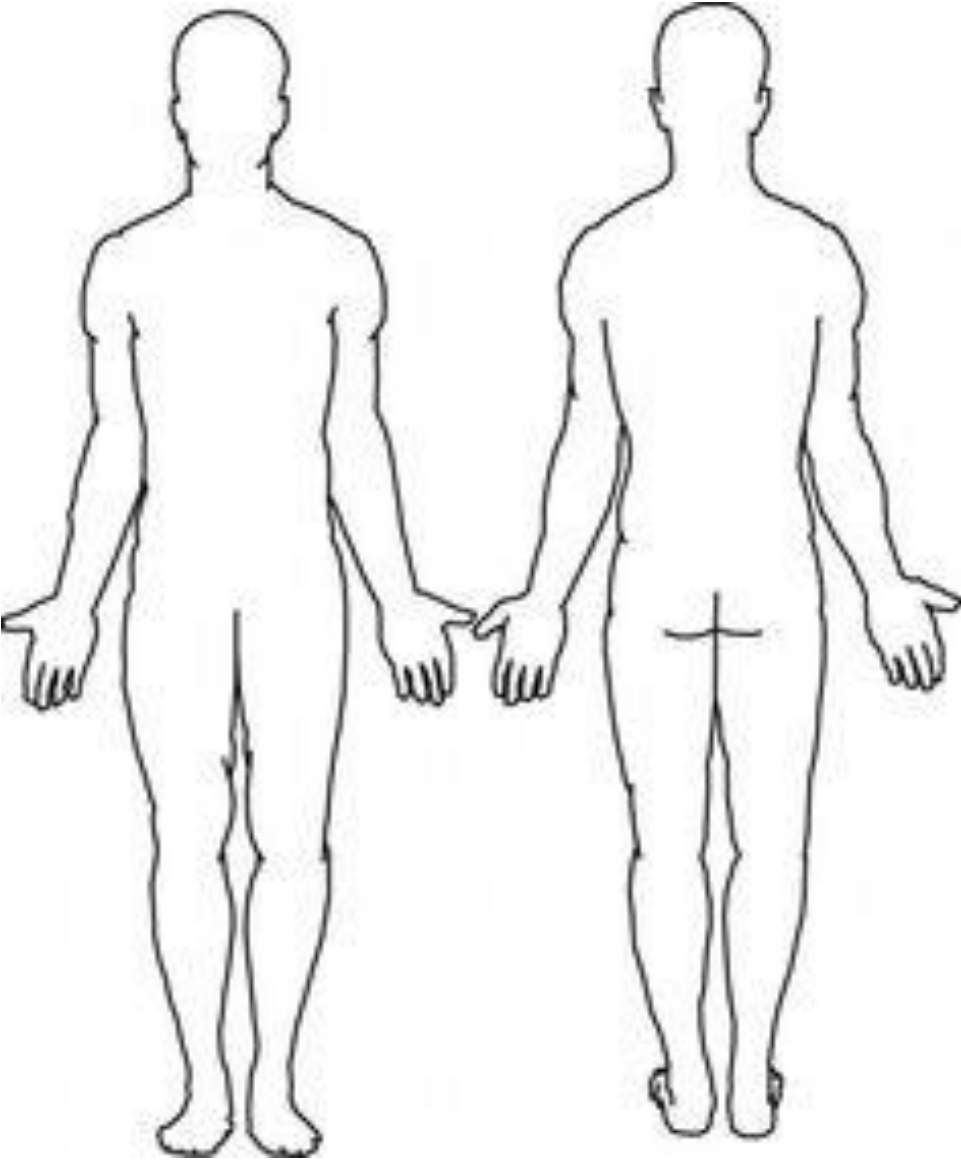
- | | |
|--|---|
| <input type="checkbox"/> Accidental Death | <input type="checkbox"/> Drowning |
| <input type="checkbox"/> Natural/Sudden/Unexpected Death | <input type="checkbox"/> Cause of Death Not Determinable by Attending Physician |
| <input type="checkbox"/> Violent Death
(<input type="checkbox"/> Homicide/ <input type="checkbox"/> Suicide) | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Suspicious Circumstances | |
| <input type="checkbox"/> In Custody Death | <input type="checkbox"/> Autopsy Ordered by ME <input type="checkbox"/> Autopsy Ordered by CA |

DECEDENT IDENTIFICATION/BODY INFORMATION					
(Last)	(First)	(Middle)	SS#:		
Street Address		City	State	Zip	
Aliases		Date of Birth	Age (if less than 2 years give months & days)		
<u>SEX</u> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	<u>CLOTHING</u> <input type="checkbox"/> Clothed <input type="checkbox"/> Partly Clothed <input type="checkbox"/> Unclothed	<u>BODY TEMPERATURE</u> <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold	<u>BLOOD</u> <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Ears <input type="checkbox"/> Clothing <input type="checkbox"/> None	<u>WORK RELATED</u> <input type="checkbox"/> Yes <input type="checkbox"/> No EMPLOYER: _____ INDUSTRY: _____	<u>OCCUPATION</u> TYPE OF WORK: _____ INDUSTRY: _____
<u>MARITAL STATUS</u> <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	<u>HEAD-HAIR</u> <input type="checkbox"/> None <input type="checkbox"/> Partly Bald <input type="checkbox"/> Blonde <input type="checkbox"/> Brown <input type="checkbox"/> Red <input type="checkbox"/> Black <input type="checkbox"/> Gray <input type="checkbox"/> White	<u>EYES - COLOR</u> <input type="checkbox"/> Black <input type="checkbox"/> Blue <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Hazel Other: _____	<u>WEIGHT</u> _____ lbs. <u>HEIGHT</u> _____ in.	<u>RIGOR</u> Neck: <input type="checkbox"/> Yes <input type="checkbox"/> No Arms: <input type="checkbox"/> Yes <input type="checkbox"/> No Legs: <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>FROTH</u> <input type="checkbox"/> Present <input type="checkbox"/> Absent Color: _____ <u>OTHER</u> (Dirt, water, etc.) <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Ears <input type="checkbox"/> None
<u>RACE</u> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other	<u>OTHER HAIR</u> <input type="checkbox"/> Mustache <input type="checkbox"/> Beard	<u>MISCELLANEOUS</u> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> Circumcised	<u>LIVOR</u> Color: _____ Fixed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Later (R/L)	<u>DECOMPOSITION</u> <input type="checkbox"/> Early <input type="checkbox"/> Advanced <input type="checkbox"/> None	<u>HISTORY OF DOMESTIC VIOLENCE</u> <input type="checkbox"/> Yes <input type="checkbox"/> No

MEANS OF DEATH – OTHER THAN NATURAL			
MOTOR VEHICLE INVOLVED <input type="checkbox"/> Yes <input type="checkbox"/> No	DOT Crash Report <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hit-Run	<input type="checkbox"/> Non-Highway
Agency: _____	Case Number: _____	Investigation LEO: _____	Number: _____
FIREARM INVOLVED <input type="checkbox"/> Yes <input type="checkbox"/> No	Firearm(s) Seized <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Rifle - Cal. _____	Handgun <input type="checkbox"/> - Cal. _____	Shotgun <input type="checkbox"/> - Gauge _____	Other: <input type="checkbox"/> Desc. _____
INSTRUMENT INVOLVED <input type="checkbox"/> Yes <input type="checkbox"/> No	Instrument(s) Seized <input type="checkbox"/> Yes <input type="checkbox"/> NO		
<input type="checkbox"/> Blunt <input type="checkbox"/> Sharp	Instrument Description: _____		
DRUG, CHEMICAL OR POISON INVOLVED <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Alcohol <input type="checkbox"/> Other Drug <input type="checkbox"/> Poison <input type="checkbox"/> Chemical Other: _____			

INFORMATION ABOUT OCCURRENCE					
ITEM	DATE	TIME (military)	LOCATION	COUNTY	TYPE OF PREMISES
INJURY OR ONSET OF ILLNESS					
LAST SEEN ALIVE					
DEATH (PRONOUNCED)					
FOUND BY			By:		
M.E. NOTIFIED			BY:	M.E. AT SCENE <input type="checkbox"/> Yes <input type="checkbox"/> No	
VIEW OF BODY				<input type="checkbox"/> NOT VIEWED	
TO HOSPITAL			BY:	DONOR <input type="checkbox"/> Yes <input type="checkbox"/> No	
M.E. INSTRUCTIONS					
NARRATIVE SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH					

SCENE INFORMATION			
Scene Visit Date:	Scene Visit Time:	Investigator Notified by:	Photos/Video
Notification Date:	Notification Time:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Address of Incident:			
(Street)		(City/Township)	(GPS Coordinates)
Incident Date:		Incident Time:	
Place of Incident (Check one):			
<input type="checkbox"/> Decedent's Home	<input type="checkbox"/> Living Facility	<input type="checkbox"/> Place of Business	<input type="checkbox"/> Other: (Specify)
<input type="checkbox"/> Highway/Road/Street	<input type="checkbox"/> School	<input type="checkbox"/> Farmstead	
<input type="checkbox"/> Jail	<input type="checkbox"/> Emergency Dept.	<input type="checkbox"/> Farm land	
<input type="checkbox"/> In custody	<input type="checkbox"/> Hospital	<input type="checkbox"/> Body of Water	
MAPPING/PHOTOGRAPHS <i>Thumbnails</i>			

CIRCUMSTANCES SURROUNDING DEATH			
Attendance of Death: <input type="checkbox"/> Witnessed Death <input type="checkbox"/> Body Found		Notes:	
Evidence of Alcohol Involved: <input type="checkbox"/> Yes <input type="checkbox"/> No		Evidence of Drugs Involved: <input type="checkbox"/> Yes <input type="checkbox"/> No	
List of Valuables: <input type="checkbox"/> See Attached Inventory		Disposition of Valuables:	
INJURIES OBSERVED ON BODY RELATIVE TO INCIDENT			
			
MEDICAL HISTORY			
CONDITION: <input type="checkbox"/> Alcoholism <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Lung Disease		<input type="checkbox"/> Fractures <input type="checkbox"/> Heart Disease <input type="checkbox"/> Seizure <input type="checkbox"/> Other	
FAMILY PHYSICIAN Doctor: _____ Address: _____ Phone #: _____		MEDICATIONS <input type="checkbox"/> YES <input type="checkbox"/> No	

SECONDARY PARTIES				
IDENTIFIED BY	Decedent Identified By: (Last) _____ (First) _____			
Relationship: <input type="checkbox"/> Family Member <input type="checkbox"/> Police <input type="checkbox"/> Health Care Professional <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Other: _____				
Means Identified by: <input type="checkbox"/> Appearance <input type="checkbox"/> ID Card <input type="checkbox"/> Dental Records <input type="checkbox"/> Fingerprints <input type="checkbox"/> DNA <input type="checkbox"/> S-Ray <input type="checkbox"/> Photograph <input type="checkbox"/> Presumptive <input type="checkbox"/> Other: _____				
Notes:				
NEXT OF KIN	Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No		Kin at Scene <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notifying Agency: _____				
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____				
Name: (Last) _____ (First) _____ (Middle) _____				
Address: (Street) _____		(City) _____		(State) _____
(Zip) _____				
Phone Number: _____		Email: _____		
Notes:				
OTHERS INVOLVED	Associated Cases: _____			
Was this Death Potentially Caused by a Secondary Party: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown			Number of Associated Fatal Injuries: _____	
If Yes, Relation to Decedent: _____			Number of Associated Non-Fatal Injuries: _____	
Notes:				
WITNESS (1)	<input type="checkbox"/> Witness to Death <input type="checkbox"/> Found Decedent <input type="checkbox"/> N/A		Relationship of Witness/Person Who Found Decedent to Decedent: <input type="checkbox"/> Family Member <input type="checkbox"/> Health Care Professional <input type="checkbox"/> Stranger <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Other: _____	
Name: _____				
Address: _____			City: _____	State: _____
(Zip) _____				
Phone Number: _____		Notes: _____		
WITNESS (2)	<input type="checkbox"/> Witness to Death <input type="checkbox"/> Found Decedent <input type="checkbox"/> N/A		Relationship of Witness/Person Who Found Decedent to Decedent: <input type="checkbox"/> Family Member <input type="checkbox"/> Health Care Professional <input type="checkbox"/> Stranger <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Other: _____	
Name: _____				
Address: _____			City: _____	State: _____
(Zip) _____				
Phone Number: _____		Notes: _____		
WITNESS (3)	<input type="checkbox"/> Witness to Death <input type="checkbox"/> Found Decedent <input type="checkbox"/> N/A		Relationship of Witness/Person Who Found Decedent to Decedent: <input type="checkbox"/> Family Member <input type="checkbox"/> Health Care Professional <input type="checkbox"/> Stranger <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Other: _____	
Name: _____				
Address: _____			City: _____	State: _____
(Zip) _____				
Phone Number: _____		Notes: _____		

OTHER INFORMATION