Case Number _____

DEATH SCENE / INVESTIGATION REPORT

County Coroner's Office

Decedent's Name _____
FIRST MIDDLE LAST

Age_____ Race _____ Sex _____ DOB _____ SS#_____

Home Address_____
Street City County State Zip

Law Enforcement Agency _____Officer_____

Begin Mileage _____ Ending Mileage _____ Total Mileage _____

ACTION	DATE	TIME	REMARKS	BY WHOM (PERSON OR AGENCY)
Notified			By Whom:	
Scene visit			Photos? ____ Yes ____ No	
NOK Notified			Person:	

DESCRIPTION OF CIRCUMSTANCES: (Include **how** the incident is thought to have occurred, decedent's **activity** at the time of the incident, the **type of place**, and the **sequence of events**). **If extra pages are used, indicate number here:**

_____

_____

_____

_____

_____

_____

_____

PLACE OF DEATH	_____On Scene _____ En-route / DOA _____ Emergency Room _____ In Surgery _____ Inpatient

EVENT	DATE	TIME	ADDRESS: CITY / COUNT / STATE / ZIP
Injury / Event			
Actual Death			
Pronounced			
At Hospital			Hospital: Taken by:

Pronounced by	Name:		Title:	
IF FOUND	**DATE**	**TIME**	**WHERE: PLACE OR STREET ADDRESS**	**BY WHOM**
When				
Last Known OK				
Condition			_____ Not Conscious _____ Dead ____ InDistress	
How know live or OK			_____ Seen _____ Heard _____ Other:	

Concerning the onset of fatal events	_____ Witness present **OR** _____ Un-witnessed / No witnesses known _____ At own residence **OR** _____ Away from home/ not at own residence _____ Indoors **OR** _____ Out-of-doors _____ In vehicle **OR** _____ Not in vehicle _____ While on the job **OR** _____ Not while on job
Place of onset of the fatal events	**Describe TYPE OF PLACE:**
Occupation and Employment status	Occupation or Job Title >>>> Industry or kind of business>>> Employment Status >>> _____ Currently employed _____ Self-employed _____ Not employed
MEDICAL HISTORY	_____ Not investigated _____ Unknown _____ No past problems _____ Medical problems
MEDICAL INFORMANT	____ None _____ Doctor _____ Med Records _____ Health Provider _____ Family _____Other

TYPE OF DISORDER	Yes	No	Unk	Specify, clarify, or comment
A) High blood pressure				
B) Heart Disease (myocardial infarction, CHF etc)				
C) Lung Disease (emphysema, asthma etc)				
D) GI Disease (ulcers, hepatitis, cirrhosis etc)				
E) Nerve System (dementia, depression, strokes etc)				
F) Substance use (alcohol, drugs, smoker etc)				
G) HIV infection				
H) Cancer or other malignancy				
I) Terminal illness				
J) Pregnant within previous 90 days				
K) Seizures (specify if due to injury, alcohol or other)				
L) Recent / old serious injury (describe)				
M) Long term effects of a previous injury (specify)				
N) Allergic reaction (specify)				

O) Other condition not in this list (specify)			

MEDICATION HISTORY	_____ Not investigated _____ Unknown _____ Rx Meds _____ OTC _____ None

Drug Names (dosage, Rx number, Rx date, pharmacy, pill count, if needed): If extra pages needed, write number here:

PROCEDURES	YES	NO	
			Scene Inspection by Certifier
			Photographs
			Alcohol (ethanol) determination on blood or serum
			Toxicology screen (tests other than ethanol)
			Other: (consults etc) specify>>>
			Imaging studies (X-rays or other imaging studies)

CAUSE OF DEATH	**INTERVAL**
Immediate:	
due to:	
due to:	
due to:	

Other Significant Conditions:

MANNER OF DEATH	_____ Homicide _____ Suicide _____ Accident _____ Natural _____Undetermined

IF INJURY CAUSED OR CONTRIBUTED TO DEATH	INJURY DATE: TIME:
How did injury occur:	
Type of place where injury occurred:	
Actual Date / Time of Death (Circle if "approx" or "found")	DATE: TIME:
Death Certified by:	DATE: TIME:
Title of Certifier:	

NOTE: DO NOT COMPLETE ITEMS ON THIS PAGE UNTIL THE CASE IS BEING CERTIFIED (OR FINALIZED)

ADDITIONAL QUESTIONS RELATED TO CERTIFICATION	YES	NO	UNKNOWN
Was an autopsy performed anywhere else?			
Were autopsy findings used to describe cause or manner of death?			
Did the events leading to death occur while the person was at work?			
Does the death meet the guidelines for "injury at work"?			
Was surgery performed within 30 days of death?			

ETHANOL _____N/A	Specimen:	Concentration/Units:

AGONAL MEDICAL TREATMENT	_____ None _____ CPR _____ Transfusion _____ IV fluids _____ Surgery

Describe (a) dates and reasons for any surgery during final hospitalization or for surgery performed at any time for conditions that led to death, (b) injuries or conditions documented at hospital, (c) known or suspected complications of anesthesia or medical procedures, (d) other comments.

Case disposition:	_____**DECLINE CASE** due to **OR** _____ **JURISDICTION ACCEPTED** for ____Topic ____ Locale ____ Autopsy ____ Inspection ____ Certification ____ Cremation Authorization
Who will sign DC?	_____

Body disposition:>>>	_____ Brought in for exam _____ Brought in for holding/claim _____ Released
Transport agency:>>>	

Released To:	Location:	Requested By:	Relationship:

Investigator: Title: Date:

ADDITIONAL COMMENTS:

BODY EXAMINATION CHART	Body Examined By:	Date:	Time: