



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:

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**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:
<b>IF FOUND</b>	<b>DATE</b>	<b>TIME</b>	<b>WHERE: PLACE OR STREET ADDRESS</b>	<b>BY WHOM</b>
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 <b>OR</b> _____ Un-witnessed / No witnesses known _____ At own residence <b>OR</b> _____ Away from home/ not at own residence _____ Indoors <b>OR</b> _____ Out-of-doors _____ In vehicle <b>OR</b> _____ Not in vehicle _____ While on the job <b>OR</b> _____ Not while on job			
Place of onset of the fatal events	<b>Describe TYPE OF PLACE:</b>			
Occupation and Employment status	Occupation or Job Title >>>> Industry or kind of business>>> Employment Status >>> _____ Currently employed _____ Self-employed _____ Not employed			
<b>MEDICAL HISTORY</b>	_____ Not investigated _____ Unknown _____ No past problems _____ Medical problems			
<b>MEDICAL INFORMANT</b>	_____ None _____ Doctor _____ Med Records _____ Health Provider _____ Family _____ Other			
<b>TYPE OF DISORDER</b>	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)			
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<b>MEDICATION HISTORY</b>	<input type="checkbox"/> Not investigated <input type="checkbox"/> Unknown <input type="checkbox"/> Rx Meds <input type="checkbox"/> OTC <input type="checkbox"/> None
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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:	

<b>MANNER OF DEATH</b>	<input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Accident <input type="checkbox"/> Natural <input type="checkbox"/> Undetermined
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<b>IF INJURY CAUSED OR CONTRIBUTED TO DEATH</b>	INJURY DATE:	TIME:
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How did injury occur:

Type of place where injury occurred:

<b>Actual Date / Time of Death (Circle if "approx" or "found")</b>	DATE:	TIME:

Death Certified by:	DATE:	TIME:
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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: _____		
<b>AGONAL MEDICAL TREATMENT</b>	_____ 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:	_____ <b>DECLINE CASE</b> due to <b>OR</b> _____ <b>JURISDICTION ACCEPTED</b> for			
Who will sign DC?	_____ Topic _____ Locale _____ Autopsy _____ Inspection _____ Certification _____ Cremation Authorization			
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:

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**BODY EXAMINATION CHART**

Body Examined By:

Date:

Time:

