DEATH INVESTIGATIVE WORKSHEET FOR EXAMINATION

Date: Investigator Name/Agency:		Request Type: ☐Full Autopsy ☐External Exam Investigation Agency Case #:
DECEDENT INFORMATION		
Decedent's Full Name:		Sex: ☐ Male ☐ Female
Date of Death (mm-dd-yyyy):		Time Pronounced:
Date of Birth:	Age:	SSN:
Residential Address:		City/State/Zip:
Decedent's Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Other (Specify):		
How was identification made?:		Decedent on Active Military Duty? ☐Yes ☐No
Decedent's Usual Occupation:		Last Seen Alive:
Decedent's Education: ☐Elementary/Secondary ☐College ☐Graduate School ☐ N/A		
Place of Death: ☐Inpatient ☐ER/Outpatient ☐Nursing Home ☐Residence ☐Other (Specify): Location Name/Address:		
Degree of Rigor: ☐None ☐Full body ☐Undeterminable		Position Body Found:
Livor Location: ☐None ☐Anterior ☐Posterior ☐Lower Extremities ☐Undeterminable		
CASE DESCRIPTION		
Criteria for Case: ☐ Unknown ☐ Apparent Natural ☐ Accident ☐ Suicide ☐ Homicide		
Is Motor Vehicle Collision Involved? ☐Yes ☐ No. If Yes, Decedent's Position: ☐ Driver ☐Passenger Another Vehicle Involved? ☐ Yes ☐ No Was Decedent Restrained? ☐Yes ☐ No		
Are Criminal Charges Anticipated? ☐Yes ☐ No. If Yes, Why?		
Weapon Involved? ☐Yes ☐No If Yes, Weapon Types:		
Injury Information:		

Circumstances of Death/Terminal Episode:
Scene Examination/Physical Examination (including body temperature):
Personal Property/Clothing:
Past Medical History [Including Social/Psychiatric/Surgical/Family/Drug-Rx/Illegal/ETOH History]:

Name of Medication	Prescribing Doctor	Dosage	Date Filled/Amount	Amount Remaining

NEXT OF KIN

NOK Name:	NOK Relationship:
NOK Address/Phone:	NOK Notified of Death? ☐ Yes ☐ No
Informant's Name and Relationship:	

MISCELLANOUS

Will agency have someone present during Autopsy ☐Yes ☐No and for taking photos? ☐Yes ☐No

If Yes, Enter Name(s)/Agency/Phone Number:

☐ By checking this box, I certify that the above information has been completed to the best of my knowledge and ability

SUMMARY OF CASE / ADDITONAL COMMENTS