

DEATH SCENE INVESTIGATION REPORT

Investigator _____ Date of Death _____

ME _____ Case Number _____



Primary Rationale for Medical Examiner Activity (choose one):

- | | |
|---|---|
| <input type="checkbox"/> Accidental Death | <input type="checkbox"/> Cause of Death Not Determinable by Attending Physician |
| <input type="checkbox"/> Natural/Sudden/Unexpected Death | <input type="checkbox"/> Cremation Authorization Permit |
| <input type="checkbox"/> Violent Death (Homicide/Suicide) | <input type="checkbox"/> No Other Physician to Sign Death Certificate |
| <input type="checkbox"/> Suspicious Circumstances | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Prison Death | |

DECEDENT IDENTIFICATION

Name: (Last) _____ (First) _____ (Middle) _____		SS#: _____	
Aliases: _____		Date of Birth: _____ Age: _____	
Decedent Was Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-human <input type="checkbox"/> Bones <input type="checkbox"/> Other Specify: _____	
Home Address: _____		Race (Check all that apply): <input type="checkbox"/> Hispanic/Spanish/Latino <input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> African Am. (not Hispanic) <input type="checkbox"/> Am. Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Unknown	
City: _____ State: _____		Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> N/A <input type="checkbox"/> Unknown	
County: _____ Zip Code: _____		Details (i.e.: Tribe, Country of Origin): _____	
Phone Numbers: Home: _____		Place of Employment: _____	
Cell: _____ Work: _____		Occupation: _____	
Other: _____ Other: _____			
<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker <input type="checkbox"/> Unknown <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____		Decedent Currently Under Governmental Supervision (i.e., Foster Care, Incarceration, Mental Health, etc.): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Agency & ID Number: _____	
Pregnant at Time of Death: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

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"/> X-ray <input type="checkbox"/> Photograph <input type="checkbox"/> Presumptive <input type="checkbox"/> Other:			
Notes: _____			ID Form Signed: <input type="checkbox"/> Yes <input type="checkbox"/> No
NEXT OF KIN		Notified: <input type="checkbox"/> Yes, Kin at Scene <input type="checkbox"/> Yes, by Agency <input type="checkbox"/> No <input type="checkbox"/> In Process	
Notifying Agency: _____			
Relationship: <input type="checkbox"/> 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: _____		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 If Yes, Relation to Decedent: _____		Number of Associated Fatal Injuries: _____	
		Number of Associated Non-Fatal Injuries: _____	
Notes: _____		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:	
WITNESSES <input type="checkbox"/> Witness to Death <input type="checkbox"/> Found Decedent <input type="checkbox"/> N/A			
Name: _____			
Address: (Street) _____ (City) _____ (State) _____ (Zip) _____			
Phone Number: _____		Notes: _____	

IF FOUND DEATH

Date Last Known Alive: Time Last Known Alive: (Military)	Found Death Date: Found Death Time: (Military) Found By:	Rigor: <input type="checkbox"/> None <input type="checkbox"/> Early <input type="checkbox"/> Moderate <input type="checkbox"/> Advanced	Livor As Expected: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If No, Please Describe:
Notes:			
Body Located: <input type="checkbox"/> Indoors <input type="checkbox"/> Outdoors Body Temperature (°F): _____ If Not Taken: <input type="checkbox"/> Cold <input type="checkbox"/> Warm Air Temperature (°F): _____	Position of Body (check one): <input type="checkbox"/> Sitting <input type="checkbox"/> On Side <input type="checkbox"/> On Back <input type="checkbox"/> On Stomach <input type="checkbox"/> Laying, Position Unspecified <input type="checkbox"/> Hanging <input type="checkbox"/> Other, Describe: Notes:		

DATE/TIME OF DEATH

Actual Date of Death:	If Applicable, Estimated Date of Death: Lower Bound: _____ Upper Bound: _____	If Applicable, Estimated Time of Death: (Military) Lower Bound: _____ Upper Bound: _____
Pronounced Date of Death:		Pronounced Time of Death: (Military)
Place of Pronounced Death: <input type="checkbox"/> Dead at Injury Location <input type="checkbox"/> Dead on Arrival at Emergency Department <input type="checkbox"/> Hospital, Emergency Department/Outpatient Facility <input type="checkbox"/> Hospital, Inpatient Facility <input type="checkbox"/> Hospital, Facility Unspecified <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Describe:		
If Death Occurred at Hospital, Hospital Name: Admission Date: _____ Admission Time: _____ Patient Record Number: _____		

CAUSE OF DEATH

	Cause of Death	Duration	ICD
Immediate:			
Due To:			
Due To:			
Due To:			
Other Significant Conditions:			

MANNER OF DEATH

<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending

This information is accurate to the best of my knowledge at the time I signed this document. I am not responsible for any errors incurred in the interpretation or translation of the information on this document that have been entered into the Michigan Medical Examiners Database for this case.

FIELD INVESTIGATOR: _____ **DATE:** _____

MEANS OF DEATH

1. VEHICLE

N/A

Type of Vehicle Associated With This Decedent Other Vehicle(s) Associated With This Incident Passenger Car..... <input type="checkbox"/> <input type="checkbox"/> SUV <input type="checkbox"/> <input type="checkbox"/> Mini-van <input type="checkbox"/> <input type="checkbox"/> Full Sized Van <input type="checkbox"/> <input type="checkbox"/> Truck..... <input type="checkbox"/> <input type="checkbox"/> Truck (3+axles)..... <input type="checkbox"/> <input type="checkbox"/> Motorcycle..... <input type="checkbox"/> <input type="checkbox"/> Bicycle <input type="checkbox"/> <input type="checkbox"/> ATV <input type="checkbox"/> <input type="checkbox"/> Snowmobile <input type="checkbox"/> <input type="checkbox"/> Watercraft <input type="checkbox"/> <input type="checkbox"/> Train..... <input type="checkbox"/> <input type="checkbox"/> Aircraft..... <input type="checkbox"/> <input type="checkbox"/> N/A <input type="checkbox"/> <input type="checkbox"/> Other:	Position of Decedent <i>Prior</i> to Death: <input type="checkbox"/> Driver Seat <input type="checkbox"/> Front Seat <input type="checkbox"/> Back Seat <input type="checkbox"/> Bicyclist <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other: _____ Decedent Remained in Vehicle: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Safety Devices Used: <input type="checkbox"/> Safety Belt <input type="checkbox"/> Helmet <input type="checkbox"/> Air Bag <input type="checkbox"/> Child Car Seat <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____ Did Device Contribute to Death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Did Device: <input type="checkbox"/> Fail <input type="checkbox"/> Was Not In Use <input type="checkbox"/> In Use, Activated Incorrectly <input type="checkbox"/> In Use, Activated Correctly
Make/Model/Year of Vehicle Associated with Decedent:	Crash Type: <input type="checkbox"/> Head On <input type="checkbox"/> Angle <input type="checkbox"/> Rear End <input type="checkbox"/> Sideswipe <input type="checkbox"/> Broadside <input type="checkbox"/> Roll-over <input type="checkbox"/> Other: _____ Single Car Impact with Fixed Object: <input type="checkbox"/> Yes <input type="checkbox"/> No Indicate Object: Road/Weather Conditions: Notes:

2. FIREARM

N/A

Type of Firearm: <input type="checkbox"/> Handgun <input type="checkbox"/> Rifle <input type="checkbox"/> Shotgun <input type="checkbox"/> Unknown <input type="checkbox"/> Other Specify Type of Firearm:	Use of Weapon at Time of Incident (check all that apply): <input type="checkbox"/> Hunting/Recreation <input type="checkbox"/> Playing <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Self-Inflicted <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Unknown <input type="checkbox"/> Criminal/Assault <input type="checkbox"/> Other: _____ <input type="checkbox"/> Self-Defense
Make/Model: Serial Number:	
Caliber/Gauge of Firearm:	Notes:
Barrel Length: in. Magazine Capacity:	
Age of Person Handling Firearm:	

3. INSTRUMENT

N/A

<input type="checkbox"/> Blunt <input type="checkbox"/> Sharp <input type="checkbox"/> Unknown Describe:
Activity at Time of Injury:

4. POISONING

N/A

Source of Poisoning: <input type="checkbox"/> Alcohol <input type="checkbox"/> Prescription Medication <input type="checkbox"/> Over-the-Counter Medication <input type="checkbox"/> Illegal Drugs <input type="checkbox"/> Food <input type="checkbox"/> Household Cleaners <input type="checkbox"/> Carbon Monoxide, Source of CO: _____ <input type="checkbox"/> Venom from Animal Bite/Sting <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
Name of Substance(s):
Safety Device: <input type="checkbox"/> Available, In Use <input type="checkbox"/> Available, Not In Use <input type="checkbox"/> Not Available <input type="checkbox"/> Unknown

MEANS OF DEATH CONTINUED

**5. DROWNING/
SUBMERSION**
 N/A

Place: <input type="checkbox"/> Pond/Lake/River <input type="checkbox"/> Well <input type="checkbox"/> Bathtub <input type="checkbox"/> Drainage Ditch <input type="checkbox"/> Pool <input type="checkbox"/> Other:	Activity at Time: <input type="checkbox"/> Working <input type="checkbox"/> Boating <input type="checkbox"/> Swimming/Playing <input type="checkbox"/> Bathing <input type="checkbox"/> Driving <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
Floatation Device: <input type="checkbox"/> Available, In Use <input type="checkbox"/> Available, Not In Use <input type="checkbox"/> Not Available <input type="checkbox"/> Unknown	Able to Swim: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown

6. FIRE/BURN
 N/A

Cause of Burn: <input type="checkbox"/> Fire <input type="checkbox"/> Scalding Liquid <input type="checkbox"/> Chemical <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ Substance:	Activity of Person Starting Fire: <input type="checkbox"/> Smoking <input type="checkbox"/> Playing with Matches/Fire <input type="checkbox"/> Cooking <input type="checkbox"/> Arson (if yes, previous history of arson? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown) <input type="checkbox"/> N/A <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
Source: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Matches/Lighter <input type="checkbox"/> Appliance <input type="checkbox"/> Faulty Wiring <input type="checkbox"/> Explosives/Explosion <input type="checkbox"/> Candles <input type="checkbox"/> Grease <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Object on Fire: <input type="checkbox"/> Vehicle <input type="checkbox"/> Clothing <input type="checkbox"/> Home <input type="checkbox"/> Other: Functional Smoke Detector: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown Notes:

7. FALL
 N/A

Reason for Fall: <input type="checkbox"/> Tripped/Slipped <input type="checkbox"/> Pushed <input type="checkbox"/> Jumped <input type="checkbox"/> Structure Gave Way <input type="checkbox"/> Medical Condition <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	From: <input type="checkbox"/> Standing Height <input type="checkbox"/> Window <input type="checkbox"/> Roof <input type="checkbox"/> Ladder <input type="checkbox"/> Natural Elevation (hill, cliff) <input type="checkbox"/> Bridge <input type="checkbox"/> Stairs <input type="checkbox"/> Sitting Height (chair, bed, wheelchair, toilet) <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
Height of Fall: ____ ft. ____ in.	Surface Conditions:

8. ASPHYXIA
 N/A

Suffocated By: <input type="checkbox"/> Bedding <input type="checkbox"/> Manual Strangulation (hands) <input type="checkbox"/> Food/Drink <input type="checkbox"/> Ligature Strangulation (hanging) <input type="checkbox"/> Trapped/Confined Space <input type="checkbox"/> Positional <input type="checkbox"/> Compression/Crushing <input type="checkbox"/> Other:	Circumstance: <input type="checkbox"/> Covered by Object <input type="checkbox"/> Swallowing <input type="checkbox"/> Self-Inflicted <input type="checkbox"/> Strangled by Another Person <input type="checkbox"/> Playing <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
Notes:	

9. SIDS
 N/A

Our County participates in the Michigan Child Death Review, please link to that data. CDR Case Number:		
Birth Weight: <input type="checkbox"/> <750 grams <input type="checkbox"/> 750 to 1,499 grams <input type="checkbox"/> 1,500 grams to 2,499 grams <input type="checkbox"/> >2,500 grams <input type="checkbox"/> Unknown	Normal Sleeping Position: <input type="checkbox"/> On Back <input type="checkbox"/> On Stomach <input type="checkbox"/> On Side <input type="checkbox"/> Varies <input type="checkbox"/> Unknown	Position when Found: <input type="checkbox"/> On Stomach, Face Down <input type="checkbox"/> On Stomach, Face Up <input type="checkbox"/> On Back <input type="checkbox"/> On Side <input type="checkbox"/> Unknown
Infant Sleeping Alone: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Mother Smoked During Pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Baby Exposed to Second-Hand Smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

FORENSIC FINDINGS

TOXICOLOGY	Type	Specimen Date	Specimen Time
<input type="checkbox"/> Yes <input type="checkbox"/> No Lab sent to:	<input type="checkbox"/> Blood		
	<input type="checkbox"/> Urine		
	<input type="checkbox"/> Vitreous		
	<input type="checkbox"/> Other:		

Alcohol Found in Decedent's System (other than putrefaction) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown Quantity:	Drugs Found in Decedent's System (other than those consistent with therapeutic intervention) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Unknown Quantity:
---	---

X-RAYS	<input type="checkbox"/> Yes <input type="checkbox"/> No X-Rays Taken at:	Body Site X-Rayed:
---------------	---	--------------------

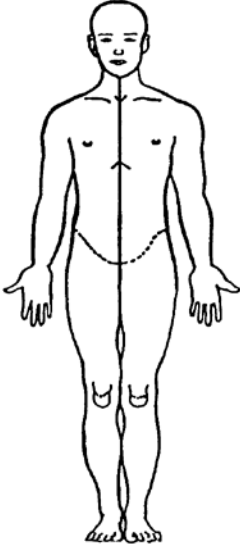
AUTOPSY <input type="checkbox"/> Yes <input type="checkbox"/> No Family Notified of Pending Autopsy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Type: <input type="checkbox"/> Full <input type="checkbox"/> Limited <input type="checkbox"/> External Exam Describe:	Findings Available Prior to Completion of Death Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> N/A Pathologist:
--	--

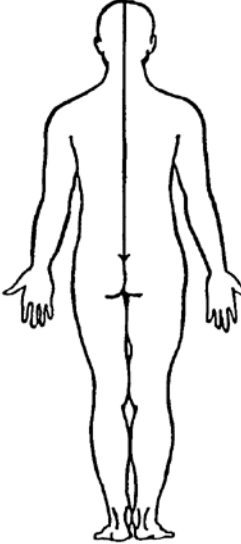
SYNDROMES RECOGNIZED AT AUTOPSY


<input type="checkbox"/> Community-acquired pneumonia, diffuse alveolar damage (ARDS) <input type="checkbox"/> Diffuse Rash <input type="checkbox"/> Sepsis syndromes; disseminated intravascular coagulopathy (DIC) <input type="checkbox"/> Hemorrhagic mediastinitis <input type="checkbox"/> Hepatitis, fulminant hepatitis <input type="checkbox"/> Encephalitis, meningitis <input type="checkbox"/> Pharyngitis, epiglottitis and other upper airway infections	<input type="checkbox"/> Myocarditis <input type="checkbox"/> Bronchitis, bronchiolitis <input type="checkbox"/> Soft tissue infections – cellulites, necrotizing fasciitis <input type="checkbox"/> Hemorrhagic colitis <input type="checkbox"/> Unexplained, possibly infectious <input type="checkbox"/> Unexplained, possibly toxic unrelated to medications or recreational drugs <input type="checkbox"/> Other, specify:
--	---


Disease(s) Confirmed by Lab:	Date(s) Confirmed:
------------------------------	--------------------

VISUAL INSPECTION









Indicate nature and location of wounds and other lesions (scars, tattoos, medical therapy, etc.) on these diagrams.

