



# OFFICE OF THE STATE CHIEF MEDICAL EXAMINER

DEPARTMENT OF HEALTH, ANDREW JOHNSON TOWER, 7<sup>th</sup> FL  
710 JAMES ROBERTSON PKWY, NASHVILLE, TN 37243

[HEALTH.OSCME@TN.GOV](mailto:HEALTH.OSCME@TN.GOV)

Case Number: \_\_\_\_\_

## Report of Medicolegal Death Investigation

DEMOGRAPHIC INFORMATION						
County of Death	Last Name	First Name	Middle	Race	Age	Sex
Residential Address		City	County		State	Zip
INDICATION FOR MEDICAL EXAMINER INVESTIGATION						
Type of Death: <input type="checkbox"/> Violence or Trauma <input type="checkbox"/> Suddenly when in apparent health <input type="checkbox"/> Prisoner or person in state custody <input type="checkbox"/> On the job or related to employment <input type="checkbox"/> Threat to public health <input type="checkbox"/> Suspected abuse/neglect of extended care resident <input type="checkbox"/> Identity is unknown or unclear <input type="checkbox"/> Suspicious/unusual/unnatural manner <input type="checkbox"/> Found dead <input type="checkbox"/> Cremation request <input type="checkbox"/> Sudden unexpected death of infants/children (USE SUIDI/SUDC) <input type="checkbox"/> Jurisdiction Declined (Skip to Narrative Summary)						
IDENTIFICATION OF BODY						
Preliminary <input type="checkbox"/>	Viewing <input type="checkbox"/>	<input type="checkbox"/> Need Scientific Identification		Dentist:		
Positive <input type="checkbox"/>	Photograph <input type="checkbox"/>	Will need dental records, antemortem x-rays.		Dentist #:		( )
If by viewing, viewed by:						
Name:			Relationship:		Is decedent known to have fingerprints on file?	
Address:			Phone #:	( )	<input type="checkbox"/> Yes <input type="checkbox"/> No	
INFORMATION ABOUT DECEDENT AND DESCRIPTION OF BODY						
Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown					
History of Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation: Type of Work		Industry: N/A <input type="checkbox"/>			
Body Temperature: <input type="checkbox"/> Cold <input type="checkbox"/> Warm <input type="checkbox"/> Refrigerated <input type="checkbox"/> Other:	Decomposition <input type="checkbox"/> Early <input type="checkbox"/> Advanced <input type="checkbox"/> None					
Rigor Mortis: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	'0' = Absent, '3' = Full		JAIL/POLICE CUSTODY <input type="checkbox"/> Yes <input type="checkbox"/> No		Livor Mortis:	
Blood/Froth: <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Ears <input type="checkbox"/> Clothing <input type="checkbox"/> None <input type="checkbox"/> Color:					<input type="checkbox"/> Absent <input type="checkbox"/> Blanchable	
Other: (Dirt, water etc.): <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Ears <input type="checkbox"/> None					<input type="checkbox"/> Fixed <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior	
INFORMATION ABOUT OCCURRENCE						
ITEM	DATE	TIME	LOCATION	COUNTY	TYPE OF PREMISES <small>(House, Trailer, Apt, Farm, Roadway, Hospital, etc.)</small>	
INJURY OR ONSET OF ILLNESS			(Where: Address) (By whom: Name & Phone Number)			
LAST KNOWN TO BE ALIVE			(Where: Address) (By whom: Name & Phone Number)			
FOUND DEAD			(Where: Address) (By whom: Name & Phone Number)			
POLICE NOTIFIED			POLICE AGENCY:	INVESTIGATOR/PHONE NUMBER:		
EMS TRANSPORT TO E.R.		Arrive	HOSPITAL:	BLOOD, URINE obtained in Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(Obtain admission blood/urine &amp; send with the body.)</b>		
DEATH (PRONOUNCED)			(By Whom/Where: Name & Address)	TOXICOLOGY Ordered: <input type="checkbox"/> No <input type="checkbox"/> Yes, specimen site: <b>(Do not draw toxicology if sending for autopsy.)</b>		

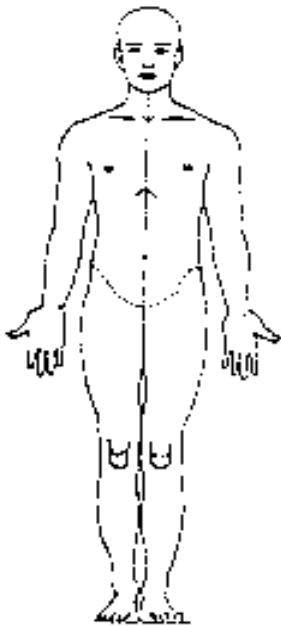
**MEANS OF DEATH (Agency or Object) – IF OTHER THAN NATURAL**

<input type="checkbox"/>	<b>MOTOR VEHICLE INVOLVED</b>	<input type="checkbox"/> Driver (If known) <input type="checkbox"/> Passenger (If known) <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other	<input type="checkbox"/> Lap Belt Used <input type="checkbox"/> Shoulder Belt Used <input type="checkbox"/> Helmet <input type="checkbox"/> Other	<input type="checkbox"/> Hit-Run <input type="checkbox"/> Air Bag Deployed <input type="checkbox"/> Other	<input type="checkbox"/> Passenger Car <input type="checkbox"/> Truck <input type="checkbox"/> Motorcycle <input type="checkbox"/> Bicycle	<input type="checkbox"/> Farm Vehicle <input type="checkbox"/> Train <input type="checkbox"/> ATV <input type="checkbox"/> Other:	
<input type="checkbox"/>	<b>GUN</b> <input type="checkbox"/> Rifle – Cal. <input type="checkbox"/> Handgun – Cal. <input type="checkbox"/> Shotgun – Cal. <input type="checkbox"/> Unknown Type	<input type="checkbox"/>	<b>OTHER INSTRUMENT:</b> <input type="checkbox"/> Blunt <input type="checkbox"/> Sharp <input type="checkbox"/> Unknown	<b>SURGICALLY TREATED:</b> <input type="checkbox"/> Yes: <input type="checkbox"/> No	<input type="checkbox"/>	<b>DRUG, POISON, CHEMICAL (Suspected)</b> <input type="checkbox"/> Alcohol <input type="checkbox"/> Other Drug, Poison, or Chemical: <input type="checkbox"/> Unknown	<input type="checkbox"/> Ingested <input type="checkbox"/> Injected <input type="checkbox"/> Inhaled <input type="checkbox"/> Topical <input type="checkbox"/> Unknown

**MEDICAL HISTORY**

<b>CONDITION:</b> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Fractures <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizure <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Recent Fall/Injury <input type="checkbox"/> Lung Disease <input type="checkbox"/> Other:	<b>FAMILY PHYSICIAN – DOCTOR:</b> <b>ADDRESS:</b> <b>PHONE #:</b> <b>MEDICATIONS (Please use attached Medication Log)</b>		
<b>NEXT OF KIN</b> Address and Phone #:			
<b>FUNERAL HOME</b> Address and Phone #:			

**NARRATIVE SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH (Add Sheet if Needed):**




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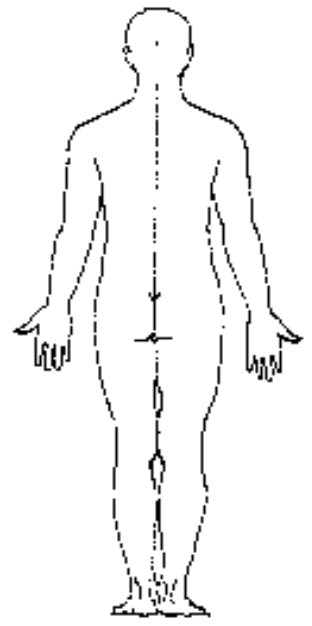
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Body Viewed by Medical Examiner or Medicolegal Death Investigator:  Yes  No

**CAUSE AND MANNER OF DEATH**

Presumed Cause of Death:	Date:	<input type="checkbox"/> NATURAL <input type="checkbox"/> HOMICIDE <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED <input type="checkbox"/> PENDING
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I hereby declare that after receiving notice of death described herein, I took charge of the body and made inquiries regarding the cause of death in accordance with Section 38-7-109 Tennessee Code Annotated and that the information contained herein regarding such death is true and correct to the best of my knowledge and belief.

Medical Examiner/Investigator:	Physician Responsible for Death Certificate:
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The accompanying body of \_\_\_\_\_ is the subject of an investigation by the medical examiner. In accordance with Tennessee Code Annotated 38-7-106, I am ordering an autopsy upon the body.  
 Order for Autopsy:  Yes  No  
 Was served to the next of kin on \_\_\_\_\_ at \_\_\_\_\_  
 Was unable to locate the next of kin by a diligent search and inquiry.

Authorizing Signature of Medical Examiner or Delegated Investigator: \_\_\_\_\_