

COUNTY CORONER/MEDICAL EXAMINER
AUTHORIZATION FOR FINAL DISPOSITION
(Cremation, Donation, or Alkaline Hydrolysis)

FUNERAL HOME INFORMATION

Decedent: _____ Date of Birth: _____

Date of Death: _____ Time of Death: _____

Place of Death: _____

Funeral Home: _____

Contact: _____ Phone: _____

Fax Number: _____

PHYSICIAN INFORMATION

Primary Physician's Name and Clinic: _____

Phone: _____ Fax Number: _____

Date last seen or clinic visit: _____

Did INJURY or TRAUMA contribute to the cause of death? Yes _____ No _____

If yes, please explain: _____

Is there any reason to postpone final disposition? Yes _____ No _____

If yes, please explain: _____

CAUSE OF DEATH

a. _____

b. _____

c. _____

d. _____

Other Significant Conditions: _____

Physician's Signature: _____ Date: _____

CORONER/MEDICAL EXAMINER INFORMATION

Medical Examiner or Authorized Staff: _____

Final Disposition Approved? Yes _____ No _____ Date: _____