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: ____________________

Revised 12/2011