# JACKSON COUNTY MEDICAL EXAMINER
## **HOSPICE** REPORT OF DEATH
## **FAX TO (816) 404-1345**
## **Voice (816) 881-6600**

Case JCMEO # H-__________________ County _____________________

Name: ____________________________________________________
(*last, first, mi* )

*Age:* ________ *Race:* __________ *Sex:* _______ *DOB:* ___________

Home Address______________________________________________Zip Code___________

Report Date________________________________ Report Time______________________

Reported By (person)_____________________________(Agency)______________________

(Phone)_____________________________________Cell Phone_______________________

**INCIDENT DATE**__________________**TIME**____________________________________

Witnessed death_____________________ Found Dead________________________________

**ADDRESS of Death**___________________________________________________________

Witness/Finder's Name_________________________________________________________

Address_________________________________________ Phone______________________

**Date/Time: Last known alive/alert (LKA)**_____________________________________

LKA by: Witness______ Finder______ spouse_______ family_____ acq_____other________

LKA how: was seen___________ was heard_______________ was talked to______________

Relative/Contact______________________________________________ _______________
Name Address Phone

Known Injuries_________________________________________________________________

**PRONOUNCED**: On Scene________ Pronounced Date/Time__________________________

Surgery Date/Time If Applicable_________________________________________________

Type of Surgery Performed if Any: ( ) Hip Repair L-R ( ) Arm L-R ( ) Brain ( ) Other_________
Hospital Where Surgery Performed_______________________________________________

**MEDICAL HISTORY**:

____heart disease
( )prior MI's
____hypertension
_____emphysema
____asthma
____diabetes
( )insulin
( )no insulin
____seizures
( ) unknown cause
( ) alcohol related
( ) trauma related
( ) birth related
( ) since childhood

____mental illness
( )Alzheimer's
____stroke
____renal disease
____terminal illness
____cancer
( )primary site__________
____allergies
____drug abuse
____chronic alcohol abuse
____recent fall
____recent injury
____old injury
____other illness

***DOCTOR'S NAME*** ______________________

***PHONE #*** ______________________________

***FAX #***___________________________________

**Medications:**

___________________________________

___________________________________

___________________________________

___________________________________

**Identified By:** visual recognition ________ Other_____________________________________

**LOCATION OF INCIDENT**

___**Residential**
( ) single family home
( ) apartment
( ) trailer
( ) rooming house

_______ **Other location** in residence.
Describe position of body
________________________
________________________
________________________
________________________

**WHERE BODY WAS FOUND**

_____**In Bedroom** ( ) In Bed
Describe position of body
________________________
________________________
________________________
________________________

_____ **Bathroom** ( ) Floor ( ) In Tub
( ) On Toilet
Describe position of body
________________________
________________________
________________________
________________________

**NARRATIVE:**_____________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

**INVESTIGATOR:**____________________________________________________________

FUNERAL HOME_________________________ Phone # ______________________________

This form must be completed & faxed to the Medical Examiner ASAP

IF THE PATIENT IS RECOVERING FROM AN INJURY, YOU ARE REQUIRED TO CALL (881-6600) THE MEDICAL EXAMINER'S OFFICE TO REPORT THE DEATH.