



JACKSON COUNTY MEDICAL EXAMINER
NURSING HOME REPORT OF DEATH
FAX TO (816) 404-1345
Voice (816) 881-6600

Case JCMEO# N- _____ 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:

<input type="checkbox"/> heart disease	<input type="checkbox"/> mental illness	<i>DOCTOR'S NAME</i> _____
<input type="checkbox"/> () prior MI's	<input type="checkbox"/> () Alzheimer's	<i>PHONE #</i> _____
<input type="checkbox"/> hypertension	<input type="checkbox"/> stroke	<i>FAX #</i> _____
<input type="checkbox"/> emphysema	<input type="checkbox"/> renal disease	
<input type="checkbox"/> asthma	<input type="checkbox"/> terminal illness	
<input type="checkbox"/> diabetes	<input type="checkbox"/> cancer	
<input type="checkbox"/> () insulin	<input type="checkbox"/> () primary site _____	Medications:
<input type="checkbox"/> () no insulin	<input type="checkbox"/> allergies	_____
<input type="checkbox"/> seizures	<input type="checkbox"/> drug abuse	_____
<input type="checkbox"/> () unknown cause	<input type="checkbox"/> chronic alcohol abuse	_____
<input type="checkbox"/> () alcohol related	<input type="checkbox"/> recent fall	_____
<input type="checkbox"/> () trauma related	<input type="checkbox"/> recent injury	_____
<input type="checkbox"/> () birth related	<input type="checkbox"/> old injury	_____
<input type="checkbox"/> () since childhood	<input type="checkbox"/> other illness	_____

Identified By: visual recognition _____ Other _____

LOCATION OF INCIDENT

Nursing Home _____

Care Home _____

Assisted Living _____

WHERE BODY WAS FOUND

In Bedroom () In Bed
Describe position of body

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

Other location
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. Mandated reporting Mo Statute 58.451 #5