JACKSON COUNTY MEDICAL EXAMINER'S OFFICE – REPORT OF DEATH

OFFICE (816) 881-6604 **FAX (816) 881-6598**

Nursing Home Death? Yes No **Hospice Death? Yes No**

Decedent Name: ______________________________ Date of Birth: ____________
Last First Middle

Home Address: ______________________________ Age: ______ Race: _____ Sex: ____
Street Address City State Zip

Report Date: ____________ Reported by (person's name & title): ______________________

Agency name: ______________________ Agency phone: ______________________

Date of Death: __________ Time of Death: ________ AM PM Location of Death: ○Residence ○Hospice Facility ○Nursing Home

Name of Facility (if different from above) ______________________

Address of Death: ______________________________ County: ____________
Street Address City State Zip

Death: Witnessed or Found (circle one) Death Pronounced by whom: ______________________

Witness/Finder's Name: ______________________ Finder's Phone: ______________________

If Found: Last Known Alive/Alert (LKA) LKA Date: ____________ LKA Time: ____________

LKA by: ○finder ○spouse ○family ○acquaintance ○other ____________

LKA how: ○was seen ○was heard ○was talked to

Funeral Home: ______________________ Funeral Home Phone: ______________________

Relative Name: ______________________ Relationship: ______________________

Address: ______________________________ Phone: ______________________
Street Address City State Zip

Admit Diagnosis: ______________________ Doctor's Name: ______________________

Cause of Death: ______________________ Doctor's Phone: ______________________

Contributing Factors: ______________________ Doctor's Fax: ______________________

○ Cardiovascular Disease
( ) Atherosclerosis
( ) Previous MI's / CVA
( ) CABG / Stents
( ) Hypertension

○ Pulmonary Disease
( ) COPD
( ) Emphysema
( ) Asthma

○ Chronic kidney disease

○ Any recent falls or trauma that can be attributed to cause death? Y/N

○ Seizures
( ) unknown cause
( ) alcohol related
( ) trauma related
( ) since childhood

○ Diabetes
( ) insulin
( ) no insulin

○ Cancer – Metastatic Y/N
( ) primary site: ____

○ Cirrhosis due to:
Ethanol / HCV / HBV / other

○ Recent surgery
____

○ Recent or remote injury which was contributory to death. **(Enter info below)**

○ Mental illness
Alzheimer's / Dementia / Other (circle one)

○ Other illness:
____
____
____

Recent or remote injury type: ______________________

How injury occurred: ______________________

Date of injury: ______________________

If recent or remote injury <u>contributed</u> to death, please call (816) 881-6604 to report death.

FOR MEO USE ONLY

Investigator: ______________________ MEO Case Number: ______________________