DEATH SCENE INVESTIGATION REPORT

Investigator _____ Date of Death _____

ME _____ Case Number _____

Primary Rationale for Medical Examiner Activity (choose one):

- ☐ Accidental Death
- ☐ Natural/Sudden/Unexpected Death
- ☐ Violent Death (Homicide/Suicide)
- ☐ Suspicious Circumstances
- ☐ Prison Death
- ☐ Cause of Death Not Determinable by Attending Physician
- ☐ Cremation Authorization Permit
- ☐ No Other Physician to Sign Death Certificate
- ☐ Other (please specify):

DECEDENT IDENTIFICATION

Name: (Last) (First) (Middle) SS#:

Aliases: Date of Birth: Age:

Decedent Was Homeless: ☐ Yes ☐ No

Home Address: _____

City: _____ State:_____

County: _____ Zip Code:_____

Phone Numbers: Home: _____

Cell: _____ Work: _____

Other: _____ Other: _____

Gender:
☐ Male
☐ Female
☐ Non-human Bones
☐ Other Specify:

Race (Check all that apply):
☐ Hispanic/Spanish/Latino
☐ White (not Hispanic)
☐ African Am. (not Hispanic)
☐ Am. Indian/Alaskan Native
☐ Asian/Pacific Islander
☐ Unknown
Details (i.e.: Tribe, Country of Origin):

Marital Status:
☐ Never Married
☐ Married
☐ Divorced
☐ Separated
☐ Widowed
☐ N/A
☐ Unknown

☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker
☐ Unknown ☐ N/A ☐ Other:

Place of Employment:
Occupation:

Pregnant at Time of Death:
☐ Yes ☐ No ☐ Unknown

Decedent Currently Under Governmental Supervision *(i.e., Foster Care, Incarceration, Mental Health, etc.)*:
☐ Yes ☐ No ☐ Unknown If Yes, Agency & ID Number:

SECONDARY PARTIES

IDENTIFIED BY

Decedent Identified By: (Last) (First)

Relationship: ☐ Family Member ☐ Police ☐ Health Care Professional ☐ Friend/Acquaintance ☐ Other:

Means Identified By: ☐ Appearance ☐ ID Card ☐ Dental Records ☐ Fingerprints ☐ DNA ☐ X-ray ☐ Photograph ☐ Presumptive ☐ Other:

Notes: ID Form Signed: ☐ Yes ☐ No

NEXT OF KIN

Notified: ☐ Yes, Kin at Scene ☐ Yes, by Agency ☐ No ☐ In Process Notifying Agency:

Relationship: ☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Legal Guardian ☐ Other:

Name: (Last) (First) (Middle)

Address: (Street) (City) (State) (Zip)

Phone Number: Notes:

OTHERS INVOLVED

Associated Cases:

Was this Death Potentially Caused by a Secondary Party:
☐ Yes ☐ No ☐ N/A ☐ Unknown If Yes, Relation to Decedent:

Number of Associated Fatal Injuries:

Number of Associated Non-Fatal Injuries:

Notes:

WITNESSES

☐ Witness to Death ☐ Found Decedent ☐ N/A

Relationship of Witness/Person Who Found Decedent to Decedent: ☐ Family Member ☐ Health Care Professional ☐ Stranger ☐ Friend/Acquaintance ☐ Other:

Name:

Address: (Street) (City) (State) (Zip)

Phone Number: Notes:

SCENE INFORMATION

Scene Visit Date:	Scene Visit Time: (Military)	Investigator Notified By:	Photos/Video Taken by Scene Investigator: ☐ Yes ☐ No
Notification Date:	Notification Time: (Military)		
Police on Scene: ☐ Yes ☐ No	Case #:	Department:	
Officer(s):			Photos/Video Taken by Police: ☐ Yes ☐ No
Address of Incident: (Street)		Apt:	
City/Village/Township of Death:		County:	Zip Code:
Incident Date:		Incident Time: (Military)	

Place of Incident (Check one):

☐ Decedent's Home ☐ Living Facility ☐ Other Home ☐ Emergency Dept. ☐ Hospital
☐ Highway ☐ Road/Street ☐ School ☐ Place of Business ☐ Body of Water
☐ Jail/Prison/Juvenile Detention ☐ Unknown ☐ Other, Specify:

Notes Regarding Place of Incident:

Describe How Injury Occurred:

Please include information about any other individuals who were involved and their role in the incident, where the injury occurred, a general narrative of the sequence of events leading up to the incident, evidence of advanced decomposition, etc.

CIRCUMSTANCES SURROUNDING DEATH

Attendance of Death: ☐ Witnessed Death ☐ Found Body	Did Injury Occur on the Job: ☐ Yes ☐ No	Was Decedent in Custody: ☐ Yes ☐ No
Was Injury Intimate Partner Violence-Related: ☐ Yes ☐ No ☐ Suspected	Medical Treatment (Check all that apply): ☐ CPR ☐ IV Fluids ☐ ACLS ☐ Do Not Resuscitate ☐ None ☐ Other:	Decedent Appropriately Clothed at Time of Death: ☐ Yes ☐ No (Please describe):
Evidence of Drugs Involved? ☐ Yes ☐ No ☐ Unknown		Evidence of Alcohol Involved? ☐ Yes ☐ No ☐ Unknown
List of Valuables:		Disposition of Valuables:

IF FOUND DEATH

Date Last Known Alive: Time Last Known Alive: (Military)	Found Death Date: Found Death Time: (Military) Found By:	Rigor: ☐ None ☐ Early ☐ Moderate ☐ Advanced	Livor As Expected: ☐ Yes ☐ No ☐ N/A If No, Please Describe:
Notes:			

Body Located: ☐ Indoors ☐ Outdoors Body Temperature (°F): _____ If *Not* Taken: ☐ Cold ☐ Warm Air Temperature (°F): _____	Position of Body (check one): ☐ Sitting ☐ On Side ☐ On Back ☐ On Stomach ☐ Laying, Position Unspecified ☐ Hanging ☐ Other, Describe: Notes:

DATE/TIME OF DEATH

Actual Date of Death:	If Applicable, Estimated Date of Death: Lower Bound:_____ Upper Bound:_____	If Applicable, Estimated Time of Death: (Military) Lower Bound:_____ Upper Bound:_____

Pronounced Date of Death:	Pronounced Time of Death: (Military)

Place of Pronounced Death:

☐ Dead at Injury Location ☐ Dead on Arrival at Emergency Department ☐ Hospital, Emergency Department/Outpatient Facility
☐ Hospital, Inpatient Facility ☐ Hospital, Facility Unspecified ☐ Unknown ☐ Other, Describe:

If Death Occurred at Hospital, Hospital Name:
Admission Date: Admission Time: Patient Record Number:

CAUSE OF DEATH

	Cause of Death	Duration	ICD
Immediate:			
Due To:			
Due To:			
Due To:			

Other Significant Conditions:

MANNER OF DEATH

☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Indeterminate ☐ Pending

This information is accurate to the best of my knowledge at the time I signed this document. I am not responsible for any errors incurred in the interpretation or translation of the information on this document that have been entered into the Michigan Medical Examiners Database for this case.

FIELD INVESTIGATOR:_____ **DATE:**_____

MEANS OF DEATH

1. VEHICLE
☐ N/A

	Type of Vehicle Associated With This Decedent	Other Vehicle(s) Associated With This Incident
Passenger Car	☐	☐
SUV	☐	☐
Mini-van	☐	☐
Full Sized Van	☐	☐
Truck	☐	☐
Truck (3+axles)	☐	☐
Motorcycle	☐	☐
Bicycle	☐	☐
ATV	☐	☐
Snowmobile	☐	☐
Watercraft	☐	☐
Train	☐	☐
Aircraft	☐	☐
N/A	☐	☐
Other:		

Position of Decedent *Prior* to Death:
☐ Driver Seat ☐ Front Seat ☐ Back Seat
☐ Bicyclist ☐ Pedestrian ☐ Other: _____

Decedent Remained in Vehicle: ☐ Yes ☐ No ☐ N/A

Safety Devices Used:
☐ Safety Belt ☐ Helmet ☐ Air Bag
☐ Child Car Seat ☐ None ☐ Unknown
☐ N/A ☐ Other: _____

Did Device Contribute to Death? ☐ Yes ☐ No ☐ Unknown

If Yes, Did Device: ☐ Fail
☐ Was Not In Use
☐ In Use, Activated Incorrectly
☐ In Use, Activated Correctly

Crash Type: ☐ Head On ☐ Angle ☐ Rear End
☐ Sideswipe ☐ Broadside ☐ Roll-over
☐ Other: _____

Single Car Impact with Fixed Object: ☐ Yes ☐ No
Indicate Object:

Road/Weather Conditions:

Make/Model/Year of Vehicle Associated with Decedent:

Notes:

2. FIREARM
☐ N/A

Type of Firearm:
☐ Handgun ☐ Rifle ☐ Shotgun
☐ Unknown ☐ Other

Specify Type of Firearm:

Make/Model: | Serial Number:

Caliber/Gauge of Firearm:

Barrel Length: in. | Magazine Capacity:

Age of Person Handling Firearm:

Use of Weapon at Time of Incident (check all that apply):
☐ Hunting/Recreation ☐ Playing
☐ Legal Intervention ☐ Self-Inflicted
☐ Domestic Violence ☐ Unknown
☐ Criminal/Assault ☐ Other: _____
☐ Self-Defense

Notes:

3. INSTRUMENT
☐ N/A

☐ Blunt ☐ Sharp ☐ Unknown Describe:

Activity at Time of Injury:

4. POISONING
☐ N/A

Source of Poisoning:
☐ Alcohol ☐ Prescription Medication ☐ Over-the-Counter Medication ☐ Illegal Drugs
☐ Food ☐ Household Cleaners ☐ Carbon Monoxide, Source of CO: _____
☐ Venom from Animal Bite/Sting ☐ Unknown ☐ Other: _____

Name of Substance(s):

Safety Device: ☐ Available, In Use ☐ Available, Not In Use ☐ Not Available ☐ Unknown

MEANS OF DEATH CONTINUED

5. DROWNING/ SUBMERSION

☐ N/A

Place: ☐ Pond/Lake/River ☐ Well ☐ Bathtub ☐ Drainage Ditch ☐ Pool ☐ Other:	Activity at Time: ☐ Working ☐ Boating ☐ Swimming/Playing ☐ Bathing ☐ Driving ☐ Unknown ☐ Other:
Floatation Device: ☐ Available, In Use ☐ Available, Not In Use ☐ Not Available ☐ Unknown	Able to Swim: ☐ Yes ☐ No ☐ N/A ☐ Unknown

6. FIRE/BURN

☐ N/A

Cause of Burn: ☐ Fire ☐ Scalding Liquid ☐ Chemical ☐ Unknown ☐ Other: _____ Substance:	Activity of Person Starting Fire: ☐ Smoking ☐ Playing with Matches/Fire ☐ Cooking ☐ Arson (if yes, previous history of arson? ☐ Yes ☐ No ☐ Unknown) ☐ N/A ☐ Unknown ☐ Other:
Source: ☐ Cigarettes ☐ Matches/Lighter ☐ Appliance ☐ Faulty Wiring ☐ Explosives/Explosion ☐ Candles ☐ Grease ☐ Unknown ☐ Other: _____	Object on Fire: ☐ Vehicle ☐ Clothing ☐ Home ☐ Other: Functional Smoke Detector: ☐ Yes ☐ No ☐ N/A ☐ Unknown Notes:

7. FALL

☐ N/A

Reason for Fall: ☐ Tripped/Slipped ☐ Pushed ☐ Jumped ☐ Structure Gave Way ☐ Medical Condition ☐ Unknown ☐ Other:	From: ☐ Standing Height ☐ Window ☐ Roof ☐ Ladder ☐ Natural Elevation (hill, cliff) ☐ Bridge ☐ Stairs ☐ Sitting Height (chair, bed, wheelchair, toilet) ☐ Unknown ☐ Other:
Height of Fall: _____ ft. _____ in.	Surface Conditions:

8. ASPHYXIA

☐ N/A

Suffocated By: ☐ Bedding ☐ Manual Strangulation (hands) ☐ Food/Drink ☐ Ligature Strangulation (hanging) ☐ Trapped/Confined Space ☐ Positional ☐ Compression/Crushing ☐ Other:	Circumstance: ☐ Covered by Object ☐ Swallowing ☐ Self-Inflicted ☐ Strangled by Another Person ☐ Playing ☐ Unknown ☐ Other:
Notes:	

9. SIDS

☐ N/A

Our County participates in the Michigan Child Death Review, please link to that data.
CDR Case Number:

Birth Weight:	Normal Sleeping Position:	Position when Found:
☐ <750 grams	☐ On Back	☐ On Stomach, Face Down
☐ 750 to 1,499 grams	☐ On Stomach	☐ On Stomach, Face Up
☐ 1,500 grams to 2,499 grams	☐ On Side	☐ On Back
☐ >2,500 grams	☐ Varies	☐ On Side
☐ Unknown	☐ Unknown	☐ Unknown

Infant Sleeping Alone: ☐ Yes ☐ No ☐ Unknown	Mother Smoked During Pregnancy: ☐ Yes ☐ No ☐ Unknown Baby Exposed to Second-Hand Smoke: ☐ Yes ☐ No ☐ Unknown

10. INFECTIOUS DISEASE/BT

☐ **N/A**

MEANS OF DEATH CONTINUED	
Disease Confirmed by Lab or Medical Record	Date Confirmed
Refer to the Forensic Findings Section for Autopsy and Lab Details	

11. OTHER

☐ **N/A**

☐ Crushing of any Kind ☐ Farm Equipment ☐ Manufacturing Equipment ☐ Abuse/Neglect
☐ Exposure to the Elements ☐ Electrocution/Lightning Strike ☐ Complications following Hospitalization
☐ Animal Bite/Mauling ☐ Other:

MEDICAL HISTORY

Information Sources (Check all that apply): ☐ Not Invest. ☐ Health Provider ☐ Medical Records ☐ Family/Friend ☐ Other:

Medical History:

☐ Depression	☐ Heart Disease	☐ Prescription Drug Abuse	☐ Smoking	
☐ Alcoholism	☐ Diabetes	☐ HIV/AIDS	☐ Psychiatric/Mental Illness	Current Smoker: ☐ Yes ☐ No
☐ Cancer	☐ Drug Abuse	☐ Hypertension	☐ Renal Disorder	Past Smoker: ☐ Yes ☐ No
☐ Dementia	☐ Emphysema	☐ Obesity	☐ Seizure Disorder	☐ Other:

Notes on Medical History:

Previous Surgery Description:

Past Suicide Attempts: ☐ Yes ☐ No

If yes, describe:

Check all symptoms noted during investigation or from recent medical records:

☐ Fever	☐ Severe or persistent headaches	☐ Seizures
☐ Bloody diarrhea/vomiting	☐ Lightheadedness or fainting	☐ Recent onset of paralysis
☐ Diarrhea/vomiting without blood	☐ Muscle aches or pains	☐ Vision problems (blurred, double, etc.)
☐ Respiratory distress	☐ Muscle weakness	☐ Necrosis of tissue
☐ Rash	☐ Altered mental state/delirium	☐ Other, specify:

Medications/Drugs: ☐ Yes ☐ No ☐ Unknown If Yes, ☐ Prescription ☐ Over-the-Counter ☐ Illegal

List of Medication/Drugs (name, # pills prescribed, date of prescription, # pills left in bottle, dosage):

Attending Physician: Clinic name:	Physician Phone: Physician Location/Address:	Last Known Date Seen by Physician:

FORENSIC FINDINGS

TOXICOLOGY	Type	Specimen Date	Specimen Time
☐ Yes ☐ No Lab sent to:	☐ Blood		
	☐ Urine		
	☐ Vitreous		
	☐ Other:		

Alcohol Found in Decedent's System (other than putrefaction)
☐ Yes ☐ No ☐ N/A ☐ Unknown
Quantity:

Drugs Found in Decedent's System (other than those consistent with therapeutic intervention)
☐ Yes ☐ No ☐ N/A ☐ Unknown
Quantity:

X-RAYS ☐ Yes ☐ No X-Rays Taken at: Body Site X-Rayed:

AUTOPSY ☐ Yes ☐ No

Family Notified of Pending Autopsy: ☐ Yes ☐ No ☐ N/A
Type: ☐ Full ☐ Limited ☐ External Exam
Describe:

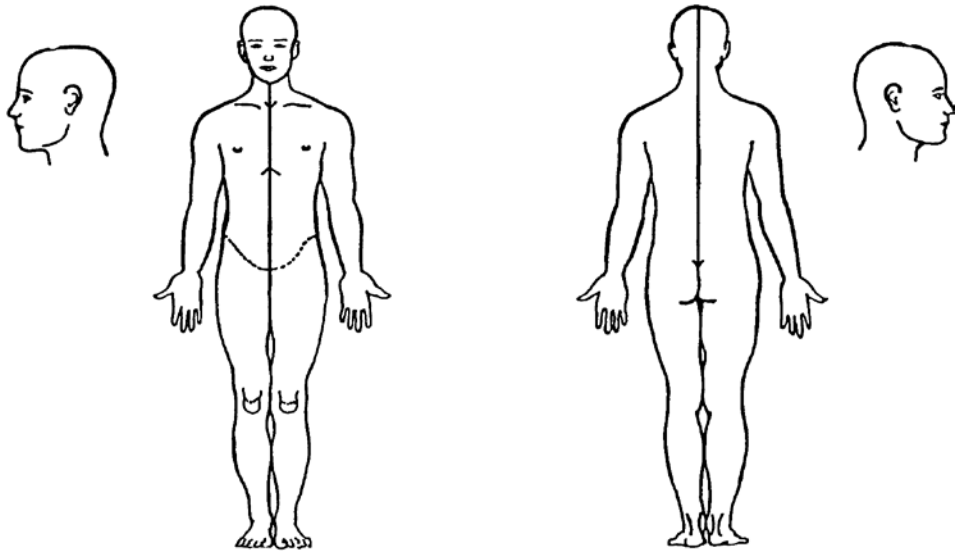
Findings Available Prior to Completion of Death Certificate:
☐ Yes ☐ No ☐ Partially ☐ N/A
Pathologist:

SYNDROMES RECOGNIZED AT AUTOPSY

☐ Community-acquired pneumonia, diffuse alveolar damage (ARDS)
☐ Diffuse Rash
☐ Sepsis syndromes; disseminated intravascular coagulopathy (DIC)
☐ Hemorrhagic mediastinitis
☐ Hepatitis, fulminant hepatitis
☐ Encephalitis, meningitis
☐ Pharyngitis, epiglottitis and other upper airway infections
☐ Myocarditis
☐ Bronchitis, bronchiolitis
☐ Soft tissue infections – cellulites, necrotizing fasciits
☐ Hemorrhagic colitis
☐ Unexplained, possibly infectious
☐ Unexplained, possibly toxic unrelated to medications or recreational drugs
☐ Other, specify:

Disease(s) Confirmed by Lab: **Date(s) Confirmed:**

VISUAL INSPECTION



Indicate nature and location of wounds and other lesions (scars, tattoos, medical therapy, etc.) on these diagrams.

ADMINISTRATION/ACCOUNTING (FOR OFFICE USE ONLY)

Required Documents:

- ☐ Investigation Report Completed
- ☐ Death Certificate Received
- ☐ Autopsy Report Received
- ☐ Toxicology Report Received
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Not an ME Case

☐ Jurisdiction Declined

Remarks:

Body Disposition:

☐ Burial/Entombment ☐ Cremation ☐ Donation

☐ Body Not Recovered ☐ Body Removed from State

Body Transported By:

To Where:

Name of Funeral Home:

APPROVED CHARGES

Type of Charge	Description	Amount	Rate	Date
Medical Examiner				
Investigator				
Diener				
Mileage				
Autopsy				
Transport				
Cremation Permit				
Supplies				
Photos				
Lab				
Medical Imaging				
Radiology				
Toxicology				
Dentist				
Total:				