IOWA OFFICE OF THE STATE MEDICAL EXAMINER
2250 S. Ankeny Blvd., Ankeny, Iowa 50023-9093
Phone#: 515-725-1400 / FAX#: 515-725-1414

Central Office Use Only

(Date of Receipt)

(DOD Code)

(COD Code)

PRELIMINARY REPORT OF INVESTIGATION BY MEDICAL EXAMINER

DECEDENT:
(First Name) (Middle Name) (Last Name)

ADDRESS:
(residence) (Number & Street or Route, Box No.) (City, State) (County) (County Assigned Case #)

INFORMATION ABOUT DECEDENT AND DESCRIPTION OF BODY

AGE (If less than 2 yrs. give months & days)

Age: _____
Date of Birth: _____

MARITAL STATUS
☐Married
☐Never Married
☐Widowed
☐Divorced
☐Separated
☐Unknown

RACE
☐White
☐Black
☐Hispanic
☐Asian
☐Other

SEX
☐Male
☐Female
☐Undetermined

HEAD-HAIR
☐None
☐Partly Bald
☐Blonde
☐Brown
☐Red
☐Black
☐Gray
☐White

OTHER HAIR
☐Mustache
☐Beard

CLOTHING
☐Clothed*
☐Partly Clothed*
☐Unclothed
_____

EYES-Color: _____
R:__ mm/L:__ mm

WEIGHT: _____ lbs.

LENGTH: _____ inches

MISCELLANEOUS
☐_______
☐_______
☐Circumcised

BODY TEMPERATURE
☐Warm ☐Cool ☐Cold
If taken:_____
site:_____

RIGOR
☐Neck: ☐0 ☐1 ☐2 ☐3
☐Arms: ☐0 ☐1 ☐2 ☐3
☐Legs: ☐0 ☐1 ☐2 ☐3
"0" = absent, "3" = full

LIVOR
Color: _____
Fixed? ☐Yes ☐No
☐Anterior
☐Posterior
☐Lateral (R / L)

BLOOD
☐Nose ☐Mouth
☐Ears ☐Clothing
☐None

FROTH
☐Present ☐Absent
Color: _____

OTHER
(Dirt, water etc.)
☐Nose _______
☐Mouth _______
☐Ears _______
☐None

DECOMPOSITION
☐Early
☐Advanced
☐None

OCCUPATION
(Please fill in both parts)
TYPE OF WORK:
_____
(Example: machinist, typist, fireman, farmer, salesman, homemaker)

INDUSTRY:
_____
(Example: textile, banking, fire dept., farming, insurance, home)

☐**No Occupational Information**

HISTORY OF DOMESTIC VIOLENCE
☐Yes
☐No

INFORMATION ABOUT OCCURRENCE

ITEM	DATE	TIME [military]	LOCATION	COUNTY	TYPE OF PREMISES (Home, farm, highway, hospital, etc.)
INJURY OR ONSET OF ILLNESS					ON THE JOB? ☐YES ☐NO
LAST SEEN ALIVE			(By whom: Name and Address)		
DEATH (PRONOUNCED)			(By whom: Name and Address)		
FOUND DEAD BY			(By whom: Name and Address)		
POLICE NOTIFIED			POLICE AGENCY:	OFFICER:	
M.E. NOTIFIED			(By whom: Name and Address)		
VIEW OF BODY			☐NOT VIEWED		
TO HOSPITAL					
WITNESSES	(Name and Address)			BLOOD SAMPLE DRAWN: ☐Yes ☐No Why Not? ☐Blood ☐Urine ☐Vitreous	

MANNER OF DEATH

☐**NATURAL** ☐**HOMICIDE** ☐**ACCIDENT** ☐**SUICIDE** ☐**UNDETERMINED** ☐**PENDING**

M.E. AUTOPSY AUTHORIZED
☐Yes ☐No

_____
PATHOLOGIST

State Case #, if applicable
____ **SME** ______

NON-M.E. AUTOPSY DONE
☐Yes ☐No

PROBABLE CAUSE OF DEATH:

1. _____
2. Due to: _____
3. Due to: _____

Contributing factor: _____

I.S.M.E. review: ________________

I hereby certify that after receiving notice of the death described herein I took charge of the body and made inquiries regarding the cause and manner of death in accordance with Chapter 331.801 and 802 and the information contained herein regarding such death is true and correct to the best of my knowledge and belief.

TYPE NAME:
(Signature of Medical Examiner/ Medical Examiner Investigator)

(Date Signed) (County of Appointment)

How Injury Occurred (24d. of death certificate):

Send ***original*** to Iowa State Medical Examiner. Copies must be forwarded to County Attorney's office(s).

MEANS OF DEATH (Agency or Object) - IF OTHER THAN NATURAL

IF MOTOR VEHICLE INVOLVED	☐Driver [if known] ☐Passenger [if known] ☐Pedestrian ☐Other	☐Lap Belt Used ☐Shoulder Belt Used ☐Crash Helmet Worn ☐Child Restraint	☐Hit-Run ☐Non-Highway ___________ ☐Air Bag Deployed	☐Passenger Car ☐Truck ☐Motorcycle ☐Motorbike	☐Farm Vehicle ☐Other: ____

IF GUN	☐Rifle - Cal. ____ ☐Handgun - Cal. ____ ☐Shotgun - Cal. ____ ☐Unknown Type	☐Stippling ☐Smudging ☐Abrasion Collar ☐Round	☐Oblong ☐Stellate ☐Surg. Treated ☐Other	☐Head ☐Neck ☐Chest ☐Abdomen	☐Buttocks ☐Thighs ☐Lower Legs ☐Feet	☐Upper Arms ☐Lower Arms ☐Hands ☐Other

IF INSTRUMENT: ☐**Blunt /** ☐**Sharp**	WHAT KIND:	TYPE & LOCATION OF INJURIES:

IF DRUG, POISON, CHEMICAL (Suspected)	☐Alcohol ☐Other Drug, Poison, or Chemical: ____ ☐Unknown	REMARKS/SYMPTOMS:	☐Ingested ☐Injected ☐Inhaled ☐Topical ☐Unknown	☐Other:

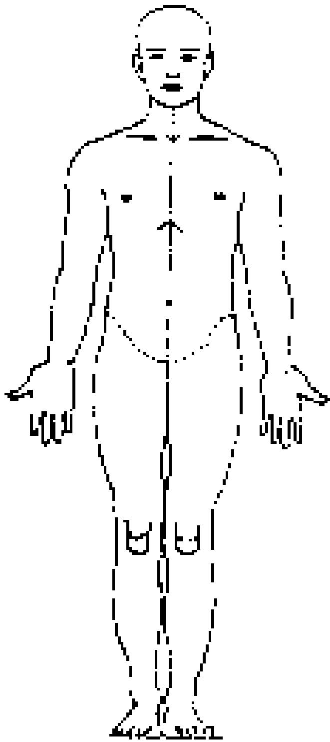
MEDICAL HISTORY

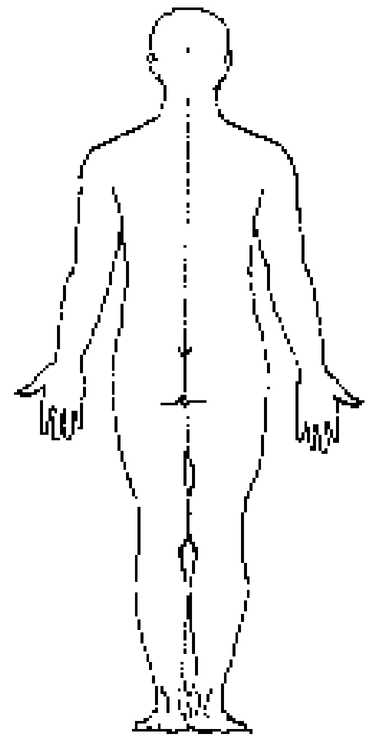
CONDITION: ☐Alcoholism ☐Cancer ☐Diabetes ☐Drug Abuse ☐Lung Disease	 ☐Fractures ☐Heart Disease ☐Seizure: ☐Other (specify):	**FAMILY PHYSICIAN –** DOCTOR: ADDRESS: PHONE #: MEDICATIONS:	**EMERGENCY MEDICAL HISTORY –** DOCTOR: WHERE TREATED: MEDICATIONS:

NEXT OF KIN - Address and Phone #:	
FUNERAL HOME – Address and Phone #	

NARRATIVE SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH (Add sheet if needed):

____





IDENTIFICATION OF BODY

☐ **Preliminary** ☐ **Positive**	**Method:**
If by viewing, viewed by:	
Address:	
Relationship:	**Telephone #:**