

AUTHORIZATION FOR DISPOSITION OF REMAINS

Name of Deceased		Case #	Date Received	Time Released		
Date of Death	Time of Death		Sex	Race	Date of Birth	Age
Address of Deceased		City	State	Zip		
Date of Death	Time of Death		Location of Death			
Funeral Home			Funeral Home Address			
Funeral Home Representative		Funeral Home	City	State	Zip	
Autopsy Requested? ___ YES ___ NO	Autopsy Performed? ___ YES ___ NO	Where Autopsy Performed		Doctor Performing Autopsy		
Cause of Death		Manner of Death		Mechanism of Death		
Person Certifying Death		Permission to Dispose of Remains ___ Yes ___ NO		Type of Disposition		

Authorized Signature of Coroner's Office

_____ Authorized Signature of Coroner's Office

_____ Title

_____ Date Authorized