County of Los Angeles INFORMATION OBTAINED BY MORTUARY FROM FAMILY Department of Medical ExaminerCoroner

Attending Physician:_____ Phone:_____

Address: _____ Date Last Attended:_____

Diagnosis:_____

_____

Surgery: _____ Date: _____ Hospital:_____

WITNESSED DEATH: ☐Yes ☐No If no, LAST KNOWN ALIVE Date:_____ Time:_____

Date and Time Discovered: _____ Where:_____

By Whom: _____ Police Agency Investigated: ☐Yes ☐ No

If Yes – Name and Division of Police Agency:_____

REST HOME OR CONVALESCENT HOSPITAL DEATH:Date Admitted:_____

Admitting Diagnosis: _____

_____

TERMINAL EVENT OR HOW DISCOVERED/ KNOWN MEDICAL HISTORY, RECENT COMPLAINTS OF ILLNESSES AND ANY PERTINENT INFORMATION:

_____

_____

_____

HISTORY OR EVIDENCE OF INJURY: ☐Yes ☐No TYPE OF INJURY: _____

Date and Time of Injury: _____ Address: _____

City:_____ State: _____

At Work: ☐Yes ☐No At Home: ☐Yes ☐No If Neither, where:_____

How Did Injury occur: _____

ALL MEDICAL EVIDENCE LIST BELOW

R No	Date Filled:	Contents:	Amount Prescribed:	Amount Remaining:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

THIS FORM COMPLETED BY: _____

DECEDENT PERSONALLY IDENTIFIED BY: / IDENTIFICATION HECHA POR:

Signed / Firma:_____ Witness / Testigo: _____

Print / Molde:_____ Print/ Molde :_____

(ESCRIBA EN LETRA DE MOLDE)

Address / Domicilio:_____ Address/ Domicilio:_____

City / Ciudad:_____ City/ Cuidad: _____

Telephone No. / Telefono:_____ Date Signed / Fecha De Firma: _____