Vital Statistic Services
Release of Human Remains Death / Fetal Death - Call Sheet

Patient Name; First:_____ Middle:_____ Last:_____

Patient Address:_____

S.S. #: _____ Date of Birth:_____ Age:_____

(If no Social Security Number List all 9s)

Sex: _____

Place of Death Facility (ER, Inpatient, etc.): _____

Facility Name or address where Death occurred: _____

_____

Date of Death:_____ Time of Death:_____

Date Type: Actual: _____ Approximate:_____ Found:_____

Time Type: Actual:_____ Approximate:_____ Unknown:_____

Time Pronounced Dead (HHMM): _____ Pronounced by: _____

Was Coroner notified? : Yes_____ No_____ Coroners Case: _____ Autopsy Performed:_____

Primary Care Physician (if known): _____

Hospice: Yes No If yes, Hospice name:_____

If Hospice:
Diagnosis / Discharge Summary: _____

_____

_____

_____

_____

Donation: _____ Coalition or Alliance Notified?_____

Who was notified: _____ Date:_____ Time:_____

Released to Funeral Home or Person Acting as Such: _____

Signature: _____ Relationship: _____

Date:_____