

TIMES

Notified by 911: _____
Arrived at Scene: _____
Left Scene: _____
Arrived at Hospital for x-ray: _____
Left Hospital: _____
Arrived at Morgue: _____
Left Morgue: _____
Total time: _____

Weston County Coroner
1 West Main
Newcastle, WY 82701
OFFICE (307) 746-8143
FAX (307) 465-2286

Date Start: _____
Date: _____
Time: _____

CORONER INVESTIGATOR WORKSHEET

Coroner Case #: _____ Date: _____
Investigator: _____

DECEDENT'S NAME: _____ Sex: _____ Race: _____
Address: _____ City: _____ State: _____
Phone: _____ Date of Birth: _____ Age: _____
SSN: _____ Birthplace: _____ Drivers License#: _____
Decedent ever in the U.S. Armed Forces? No () Yes () Branch: _____

DECEDENT IDENTIFIED BY WHAT MEANS: _____
Family, Known to Police and/or Person at Scene, Driver's License, Fingerprints, etc.

PLACE OF DEATH:
Decedent's Home Hospital/ICU Hospital/ER Nursing Home Roadway GPS below Other-Specify
Did the decedent originate from outside Weston County? If 'YES' refer to CORONER ASSIST FORM. From which
county did the decedent originate? _____

Location of Death/Address: _____
Location/Date/Time of Injury: _____

DATE OF DEATH (Actual/Witnessed): _____ **OR DATE FOUND DEAD** (Unknown/Unwitnessed): _____
Circle one

TIME OF DEATH (Actual/Witnessed): _____ **OR TIME FOUND DEAD** (Unknown/Unwitnessed): _____
Circle one

PRONOUNCED DEAD: (Mo/Day/Yr) _____ Hour: _____

PRONOUNCED BY: Police () Paramedic () EMT () Firefighter () Nurse () Physician ()
Person making Pronouncement of Death: _____

Coroner notified by: PSC () WCMH () WHP () NPD () WCSO () Funeral Home () Other ()
Date and Time notified: _____

Accident Involved? Yes () No () Type of Accident: _____

USUAL OCCUPATION: _____

Injury at Work: Yes () No () Name and place of work: _____

Driver/Operator () Passenger () Pedestrian () Other () Specify: _____

GPS Reading: N _____ W _____

Decedent's Name _____

PHYSICIAN THE DECEDENT HAS SEEN TO OBTAIN MEDICAL RECORDS:

MEDICAL HISTORY

Decedent's Physician(s): _____ Date Decedent was last seen by their physician(s): _____ Recent and past medical complaints: _____

Does the Decedent have a **PACEMAKER**? Yes No

IS THIS PERSON A KNOWN DONOR? Yes No

Physical Description: HT: _____ WT: _____ Hair Color: _____ Eye Color: _____
Nourishment: Normal Obese Thin

Does decedent have a history of drug/alcohol abuse? Yes () No () Unknown ()

Is the decedent a **SMOKER**? _____ History of smoking: _____

Was the Decedent on any prescribed medications? Yes () No () Unknown ()

If medication collected, by whom: _____

BLOOD/URINE DRAWN FOR TOXICOLOGY? Yes No

CORONER TO SIGN THE DEATH CERTIFICATE:

Cynthia Crabtree () Other Physician: _____

NEXT OF KIN:

MARITAL STATUS: Married Divorced Married/Separated Never Married Widowed Unknown

Next of Kin: _____ Relationship to Decedent: _____

Address: _____ Phone: _____

Other Family & Phone: _____

Next of Kin notified: Yes () No () By Whom: _____

Date Notified: _____ Time Notified: _____

If not notified, Location of Next of Kin: _____

DECEDENT TAKEN TO MORGUE? Yes () No ()

Secured in morgue cooler: **Date and Time:** _____

FUNERAL HOME: Wordon's () Other: _____

FUNERAL HOME CHOSEN BY: Family () Coroner ()

Decedent transferred to another agency: Yes () No () If yes, Agency name: _____

Primary Coroner's Investigator: _____

Assisting Coroner's Investigator: _____

TO BE COMPLETED BY CORONER

MANNER OF DEATH:

Natural () Accidental () Suicide () Homicide () Undetermined () Possible SUID ()

Cause of Death: As Stated on Death Certificate

DONOR Yes No **Donor Alliance** **RMLEB**