

**COUNTY CORONER/MEDICAL EXAMINER'S OFFICE
Cremation Approval**

FUNERAL HOME TO COMPLETE (please print or type)

Decedent _____ DOB _____
Date of Death _____ Time of Death _____
Place of Death _____ County _____
Primary Physician's Name _____
Phone _____ Fax _____
Funeral Home _____
Contact _____
Phone _____ Fax _____
Date Cremation Desired _____

PHYSICIAN TO COMPLETE

Please fax to: _____

Date last seen or clinic visit _____

Was there any TRAUMA that contributed to the death?
(i.e. motor vehicle accident, fractures, falls, surgical procedures, etc.) Yes _____ No _____

If yes, please describe _____

Is there any reason to postpone cremation? Yes _____ No _____

If yes, please explain _____

CAUSE OF DEATH AS IT WILL APPEAR ON THE DEATH CERTIFICATE:

Line 33a _____

Line 33b _____

Line 33c _____

Line 34, Other Significant Conditions _____

Physician's Signature _____ **Date** _____

CORONER/MEDICAL EXAMINER TO COMPLETE

Authorized Signature _____

OK to Cremate? Yes _____ No _____ Date _____