

## Medical Examiner's Office

## **Cremation Approval**

## Hennepin, Dakota & Scott Counties Fax 612-321-3556

		ME Case	#
FUNERAL HOME TO COMPLETE: (please prin	t or type <u>legibl</u>	<u> v</u> )	(if known)
DECEDENT:		D.O.B.:	
-			(gestational age if fetus)
Date of Death:	Time of Dea	ath:	
Place of Death:	0"	County:	
Street address  Residence Nursing Home Assisted Living	-		
PRIMARY PHYSICIAN:			
Phone:	FAX		
FUNERAL HOME:			
Contact:			
Phone:	FAX		
MEDICAL PROVIDER TO COMPLETE:	Please <b>FAX</b>	to:	
Date last seen <u>or</u> last clinic visit:			
Was there any TRAUMA that caused/contributed (i.e. motor vehicle accident, fractures, falls, drug overdos		`	Yes No
If YES preport to Medical Examiner at 6	612-215-6300		
Is the manner of death NATURAL?		`	Yes No
If NO report to Medical Examiner at 6	612-215-6300		
CAUSE OF DEATH AS IT WILL APPEAR ON THE	E DEATH CERTI	FICATE:	
Line 33a			
Line 33b			
Line 33c			
Other Significant Conditions:			
Provider's Signature:		Date:	
MEDICAL EXAMINER TO COMPLETE:			
M.E. Staff Signature:			
OK to Cremate? Yes No		Date:	

Yes--but **HOLD DC** pending notification by the Medical Examiner re jurisdiction