IOWA OFFICE OF THE STATE MEDICAL EXAMINER

2250 South Ankeny Blvd. Ankeny, IA 515-725-1400

PRELIMINARY MEDICAL EXAMINER REPORT

Worksheet for EMER (Electronic Medical Examiner Reporting)

☐ JURISDICTION DECLINED

AUTOPSY
☐ No ☐ County
☐ IOSME ☐ Private/Hospital
Facility Where Autopsy Performed:

Bag Lock #:

DECEDENT: _____
(First Name) (Middle Name) (Last Name) (Suffix)

ADDRESS: _____ Iowa
(residence) (Number and Street or Route, Box No.) (City) (State) (Zip Code) (County) (County Assigned Case #)

INFORMATION ABOUT DECEDENT AND DESCRIPTION OF BODY

Age
If <2 years, give months & days
Age: Years
Date of Birth:

Gender
☐ Male
☐ Female
☐ Unknown

Weight: _____ lbs.
Length: _____ inches

Body Temperature
☐ Warm
☐ Cool
☐ Cold

Froth Present
☐ Yes ☐ No

Injury At Work
Y=Yes, N=No, U= Unknown
X=Not Applicable

Occupation
Please fill in both parts
Type of Work: _____
(e.g., machinist, typist, fireman, farmer, salesman, homemaker)
Industry: _____
(e.g., textile, banking, fire dept.,farming, insurance, home)

Marital Status
☐ Married
☐ Never Married
☐ Widowed
☐ Divorced
☐ Married but Separated
☐ Common Law
☐ Unknown

Race
☐ White
☐ Black
☐ Asian
☐ Native American
☐ Other: _____ Description

Smoking History
☐ Yes ☐ No ☐ Unknown

Highest Education Level
☐ Served in the Armed Forces

Rigor
☐ None
☐ Mild
☐ Moderate
☐ Full

Decomposition
☐ Early
☐ Moderate
☐ Advanced
☐ None

Livor
Check all that apply
☐ Fixed ☐ Unfixed
☐ Anterior
☐ Posterior
☐ Upper Body
☐ Lower Body
☐ Left Side
☐ Right Side

Pregnant
☐ Not Pregnant Within Last Year
☐ Pregnant At Time of Death
☐ Not Pregnant, But Pregnant Within 42 Days of Death
☐ Not Pregnant, But Pregnant 43 Days to 1 Year Before Death
☐ Not Applicable
☐ Unknown
Gestation: _____
Weight of Fetus: _____

Law Enforcement Record Of Domestic Violence
☐ Yes ☐ No

Law Enforcement Related Death

INFORMATION ABOUT OCCURRENCE

ITEM	DATE	TIME (military)	TYPE OF PREMISES (Home, Farm, Highway, Hospital, etc.)	LOCATION	COUNTY and ZIP CODE
INJURY (Address)				Address of Injury	
LAST SEEN ALIVE (Address/By Whom)				Address Where Last Seen or Heard From — By Whom	
DEATH PRONOUNCED				Address Where Pronounced — Name of Pronouncer	
FOUND DEAD BY (Address/By Whom)				Address Where Found — Found by Whom	
POLICE NOTIFIED			**AGENCY NAME:**	**OFFICER NAME:**	**CONTACT NUMBER:**
POLICE NOTIFIED			**AGENCY NAME:**	**OFFICER NAME:**	**CONTACT NUMBER:**
ME/MEI NOTIFIED (By Whom)			NAME and AGENCY of Person Who Made Notification to ME/MEI		
TO HOSPITAL			Name of Hospital:		

Went to Scene: ☐ Yes ☐ No			**Scene Photos Taken:**	☐ Yes	☐ No	
Arrived on Scene			**Scene Video Taken:**	☐ Yes	☐ No	
Departed Scene			**Video Available to IOSME:**	☐ Yes	☐ No	
Viewed Body: ☐ Yes ☐ No			**If Infant, Doll Re-enactment:**	☐ Performed	☐ Scheduled	☐ Denied
Samples Drawn: ☐ Blood ☐ Urine ☐ Vitreous			If denied, why?			
Iowa Donor Network Notified ☐ Yes ☐ No			**1-800-831-4131**			

MANNER OF DEATH

☐ **Natural** ☐ **Homicide** ☐ **Accident** ☐ **Suicide** ☐ **Undetermined** ☐ **Pending Investigation** ☐ **Preliminary Investigation**

Probable Cause Of Death:

Due to:

Due to:

Contributing factor(s):

How Injury Occurred (required for death certificate):

_____, _____
ME/MEI Conducting Investigation **ME/MEI Date Signed**

Agency Name

ME/MEI EMER Approver **ME/MEI Entry Complete Date**

County of Appointment

MEANS OF DEATH

☐ Natural ☐ Carbon Monoxide-Vehicle ☐ Pedestrian ☐ Drowning ☐ Asphxiation ☐ Other
☐ Suicide ☐ Carbon Monoxide-Dwelling ☐ Firearm ☐ Fire/Thermal ☐ Drug/Alcohol/Poison Other Description:
☐ Hanging ☐ Vehicles ☐ Instrument ☐ Falling ☐ Suspected Abuse/Neglect

SUICIDE

Past Suicidal Ideations
Narrative:

Past Suicide Attempt
Narrative:

History Mental Disorder
Narrative:

Treated By

Treatment Narrative:

☐ Suicide Note Found
☐ Copy of Note Obtained
☐ Handwriting Sample Obtained

☐ Residence Secured

☐ Alcohol Found at Scene

Drugs Found at Scene:
☐ Non-Prescription
☐ Prescribed to Decedent
☐ Prescribed to Other
☐ Illegal

HANGING

Suspension

Body Location Description:

Body Position Description:

☐ Possible Autoerotic Asphyxiation

Ligature Type:

Ligature Length: in.

Description of Ligature:

Ligature Texture:

Object/Source of Attachment:

Other:

Point of Suspension On Body:

Knot Type:

Description of Knot:

Platform:
☐ Platform Used
☐ Platform Overturned
☐ Platform Scuff Marks Found
☐ No Platform

Platform Distance From Ground
in.

Platform Distance From Body
in.

Description of Platform:

CARBON MONOXIDE-VEHICLE

Vehicle Year: **Vehicle Model:**
Vehicle Make: **Gas Tank Level:**

Vehicle Additional Info:
☐ Key in Ignition ☐ Key Position On
☐ Motor Running ☐ Restart Possible
☐ Doors Locked ☐ Doors Open
☐ Windows Closed

☐ Air Conditioning On ☐ Heater On
☐ Tailpipe Condensation ☐ Unknown

Vehicle Garaged:
Garage Attached to House:

Garage Type:

Garage Door Position:

Describe attempts to seal doors / windows:

CARBON MONOXIDE-DWELLING

Dwelling Type:

Garage Attached to Dwelling:

Source of Carbon Monoxide

- ☐ Vehicle
- ☐ Furnance
- ☐ Grill
- ☐ Generator
- ☐ Fireplace

- ☐ Others were harmed
- ☐ Animals were harmed

Heating System Type:

- ☐ Central Heating System
- ☐ Gas Furnace
- ☐ Oil Furnace
- ☐ Space Heater
- ☐ Wood Stove
- ☐ Other:

- ☐ Heating System On
- ☐ Recent Heating Problems

Room Temperature (F):
Thermostat Setting (F): Thermostat Functioning:

Heating System Repaired; Repair Date:
Heating System Recently Installed; Installed Date:

Heating System Narrative:

VEHICLES

Type of Road:

Estimated Speed:
Construction Zone:
At Intersection:
Intersection Street(s):

Intersection Control Present: NO
Intersection Control Type:

Crash Type

- ☐ Head On
- ☐ Angle
- ☐ Driver Side Impact
- ☐ Left Roadway
- ☐ Passenger Side Impact
- ☐ Rollover
- ☐ Rear End
- ☐ Other

Additional Crash Type Info:

Weather Condition:

Accident Description (Location Narrative):

Deceased Position in Vehicle:

Vehicle Type:

Vehicle:
Year:
Make:
Model:

Distractions Present during the Accident

- ☐ Cell Phone
- ☐ Changing Music
- ☐ Drag Racing:
- ☐ Alcohol Present in Vehicle
- ☐ Drugs Present in Vehicle
- ☐ Other:

If Decedent was Driver:

- ☐ Sleep Deprived

If under 18
# of Vehicle Occupants:
List Age of Each Occupant:

Date License/Permit Issued:

License Type:

Other Vehicles:
Vehicle Type:

Vehicle:
Year:
Make:
Model:

Additional Vehicles:

Restraint Used in Vehicle

- ☐ Restrained in Vehicle
- ☐ Unrestrained in Vehicle
- ☐ Unknown if Restraint Used
- ☐ Ejected from Vehicle
- ☐ Partially Ejected from Vehicle

Restraint Type:

Additional Restraint Info:

- ☐ Air Bags in Vehicle
- ☐ Air Bags Deployed
- ☐ Child Restraint

Point of Impact:

Tire Marks Description:

Helmet Worn:
Helmet Damage:

PEDESTRIAN

Pedestrian Circumstances

- ☐ If Intentional - Suicide?

Describe the location and direction of the Pedestrian:

Pedestrian Activity/Location

- ☐ Standing or Otherwise Immobile
- ☐ Walking
- ☐ Running
- ☐ Playing
- ☐ Working on Vehicle
- ☐ Entering Vehicle
- ☐ Exiting Vehicle
- ☐ Crossing at Intersection
- ☐ Crossing at Non-intersection
- ☐ In Course of Employment
- ☐ On Sidewalk
- ☐ Cycling
- ☐ Unknown

FIREARM

Firearm Type

Make:
Model:
Caliber/Gauge:
Firearm (Barrel) Length:

Owner of Firearm:

Type of Firearm Narrative (Description):

Activity:
- ☐ Hunting
- ☐ Playing
- ☐ Self-Infliction
- ☐ Homicide (Criminal Assault)
- ☐ Recreation

Circumstances:
- ☐ Legal Intervention
- ☐ Domestic Violence
- ☐ Self Defense

Activity Narrative:

If Self-Inlicted Suspected

Cause Narrative:

INSTRUMENT

Edge Type:

If Blade, Length:

Blade Type
- ☐ Serrated Blade
- ☐ Non-Serrated Blade
- ☐ Fixed Blade
- ☐ Folding Blade
- ☐ Single Edge Blade
- ☐ Double Edge Blade
- ☐ Other

Instrument Description

Other Blade Description

DROWNING

Location:

Flotation Device

Swimming Skill

Activity Narrative

FIRE/THERMAL

Cause of Fire
- ☐ Appliance
- ☐ Candles
- ☐ Cigarettes
- ☐ Explosive/Explosion
- ☐ Faulty Wiring/Electrical
- ☐ Grease
- ☐ Intentional
- ☐ Lighter
- ☐ Matches
- ☐ Unknown

Thermal Inuries Cause:

Burning Object Type:

Cause of Fire Narrative

FALLING

Fall Height:
ft.
Fall Reason:

Position Fell From:

Fall Reason Narrative

ASPHYXIATION

Asphyxiated By:

- ☐ Possible Autoerotic

Asphyxiation Narrative

DRUG/ALCOHOL/POISON

Poisoning Source

- ☐ Alcohol
- ☐ Suspicion of Alcohol Withdrawal
- ☐ Over-the-Counter Medication
  - ☐ Prescribed to Decedent
  - ☐ Prescribed to Other
- ☐ Illegal Substance
- ☐ Food
- ☐ Animal Bite/Sting
- ☐ Household Cleaner
- ☐ Other, Drug, Poison, or Chemical:
- ☐ Unknown

Route of Poisoning

- ☐ Ingested
- ☐ Injected
- ☐ Inhaled
- ☐ Topical
- ☐ Unknown
- ☐ Other:

Remarks/Symptoms:

INFANT (0-3)

Mother

Name

Date of Birth:
Address:

City:
County:
State: Iowa Zip:
Phone (inc area code):
Other States Where Resided:

History of:

- ☐ Smoking
- ☐ Drugs
- ☐ Alcohol
- ☐ Mental Illness

Father

Name

Date of Birth:
Address:

City:
County:
State: Iowa Zip:
Phone (inc area code):
Other States Where Resided:

History of:

- ☐ Smoking
- ☐ Drugs
- ☐ Alcohol
- ☐ Mental Illness

Caregiver at Time of Death

Name

Date of Birth:
Address:

City:
County:
State: Iowa Zip:
Phone (inc area code):
Other States Where Resided:

Relationship to Decedent:

How Long Cared for Child:

History of:

- ☐ Smoking
- ☐ Drugs
- ☐ Alcohol
- ☐ Mental Illness

Position at Time of Death

Who Found Child? (parent, sitter, etc.)

- ☐ Parent
- ☐ Grandparent
- ☐ Aunt
- ☐ Uncle
- ☐ Sibling
- ☐ Sitter
- ☐ Friend
- ☐ Significant Other of Parent
- ☐ Other

Where Was Child Found? (bedroom, crib, etc.)

In What Position Was the Child Found by Care Provider?

In What Position Was the Child Placed Down?

What Was Child's Usual Sleep Position?

Was Child Sleeping with Someone Else?
If Yes, with Whom?

Was This the Usual Sleep Arrangement?
Airway Obstructed?
Airway Obstructed Reason

In What Condition Was the Child Found? (warm, cold, still, mottled, etc.)?

Bedding

Sleep Environment?

If On Mattress, Type?

Covering Narrative:

Bed Contents:

Sleep Environment Narrative:

Describe Bedding Type (baby blankets, adult blankets, pillows, etc.):

Dangerous objects nearby:
If Yes, Describe:

Home Where Found

History of:

- ☐ Smoking
- ☐ Drugs
- ☐ Alcohol

Room Temperature (F): **F**
Thermostat Setting (F): **F**

Describe Heating and Cooling System:

How many reside in residence?

Check All That Apply

If daycare:

- ☐ In-Home
- ☐ Commercial
- ☐ Licensed
- ☐ Unlicensed

What is the child to adult ratio?

- ☐ Home Childproofed

INFANT (0-3)

Feeding History:

When Did Child Last Eat?

Date

Time

What Did Child Last Eat?

Quantity?

Who Fed Child Last?

Who prepared food?

Describe Normal Dietary Habits (foods, amounts, etc.):

Appropriate food for child in residence?

Health Information

Allergies:

Birth Defects:

Treatment Followed from Last Visit to Physician?

Existing Diagnoses?

History of:

☐ Prior Hospitalization?

Prior Hospitalization and/or ER Visit Narrative:

☐ Genetic / Inheritable Disease Processes in Family?

Specify:

☐ Prior Episodes of Apnea?

Specify:

☐ Prior Episodes of Cyanosis?

Specify:

☐ Prior Episodes of Seizure Activity?

Specify:

☐ Anyone Else in Household or Other Contacts (e.g. daycare) Recently Ill?

Specify:

Immunizations Current?

Birth Information

Birth Weight:

Length:

Birth Location:

Check All That Apply

Neonatal Complications?

If Yes, Specify:

Multiple Birth?

Gestational Age:

Any Illness or Complications During Pregnancy?

If Yes, What Type?

Delivery:

Any Maternal Risk Factors During Pregnancy (ethanol/alcohol, drugs, smoking/tobacco)?

If Yes, What?

Any Birth Complications?

If Yes, What type?

Risk Indicators

- ☐ Caregiver on Registry
- ☐ Caregiver Substance Abuse
- ☐ History of Domestic Violence in Household
- ☐ History of Previous Pregnancy Loss
- ☐ Objection to Autopsy
- ☐ Prior Child Deaths Involvement
- ☐ Prior Sibling Deaths
- ☐ Prior Sudden Death in Family
- ☐ Recent Fall/Injury
- ☐ Recurrent Medical Care
- ☐ Trauma
- ☐ Other:

Risk Indicators

- ☐ Acute Change in Diet
- ☐ Acute Change in Sleeping
- ☐ Poisoning / Intoxication
- ☐ Asphyxia (overlay, wedged, etc.)
- ☐ Hyperthermia / Hypothermia
- ☐ Bed Sharing
- ☐ Unsafe Sleep Conditions
- ☐ Religious / Cultural Remedies
- ☐ Previous BRUE (Brief Resolved Unexplained Event)

Does child have access to poisons/drugs/household chemicals?

If Yes, Explain:

Additional Comments:

CHILD/TEEN (AGE 4 - 17)

Caregiver
- ☐ Mother
- ☐ Father
- ☐ Other:

Name:

Phone (inc area code):
Address:
Iowa
County:
Other States Where Resided:

Additional Caregiver Information:

Caregiver History
- ☐ Domestic Violence
- ☐ Substance Abuse
- ☐ Mental Illness
- ☐ Perpetrator
- ☐ Incarceration
- ☐ DHS Involvement

CHILD/TEEN (AGE 4-17)

Health Information

Recent Illness or Injuries

Allergies:

Birth Defects:

History of Genetic/Inheritable Disease Processes in Family?

Mental Health History

Treatment:

Mental Health Narrative:

VIOLENT DEATH
(POTENTIAL SUICIDE OR HOMICIDE)

Suspicious Behavior Noticed By
- ☐ School
- ☐ Family
- ☐ Friends

If Yes, by Whom (Name):

Bullying
- ☐ Previous DHS Involvement
- ☐ Pressure to Perform
- ☐ Learning Disability/Special Education
- ☐ Incarcerations
- ☐ Probation
- ☐ Parole

BEHAVIOR
- ☐ Recent Drop in Academic Performance
- ☐ Recent Drop in Extra-Curricular Activities
- ☐ Recent Trouble at School
- ☐ Recent Trouble with Law Enforcement
- ☐ Alcohol Use
- ☐ Depression
- ☐ Anxiety
- ☐ Drug Use
  If Yes, What Drugs?
- ☐ History or Allegations of Physical or Sexual Abuse in the Home

By Whom?

Sexual Orientation:
- ☐ Bullying Due to Gender Expression Dysphoria
- ☐ Recent Parent Divorce
- ☐ Pregnant or Impregnated a Female

VIOLENT DEATH

Significant Losses of Parent/Caregiver
- ☐ Death
- ☐ Suicide
- ☐ Separation/Divorce

If Yes, Whom and How:

Significant Losses of Close Friend:
- ☐ Death
- ☐ Suicide
- ☐ Separation/Move

If Yes, Whom and How:

Other Loss
- ☐ Loss of Job
- ☐ Loss of Pet
- ☐ Romantic Breakup/Conflict
- ☐ Change in Schools

CHILD/TEEN (AGE 4-17)

Miscellaneous
History of Participation In:
- ☐ "Choking Games"
- ☐ "Autoerotic Asphyxia"
- ☐ "Medication Grab Bag"
- ☐ "Rainbow Parties"
- ☐ Other:

Demeanor:
- ☐ Friendly with Peers
- ☐ Socially Withdrawn
- ☐ Participation in Extracurricular Activities

Circumstances:
- ☐ Farm-related
- ☐ Job-related
- ☐ Sports-related
- ☐ Self-Mutilation

Teen Narrative:

DEPENDENT ABUSE

Was this death expected?

Is This Death Suspicious For:

- ☐ Physical Abuse
- ☐ Financial Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Insurance Collection
- ☐ Inappropriate Care (e.g. mishandling of resources/medication)

Decedent Mentation:

- ☐ Recent change in mentation or condition
- ☐ Communicative and Appropriate

Dementia:

Ambulation:

Senses and Communication

Verbal

Hearing

Eyesight

Sensation

DEPENDENT ABUSE

Living Situation

Communicative & Appropriate

Caregiver Dementia

Degree of Independence:

Nursing Assistance:

Name:

Agency:

Frequency:

Housekeeping

- ☐ Self
- ☐ Spouse/Significant Other
- ☐ Friend
- ☐ Hired Assistance
- ☐ Child/Other Relative

Access to Comfort

- ☐ Television Available and Within Reach
- ☐ Reading Materials/Games/Hobbies Available
- ☐ Mail Accessible and Current
- ☐ Gainfully Employed or Volunteering
- ☐ Lighted Rooms with Access to Switch
- ☐ Access to Restroom/Hygiene Facilities (e.g. urinal, commode, etc.)
- ☐ Diapered
  - ☐ Clean Changed
  - ☐ Inappropriate Maintenance

Access to Food

- ☐ Able to Handle Eating Independently
- ☐ Must be Fed by Others
- ☐ Able to Cook
- ☐ Able to Shop for Food Independently
- ☐ Requires Food Shopping Assistance By:

- ☐ Cupboards Well Stocked
- ☐ Refrigerator Well Stocked
- ☐ Food and Water Within Reach

Utilities:

How is residence heated?

- ☐ Central Heating System
- ☐ Gas Furnace
- ☐ Oil Furnace
- ☐ Space Heater
- ☐ Wood Stove
- ☐ Other:

How is residence cooled?

Describe Heating and Cooling System:

Room Temperature (F):

Thermostat Setting (F):

Outside Temperature (F):

- ☐ Electricity Operational
- ☐ Water Operational

Water Heater Temperature:

Access to Communication

- ☐ Telephone within Reach
- ☐ Computer or Tablet within Reach
- ☐ Computer Literate

Regular Contact with:

Name:

Phone (inc area code):
How Often:
Relationship to Deceased:

Name:

Phone (inc area code):
How Often:
Relationship to Deceased:

Name:

Phone (inc area code):
How Often:
Relationship to Deceased:

Required Assistance Device

Hearing Aid

Eye Glasses

Walker/Cane

Wheelchair

Other:

Normal Sleeping Arrangements

DEPENDENT ABUSE

Clothing
- ☐ Appropriate for Season
- ☐ Appropriate Size
- ☐ Clean
- ☐ Outerwear Available
- ☐ Shoes Available

Transportation
- ☐ Able to Drive Self
- ☐ Owns Automobile
- ☐ Uses Bicycle
- ☐ Other:

Available Chauffer
- ☐ Spouse/Significant Other
- ☐ Friend
- ☐ Hired Assistance
- ☐ Child/Other Relative:

Finances
- ☐ Employed
- ☐ No Known Income
- ☐ On Retirement/Subsidy
- ☐ Dependent of:

Who has Access to Money/Accounts:
- ☐ Self
- ☐ Spouse/Significant Other
- ☐ Friend
- ☐ Hired Assistance
- ☐ Child:
- ☐ Other:

MEDICAL HISTORY

Recent Medical History:	**Past Medical History:**

PHYSICIAN: **Type:** **Doctor:** **Where Treated:** **Address:** **Phone:**	**PHYSICIAN:** **Type:** **Doctor:** **Where Treated:** **Address:** **Phone:**	**PHYSICIAN:** **Type:** **Doctor:** **Where Treated:** **Address:** **Phone:**	**PHYSICIAN:** **Type:** **Doctor:** **Where Treated:** **Address:** **Phone:**	**DENTIST** **Doctor:** **Where Treated:** **Address:** **Phone:**

Resuscitation Efforts: ☐ Yes ☐ No **Check All That Apply:** ☐ ACLS ☐ LUCAS Device ☐ PALS ☐ Other:	**Responding EMS:** Name: Phone: *(inc area code)*
Next of Kin - Name, Relationship and Phone	
Transporting Agency for Autopsy - Name, Phone	
Funeral Home - Name, Phone	

NARRATIVE SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH (add sheet if needed):

Brief Case Description (1 to 3 sentences):

History/Circumstances (surrounding the death):

Scene Description (include location and position of body):

Case Assessment (impression of reason for death):

Reason for Disposition:

IDENTIFICATION OF BODY

Identification: **Method:**

If by viewing, viewed by: _____

Relationship: _____ **Phone (inc area code):** _____