

**KENTUCKY JUSTICE CABINET
STATE MEDICAL EXAMINER'S OFFICE**

CORONERS AUTHORIZATION FOR POST-MORTEM EXAMINATION

I hereby authorize the Kentucky Medical Examiner Division to perform a Post-Mortem Examination on this deceased body and to remove and retain such organs and tissues as may be necessary to determine the identification and/or the cause of death and/or the manner of death of this deceased person. This authorization is pursuant to KRS. Chapter 72.

NAME OF DECEDENT: _____

AGE: _____ **SEX:** _____ **RACE:** _____

LOCATION WHERE DEATH OCCURRED: _____

DATE OF DEATH: _____ **TIME OF DEATH:** _____ **AM** _____ **PM** _____

TYPE OF DEATH THAT IS SUSPECTED: _____

HISTORY: (WHAT HAPPENED) _____

POLICE AGENCY: _____ **INVESTIGATOR:** _____

If prescription drug related, state name of physicians and pharmacies on prescriptions:

Medication: _____ **PHYSICIAN:** _____

Medication: _____ **PHYSICIAN:** _____

Medication: _____ **PHYSICIAN:** _____

Signed: _____

Coroner or Deputy Coroner

County

CORONER: Please keep pink copy and send white and yellow copy to Medical Examiner.