

5

Please read and answer all the following questions before signing

Was the decedent legally married at the time of death?	Yes	No
Does the decedent have any living adult children?	Yes	No
Does the decedent have any living parents?	Yes	No
Does the decedent have a durable power of attorney or Advanced Health Care Directive under Probate Code Section 4600 et seq?	Yes	No

Case No.

Case Name

HEALTH AND SAFETY CODE § 7100• CUSTODY AND DUTY OF INTERMENT

"WARNING: The person signing this Order for Release is liable for all damages caused by any untruthful statements contained in this document. (Health and Safety Code Section 7110). It is also a criminal offense to knowingly file a false statement with a government agency. (Penal Code Section 115 and 470)"

- (1) An agent under a power of attorney for health care who has the right and duty of disposition under Division 4.7 (commencing with Section 4600) of the Probate Code;
- (2) The competent surviving spouse;
- (3) The sole surviving competent adult child of the decedent or, if there is more than one competent adult child of the decedent, the majority of the surviving competent adult children.
- (4) The surviving competent parent or parents of the decedent. If one of the surviving competent parents is absent, the remaining competent parent shall be vested with the rights and duties of this section after reasonable efforts have been unsuccessful in locating the absent surviving competent parent.
- (5) The sole surviving competent adult sibling of the decedent or, if there is more than one surviving competent adult sibling of the decedent, the majority of the surviving competent adult siblings.
- (6) The surviving competent adult person or persons respectively in the next degrees of kinship;
- (7) A conservator of the person or estate appointed under Part 3 (commencing with Section 1800) of Division 4 of the Probate Code when the decedent has sufficient assets.
- (8) The public administrator.

Therefore, please release the body upon completion of your death investigation of said deceased to:

NAME OF MORTUARY _____		MORTUARY TELEPHONE NUMBER _____	
NAME OF NEXT-OF-KIN (PLEASE PRINT LEGIBLY) _____		RELATIONSHIP _____	NEXT-OF-KIN'S SIGNATURE _____
ADDRESS _____	CITY _____	STATE _____	ZIP CODE _____
TELEPHONE NUMBER _____		DATE SIGNED _____	

IF THE LEGAL NEXT-OF-KIN IS NOT HANDLING, PLEASE ENTER NEXT-OF-KIN INFORMATION BELOW AND EXPLAIN WHY THEY ARE NOT HANDLING. ATTACH SUPPORTING AUTHORIZATION DOCUMENTS, E.G. WILLS, POWER OF ATTORNEY, FAXES, ETC.

NAME _____	RELATIONSHIP _____	ADDRESS / CITY / STATE / ZIP CODE _____	TELEPHONE NUMBER _____
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Only to be filled out on the day of pick up/Release.

MORTUARY ATTENDANT/DRIVER:

FIRST NAME _____	LAST NAME _____
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NAME OF TRANSPORT COMPANY: \_\_\_\_\_

DATE OF PICK UP \_\_\_\_\_

For Medical Examiner Personnel Only

APPROVING SENIOR/SUPERVISOR \_\_\_\_\_

CRYPT \_\_\_\_\_

Attending Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Date Last Attended: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_ Hospital: \_\_\_\_\_

WITNESSED DEATH:  Yes  No If no, LAST KNOWN ALIVE Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date and Time Discovered: \_\_\_\_\_ Where: \_\_\_\_\_

By Whom: \_\_\_\_\_ Police Agency Investigated:  Yes  No

If Yes - Name and Division of Police Agency: \_\_\_\_\_

REST HOME OR CONVALESCENT HOSPITAL DEATH: Date Admitted: \_\_\_\_\_

Admitting Diagnosis: \_\_\_\_\_

TERMINAL EVENT OR HOW DISCOVERED/ KNOWN MEDICAL HISTORY, RECENT COMPLAINTS OF ILLNESSES AND ANY PERTINENT INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HISTORY OR EVIDENCE OF INJURY:  Yes  No TYPE OF INJURY: \_\_\_\_\_

Date and Time of Injury: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

At Work:  Yes  No At Home:  Yes  No If Neither, where: \_\_\_\_\_

How Did Injury occur: \_\_\_\_\_

ALL MEDICAL EVIDENCE LIST BELOW

R No	Date Filled:	Contents:	Amount Prescribed:	Amount Remaining:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Decedent Gender Identity: \_\_\_\_\_ Decedent Sexual Orientation: \_\_\_\_\_

THIS FORM COMPLETED BY:

DECEDENT PERSONALLY IDENTIFIED BY: / IDENTIFICACION HECHA POR:

Signed / Firma: \_\_\_\_\_

Witness / Testigo: \_\_\_\_\_

Print / Molde: \_\_\_\_\_

Print/ Molde : \_\_\_\_\_

(ESCRIBA EN LETRA DE MOLDE)

Address / Domicilio: \_\_\_\_\_

Address/ Domicilio: \_\_\_\_\_

City / Ciudad: \_\_\_\_\_

City/ Ciudad: \_\_\_\_\_

Telephone No. / Telefono: \_\_\_\_\_

Date Signed / Fecha De Firma: \_\_\_\_\_