

Medical Examiner Department  
Indigent Cremation Service



Decedent Information

ICS Case Number: \_\_\_\_\_

1. Deceased: \_\_\_\_\_ 2. Sex: \_\_\_\_\_ 3. Age: \_\_\_\_\_  
(first, middle, last)
4. Race: ☐ White ☐ Black ☐ Other (Alaskan, Asian, American Indian or Unknown)
5. Decedent of Hispanic or Haitian origin? ☐ Yes (If yes, please specify) ☐ No  
☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Central/South American ☐ Other Hispanic (Specify) ☐ Haitian
6. Date of Death: \_\_\_\_\_ 7. Time of Death: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.
8. Date of Birth: \_\_\_\_\_ 9. Social Security No.: \_\_\_\_\_
10. Place of Birth: \_\_\_\_\_  
City/State
11. Marital Status: \_\_\_\_\_ 12. Surviving Spouse: \_\_\_\_\_  
(married, married but separated, never married, single, divorced, widowed)
13. Was decedent in the U.S. Armed Forces: ☐ Yes ☐ No ☐ Unk 14. Highest Grade Completed \_\_\_\_\_
15. Place of Death: \_\_\_\_\_  
Hospital/E.R., nursing home, residence, other (please specify)
16. Was death inside city limits: ☐ Yes ☐ No
17. City, Town or location of death: \_\_\_\_\_
18. Decedent's Usual Occupation: \_\_\_\_\_ 19. Kind of Business: \_\_\_\_\_
20. Residence / Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_
21. State: \_\_\_\_\_ County: \_\_\_\_\_
22. \_\_\_\_\_ 23. \_\_\_\_\_  
Father's Name Mother's Maiden Name
24. Informant's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Informant's Address: \_\_\_\_\_
25. Attending physician: \_\_\_\_\_ Lic #: \_\_\_\_\_  
Full Name
- Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_
- Address: \_\_\_\_\_
26. Form Completed by: \_\_\_\_\_  
Name Title Phone