



Medical Examiner Department
Indigent Cremation Service



Decedent Information
(Infant Death)

ICS Case Number:

1. Deceased: (first, middle, last) 2. Sex:

3. Race: White Black Asian Indian Amer. Indian Chinese Filipino Korean Vietnamese

4. Decedent of Hispanic or Haitian origin? Yes (If yes, please specify) No
Mexican Cuban Puerto Rican Central/South American Other Hispanic (Specify) Haitian

Fetal Deaths:

5. Clinical estimate of gestation: (Weeks) 6. Date of Delivery:

7. Weight of fetus (lbs./oz. OR grams) 8. Time of Delivery:
(lbs.) (oz.) (grams)

9. Estimated time of fetal death
Before Labor During Labor During Delivery Unknown

10. Under One Year Under One Day 11. Time of Death: (24 hours)
Months Days Hours Minutes Seconds
12. Date of Death:

13. Place of Death:
Hospital/E.R./Residence/Other (please specify)

Parents:

14. Mother's Name: Date of Birth:

15. Address:

16. Father's Name: Date of Birth:

17. Informant's Name and Mailing Address:

18. Attending Physician:

19. Address:

20. City/State/Zip Code:

21. Phone:

22. Form Completed by: Name Title Phone