PRELIMINARY INFORMATION FORM

KENOSHA COUNTY MEDICAL EXAMINER'S OFFICE
1000 55th Street
Kenosha, Wisconsin 53140
Office (262) 653-3869 FAX (262) 653-3877

Name of the Deceased: _____

Home/Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Date of Death: _____ Age: _____

Person Pronouncing Death: _____ Time of Death: _____

Death Certificate Signed By: _____

Place of Death (i.e.-Hospital, Residence, N.H.): _____

Name and Location of Funeral Home: _____

Funeral Director: _____ F.H. Phone Number: _____

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Name of Person Requesting Cremation: _____

Relationship to Deceased: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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Direct Cremation: ☐ Yes ☐ No If "No", date/time of viewing: _____

View at which location: _____

Is the body at the location now: ☐ Yes ☐ No If "No", then when: _____

Autopsy Performed: ☐ Yes ☐ No If "yes", where performed: _____

Name of Crematory: _____

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**** This form does not constitute or imply permission to cremate and is intended solely for information gathering purposes only.***