

## FATAL FIRE SCENE OBSERVATIONS

Incident Number	Location	Date of Incident
Observations of	Rank/Position	Contact Telephone Number

Deceased's Name (include middle initial, former, alias, or maiden name)			
Date of Birth (MM/DD/YYYY)	Height	Weight	Sex/Race
Home Address		Home Phone	Alternate Phone (specify)
Other identifiers including tattoos/scars			
Pronounced Dead by:		Transported to:	
Location of Pronouncement:		Transported by:	

Marital Status	Name of spouse including ex spouse(s)		
Next of Kin		Relationship	
Date next of Kin notified	Name of person notifying kin		

Occupation	Employer
Deceased's Doctor	Deceased's Dentist
Description of clothing/jewelry	
Was deceased a smoker <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> cigarette <input type="checkbox"/> cigar <input type="checkbox"/> pipe <input type="checkbox"/> other	Was deceased using alcohol immediately prior <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes Describe
Did deceased have medical conditions which might be relative to this death investigation <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:	

Where was deceased initially found	Who located deceased
What position was the body found in	
Describe deceased's appearance	
Was body photographed in place <input type="checkbox"/> No <input type="checkbox"/> Yes by who	Significant blood present under/near/on body <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where

Autopsy requested <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of Autopsy	Who preformed autopsy
Full body X rays completed <input type="checkbox"/> No <input type="checkbox"/> Yes	Other X Rays	
Identification made from <input type="checkbox"/> physical appearance <input type="checkbox"/> dental records <input type="checkbox"/> fingerprints <input type="checkbox"/> prior injury comparison <input type="checkbox"/> other		
Evidence of pre fire injury <input type="checkbox"/> No <input type="checkbox"/> Yes Describe		
Blood Samples Taken <input type="checkbox"/> No <input type="checkbox"/> Yes CO level                      Blood Alcohol                      Other		
Cause of Death		

**Indicate areas of injury and burn:**

