

**Death Investigation
Preliminary Findings
CJ Skills Medical Examiner**

Phone: (555)555-5555 Fax (555)555-5550

Date: _____ Time: _____ Case Number: _____

Location: _____

Victim's Name: _____

Race: _____ Sex: _____ DOB: _____ Social Security Number: _____

Witness/finder's name: _____

Address: _____ Phone: _____

Spouse _____ Family _____ Acquaintance _____ Stranger _____ Police _____ Other _____

How found: Dead _____ Unconscious _____ Conscious _____ **Last known alive/alert** _____

LKA by: Witness _____ Spouse _____ Family _____ Acq _____ Stranger _____ Police _____ Other _____

LKA how: Was seen _____ was heard _____ was talked to _____

Relative/Contact: _____

| Name | Address | Phone |
|------|---------|-------|
|------|---------|-------|

Medical History: Unknown _____ None _____ Information not asked for _____

| | | |
|--|---|----------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness | Doctor's Name _____ |
|--|---|----------------------------|

| | | |
|----------------|-----------------|---------------------------|
| () Prior MI's | () Alzheimer's | Phone Number _____ |
|----------------|-----------------|---------------------------|

| | | |
|---------------------------------------|---------------------------------|-------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | Fax Number _____ |
|---------------------------------------|---------------------------------|-------------------------|

| | | |
|------------------------------------|--|--------------------|
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Renal Disease | Medications |
|------------------------------------|--|--------------------|

| | | |
|---------------------------------|---|-------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Terminal Illness | _____ |
|---------------------------------|---|-------|

| | | |
|-----------------------------------|---------------------------------|-------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | _____ |
|-----------------------------------|---------------------------------|-------|

| | | |
|-------------|--------------------|-------|
| () Insulin | Primary site _____ | _____ |
|-------------|--------------------|-------|

| | | |
|----------------|------------------------------------|-------|
| () No Insulin | <input type="checkbox"/> Allergies | _____ |
|----------------|------------------------------------|-------|

| | | |
|-----------------------------------|-------------------------------------|-------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Drug Abuse | _____ |
|-----------------------------------|-------------------------------------|-------|

| | | |
|-------------------|--|-------|
| () Unknown Cause | <input type="checkbox"/> Chronic Alcohol | _____ |
|-------------------|--|-------|

| | | |
|---------------------|--------------------------------------|-------|
| () Alcohol Related | <input type="checkbox"/> Recent Fall | _____ |
|---------------------|--------------------------------------|-------|

| | | |
|--------------------|--|-------|
| () Trauma Related | <input type="checkbox"/> Recent Injury | _____ |
|--------------------|--|-------|

| | | |
|-------------------|-------------------------------------|-------|
| () Birth related | <input type="checkbox"/> Old injury | _____ |
|-------------------|-------------------------------------|-------|

| | | |
|---------------------|--|-------|
| () Since Childhood | <input type="checkbox"/> Other Illness | _____ |
|---------------------|--|-------|

Case Number: _____

Missing Person Affidavit

Concerning:

Last Name: _____ First Name: _____ Middle: _____

Race _____ Sex _____ Date of Birth _____

I, the undersigned, do hereby certify the above name, date of birth, race, and sex is correct and further certify the following concerning the above named person.

() **Category D:** Missing person who is physically or mentally disabled.

The above person has been under my care and is physically or mentally disabled.

Diagnosis: _____

() **Category I:** Missing person whose disappearance was involuntary (includes child custody violations. Obtain court documents to verify)

My lawful relationship to the above mentioned person is _____ and I believe he/she is missing under circumstances other than voluntary because _____

() **Category E:** Missing person whose physical safety is endangered.

My lawful relationship to the above mentioned person is _____ and I believe he/she is in the company of another person under circumstances indicating that his/her physical safety is n danger because _____

() **Category J:** Missing person, Juvenile (under 17 years of age, or older if the Juvenile Court has extended jurisdiction)

My lawful relationship to the above mentioned person is _____ and further, said person is missing from his/her lawful place of residency without my permission or of any other duly authorized.

Signature: _____

Date: _____ Time: _____

Witness: _____

Traffic Violations

20-2 Yield right of way
 20-3 C&I Driving
 20-4 DUI
 20-5 Keep right of center
 20-6 Driving lane violation
 20-8 Overtaking a vehicle
 20-10 Following too close
 20-11 Turn and stopping signals
 20-12 Follow/stop w/i 1blk emergency vehicle
 20-13 Crossing fire hose
 20-14 Drive with view obstructed
 20-15 Clinging to moving vehicle
 20-16 Manner of riding motorcycle
 20-17 Manner of riding in vehicle
 20-18 Using vehicle for advertising
 20-19 Driving on sidewalks, etc.
 20-20 Observing barricades
 20-21 Driving through funeral procession
 20-24 Obstructing parade routes
 20-26 Removal of ignition keys
 20-27 Leaving vehicle unattended
 20-28 Parking vehicle on street for sale
 20-29 Selling from parked vehicle
 20-30 Repairing vehicle on street
 20-31 City license required
 20-32 Operators license required
 20-33 Train blocking street
 20-34.1 Cover for vehicle load
 20-35 State vehicle license required/improper display of plates/no front tag/expired tag
 20-35.2 Child restraint
 20-35.3 Motorcycle helmet violation
 20-35.4 seatbelt violation
 20-35.5 Fail to provide proof of insurance
 20-58 Fail to yield to emergency vehicle
 20-59 Fail to report injury/property/parked accident
 20-65 Traffic signs and signals-fail to obey signs
 20-66 Interference with signs and signals
 20-74 Speed too fast for conditions
 20-75 Speeding (posted limit)
 20-76 Driving too slow
 20-78 Turn lane violation
 20-80 Turn signal violation
 20-81 U-turn limitations
 20-83 One-way streets and alleys
 20-85 stop from parking lots
 20-90 Fail to yield posted
 20-93 Stop sign violation
 20-95 Obstructing intersection
 20-96 Stop and school stop sign
 20-96.1 Stop for school bus
 20-109 Vehicle yield to pedestrians

Offenses

22-2 Affray-2 persons
 22-3 Assault or breach of peace
 22-11.1 Disorderly Conduct
 22-15 Intoxicated person (S.A.K.)
 22.15.1 Trespass upon schools
 22.15.2 Explosives/blasting agents
 22-16 False fire alarm
 22-16.1 Firearms
 22-21 CCW
 22-25 Simulated drugs
 22-26 Possess Paraphernalia
 22-27 Possess Marijuana
 22-30 Vandalism
 22-38 Misrepresentation as officer
 22-40 Stealing
 22-50 Littering
 22-56 Trespass

Alcohol

3-3 MIP (non-intox.)
 3-23 MIP (intox.)
 3-24 Open container/drinking in public

FIELD REPORT

Case Report Number: _____ Date Reported _____ Time Reported: _____

Crime: _____ Location: _____

Date Occurred: _____ Time Occurred: _____

Persons Involved

Type: Victim _____ Witness _____ Suspect _____ Reporting Party _____ Other _____

Name: _____

Sex: Male _____ Female _____ Race _____ DOB _____ Age _____ Height _____

Weight _____ Eye Color _____ Hair Color _____ SSN# _____

Address: _____

Phone: _____

Persons Involved

Type: Victim _____ Witness _____ Suspect _____ Reporting Party _____ Other _____

Name: _____

Sex: Male _____ Female _____ Race _____ DOB _____ Age _____ Height _____

Weight _____ Eye Color _____ Hair Color _____ SSN# _____

Address: _____

Phone: _____

Persons Involved

Type: Victim _____ Witness _____ Suspect _____ Reporting Party _____ Other _____

Name: _____

Sex: Male _____ Female _____ Race _____ DOB _____ Age _____ Height _____

Weight _____ Eye Color _____ Hair Color _____ SSN# _____

Address: _____

Phone: _____

