



St. Clair Twp.
New Miami
Life Squad

Document No.: **OPS-F-008** Revision: - Pg. 1 OF 1

Title: Form, Death Scene Report

Time Of Dispatch: _____ Date ____/____/____ Run Number _____

Name Of Decedent: _____ DOB ____/____/____ Age: _____

Address: _____ SSN ____/____/____

City: _____ State: _____ Zip Code: _____

Physician: _____ Physician Phone : (____)-____-____

Decedent's Medical History: _____

Decedent's Medications: _____

Date of Last Hospital or Doctor Contact: _____

Decedent's Occupation: _____

Name of Person Who Found Decedent: _____

Address: _____ State: _____ Zip Code: _____

Phone: (____)-____-____

Decedent's Next of Kin: _____

Address: _____ State: _____ Zip Code: _____

Phone: (____)-____-____

Signs of Violence? **Y/N** If Yes Explain: _____

Decedent Released To: _____

_____ ID: _____ ID: _____

_____ ID: _____ ID: _____