

\*\*\*PRELIMINARY INFORMATION FORM\*\*\*

**KENOSHA COUNTY MEDICAL EXAMINER'S OFFICE**

8600 Sheridan Road  
Kenosha, Wisconsin 53143  
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 \_\_\_\_\_

Time of Death \_\_\_\_\_

Physician Pronouncing Death: \_\_\_\_\_

Death Certificate Signed By: \_\_\_\_\_

Where Death Occurred (Where pronounced i.e. hospital, residence, nursing home):

\_\_\_\_\_

Name and Location of Funeral Home: \_\_\_\_\_

Name of Funeral Director \_\_\_\_\_

Funeral Home Phone Number \_\_\_\_\_

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**Name of Person Requesting Cremation** \_\_\_\_\_

**Relationship to Deceased** \_\_\_\_\_

**Street Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Phone Number** (\_\_\_\_\_) - \_\_\_\_\_

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Direct Cremation: \_\_\_ Yes \_\_\_ No

Lie in Repose: \_\_\_ Yes \_\_\_ No If "Yes", date / time \_\_\_\_\_

View at Which Location \_\_\_\_\_

Is the Body at This Location Now: \_\_\_ Yes \_\_\_ No If "No", then When \_\_\_\_\_

Autopsy Performed: \_\_\_ Yes \_\_\_ No If "yes", where performed \_\_\_\_\_

Where Cremating \_\_\_\_\_

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