



HENNEPIN COUNTY MEDICAL EXAMINER'S OFFICE
Cremation Approval

FUNERAL HOME TO COMPLETE: (please print or type)

Decedent: _____ D.O.B.: _____

Date of Death: _____ Time of Death: _____

Place of Death: _____

Primary Physician's Name and Clinic: _____

Phone: _____ FAX: _____

Funeral Home: _____

Contact: _____

Phone: _____ FAX: _____

DATE CREMATION DESIRED: _____

PHYSICIAN TO COMPLETE: Please FAX to: **612-466-9990**

Date last seen or last clinic visit: _____

Was there any TRAUMA that contributed to the death? Yes _____ No _____

(i.e. motor vehicle accident, fractures, falls, surgical procedures, etc.)

If YES please describe: _____

Is there any reason to postpone cremation? Yes _____ No _____

If YES, please explain: _____

CAUSE OF DEATH AS IT WILL APPEAR ON THE DEATH CERTIFICATE:

Line 33a. _____

Line 33b. _____

Line 33c. _____

Other Significant Conditions: _____

Physician's Signature: _____ Date: _____

MEDICAL EXAMINER TO COMPLETE:

Investigator Signature: _____

OK to Cremate? Yes _____ No _____ Date: _____