

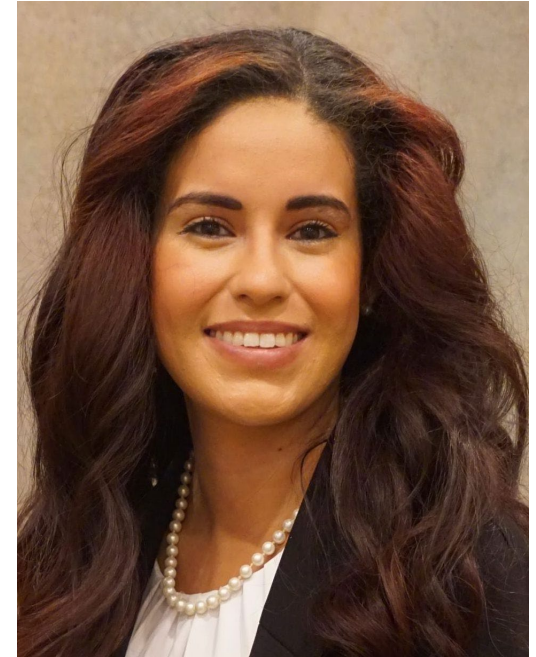
# Legislative Council Study on Uniform Death Reporting

FSCA / WFDA Presentation

August 17, 2022

# Introductions

James Klemmer  
Heritage Funeral Homes



Nicole Krause  
Krause Funeral Home

# Funeral Director Involvement

- Signing and filing of death certificates
- Transfer orders / cremation permits
- Further collection of data

# Current Death Reporting Models

## Faxing Information To Doctor

- Funeral Director enters phone number, fax and address of doctor
- Doctor may be at different phone/fax when we send paperwork
- Doctor has 5 business days to send information back
- If we need a different phone/fax, the 5-business day process starts over
- Funeral Director enters information (not doctor)
- Illegible and possibly not accurate

# Notice Of Removal

DEPARTMENT OF HEALTH SERVICES  
Division of Public Health  
F-90043 PART 1 (06/2022)

**PART 1**

STATE OF WISCONSIN  
Chapter 89, Wis. Stats.  
Page 1 of 2

**NOTICE OF REMOVAL OF A HUMAN CORPSE FROM A FACILITY**  
Hospital / Nursing Home / Hospice Care

Items 1-21 of Part 1 and all items in Part 2 to be completed by the facility or hospice administrator (or a designee).  
Items 22-26 to be completed by a Wisconsin funeral director, crematorium/examiner, or family member.

1. DECEDENT'S CURRENT LEGAL NAME- First		Middle		Last		Suffix	
AKA:							
2. SEX	3. AGE AT DEATH		Years <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/>	Hours <input type="checkbox"/> Mins <input type="checkbox"/>	4. SOCIAL SECURITY NUMBER		5. DATE PRONOUNCED DEAD
6. TIME PRONOUNCED DEAD (0000-2359)							
7. DEATH PRONOUNCED BY: (Only professions listed may pronounce death. Check only one.) <input type="checkbox"/> Physician <input type="checkbox"/> Coroner/M.E. <input type="checkbox"/> Deputy Coroner/M.E. <input type="checkbox"/> Hospice R.N. (ONLY if 9 is Yes) <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Naturopathic Doctor							
8. PRONOUNCER'S NAME				9. HOSPICE RESPONSIBLE FOR CARE?: 10. HOSPICE NAME			
<input type="checkbox"/> Yes <input type="checkbox"/> No							
11. HOSPITAL DEATH (Includes hospice patients) <input type="checkbox"/> Inpatient <input type="checkbox"/> DOA from NH <input type="checkbox"/> DOA from Other <input type="checkbox"/> Outpatient <input type="checkbox"/> ER from NH <input type="checkbox"/> ER from Other				12. OTHER PLACE OF DEATH (Complete the item if the death did not occur at a hospital. Includes hospice patients) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Residence <input type="checkbox"/> Hospice Facility <input type="checkbox"/> CBRF <input type="checkbox"/> Residence Care Apt (RCAC) <input type="checkbox"/> Adult Family Home (AFH) <input type="checkbox"/> Other			
13. FACILITY NAME (if applicable)				14. COUNTY OF DEATH		15. CITY, VILLAGE, OR TOWNSHIP OF DEATH	
				<input type="checkbox"/> City <input type="checkbox"/> Village <input type="checkbox"/> Township		17. ZIP CODE	
16. ADDRESS OF DEATH							
18. MEDICAL CERTIFIER INFORMATION <input type="checkbox"/> PHYSICIAN LICENSE # Physician with a valid Wisconsin physician license (not 1 <sup>st</sup> year resident) Physician with a temporary Wisconsin physician license Other licensed physician working in a Veteran's Hospital <input type="checkbox"/> WISCONSIN CORONER/M.E. or DEPUTY CORONER/M.E.				19. CERTIFIER'S NAME & TITLE - death certificate to be signed by:			
22. CERTIFIER'S FACILITY NAME				20. CERTIFIER'S PHONE NUMBER		21. CERTIFIER'S FAX NUMBER	
24. ALTERNATE CERTIFIER'S NAME				25. ALT. PHONE NUMBER		26. ALT. FAX NUMBER	
<b>COMMUNICABLE DISEASE ALERT: See PART 2 - PART 2 MUST be completed even if the decedent has none of the conditions listed</b> In accordance with Wis. Stat. s. 69.18(3)(g) and Administrative Rule DHS 135.04(3), the facility or hospice must complete Part 2 of this form at the time the body is removed from their facility. Part 2 of this form is to be completed and GIVEN TO THE PERSON REMOVING THE BODY AT THE TIME THE BODY IS REMOVED. Part 2 of this form is NOT to be transmitted to the local vital records office.							
<b>REPORTABLE DEATHS</b> - (Per Wis. Stats. ss. 30.07, 69.18, 157, 348.71, 350, and 919) Prior to removal and embalming of body, you <b>MUST</b> notify the coroner or medical examiner of the county where the death took place, if any of the following circumstances regarding the decedent's death apply: all homicides, suicides or poisonings, all deaths following an accidental injury (includes any type of injury that occurred at any time if the injury significantly affected the health of the decedent), all deaths following an abortion procedure, all deaths involving a motor vehicle (includes snowmobiles, ATVs, boats, etc.), all deaths with no physician or spiritual healer in attendance within 30 days, all deaths of correctional inmates, when the physician refuses to sign the death certificate, and all deaths in which there are unexplained, unusual, or suspicious circumstances.							
27. NOTIFICATION OF THE CORONER/MEDICAL EXAMINER REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes ; 28. STATE & COUNTY OF INCIDENT (required if 27 is Yes) (This form does NOT constitute notification of the Coroner or Medical Examiner)							
29. NAME OF STAFF PERSON COMPLETING THIS SECTION		30. SIGNATURE OF PERSON COMPLETING THIS SECTION			31. PHONE NUMBER		
32. STATUS OF PERSON REMOVING BODY (Check one) <input type="checkbox"/> Wisconsin Licensed Funeral Home Representative <input type="checkbox"/> Coroner/M.E. (pursuant to a death investigation per ss. 979.01 and 979.10, Wis. Stats., for body storage or disposition) <input type="checkbox"/> Family Disposition (Per Wisconsin Statutes section 69.18, an immediate family member removing a body must personally consult the final disposition and is responsible for the preparation of the Notice of Removal and the preparation and filing of the Report for Final Disposition and Death Certificate)							
33. FUNERAL DIRECTOR'S NAME & WI LICENSE NUMBER (or person acting as such)							
34. FUNERAL HOME NAME (if applicable)				35. MAILING ADDRESS OF FUNERAL HOME (or of person acting as such)			
36. SIGNATURE - FUNERAL DIRECTOR (or person acting as such)				37. DATE SIGNED		38. PHONE NUMBER	
<b>IMPORTANT NOTES</b>							
<ul style="list-style-type: none"> <li>The facility/hospice <b>MUST</b> send this form to the local registrar (Register of Deeds or Milwaukee City Health Office or West Allis City Health Office) within 24 hours of death (Wis. Stat. s. 69.18). The facility/hospice should keep one copy of the form for the medical chart. The funeral director (or other person removing the body) also requires a copy. For hospice deaths, the funeral director may fax the Notice of Removal to the hospice organization for filing. See instructions on time extension.</li> <li>This form is not required for stillbirths, but may be used to document release of the remains. Hospital staff and funeral directors must verify the actual legal status of the neonate (liveborn or stillborn) before removal of the body to insure legal documentation of the event.</li> <li>Hospice R.N.s may only pronounce death under conditions specified in Wis. Stat. s. 69.18(1)(c). For articulated deaths of enrolled hospice patients.</li> <li>Each Coroner/M.E. has county-specific written policies on reporting deaths. Reporting nonhospital/hospice home deaths (including deaths under hospice care) may still be mandatory (Wis. Stats. ss. 979.01, 979.10, and 69.18(2), and/or DHS Administrative Rule 135.06).</li> </ul>							

DEPARTMENT OF HEALTH SERVICES  
Division of Public Health  
0132922

**PART 2**

STATE OF WISCONSIN  
Chapter 89, Wis. Stats.  
Page 2 of 3

**NOTICE OF REMOVAL OF A HUMAN CORPSE FROM A FACILITY**  
**Communicable Diseases Reportable to Personnel Involved in Postmortem Activities**  
(Confidential Information Available Only to the Funeral Director or Person Acting as Such)

DO NOT TRANSMIT THIS PORTION OF THE NOTICE OF REMOVAL TO THE LOCAL VITAL RECORDS OFFICE.

1. DECEDENT'S CURRENT LEGAL NAME- First		Middle		Last		Suffix	
AKA:							
2. SEX	3. AGE AT DEATH		Years <input type="checkbox"/> Days <input type="checkbox"/> Minutes <input type="checkbox"/>	Hours <input type="checkbox"/> Mins <input type="checkbox"/>	4. DATE PRONOUNCED DEAD		5. TIME PRONOUNCED DEAD
6. FACILITY NAME							
7. FACILITY MAILING ADDRESS							
Per Wisconsin Statute ss. 69.18(3)(g) and 252.15 (3m)(d)7 and DHS Administrative Rule 135.04(3), a hospital, nursing home, or hospice must provide information concerning certain existing communicable diseases to the funeral director, the person acting as funeral director, the Coroner/M.E., or the representative of the Coroner/M.E. at the time the body is removed. See important notes below. Both 8 and 9 below must be completed.							
8. To the best of my knowledge and belief, the above-named decedent's medical record documents the presence of the following communicable disease(s) suspected or confirmed for this person:							
<input type="checkbox"/> Clostridium Difficile				<input type="checkbox"/> Smallpox and other orthopox diseases			
<input type="checkbox"/> HIV (Positive Results) (Available only to funeral directors per s.252.15(5), Wis. Stats.)				<input type="checkbox"/> Staph			
<input type="checkbox"/> Other serious blood-borne transmissible disease (e.g., Hepatitis)				<input type="checkbox"/> Tuberculosis			
<input type="checkbox"/> Methicillin-Resistant Staphylococcal Aureus (MRSA)				<input type="checkbox"/> Tularemia			
<input type="checkbox"/> Plague				<input type="checkbox"/> Vancomycin-Resistant Staphylococcal Aureus (VRSa)			
<input type="checkbox"/> Prion diseases (such as CJD)				<input type="checkbox"/> Varicella			
<input type="checkbox"/> Rabies (human)				<input type="checkbox"/> Viral hemorrhagic fevers			
<input type="checkbox"/> SARS							
<input type="checkbox"/> The designee completing this report examined the patient's active medical record but did not find any of the above-mentioned conditions documented in the active medical record available to him or her at the time of release of the body.							
<input type="checkbox"/> The decedent died in the ER or was DOA and there was no historical medical record at the facility at the time of release of the body.							
9. NAME OF STAFF PERSON COMPLETING PART 2 (must be a person who can reasonably attest to the above statements)							
10. SIGNATURE - STAFF PERSON COMPLETING PART 2				11. DATE SIGNED		12. PHONE NUMBER	
<b>IMPORTANT NOTES</b>							
<ul style="list-style-type: none"> <li>Per Wisconsin Statute section 69.18 (3)(g), it is the legal responsibility of the health care facility or hospice agency to provide the funeral director, or person acting as such, with information about any known dangerous communicable diseases documents in the decedent's medical record.</li> <li>It is understood that, in some cases, diseases may be present but undiagnosed or the facility may not be aware of a prior diagnosis that is not documented in the medical records available to the medical facility.</li> <li>Funeral directors, or persons acting as such, and Coroners/M.E.s and their representatives must use universal precautions when handling <u>all</u> bodies to prevent the transmission of bloodborne pathogens and to be in compliance with OSHA standards.</li> </ul>							

# Blank Attestation

What Funeral Homes send for Doctors to obtain:

- Cause Of Death
- Doctor's Signature.

FAX ATTESTATION FOR MEDICAL CERTIFICATION					
State of Wisconsin, Department of Health Services, Division of Public Health, State Vital Records Office					
TO: [REDACTED]		TRACKING NUMBER: [REDACTED]			
FROM: [REDACTED] - KRAUSE FUNERAL HOME INC		DATE AND TIME SENT: [REDACTED]			
PHONE NUMBER OF SENDER: [REDACTED]					
<small>This fax is intended only for use of the person or entity to which it is addressed. It contains confidential information. If you are not the intended recipient, you are notified that any review, use, copying, dissemination or distribution is strictly prohibited. Please call the sender phone number, above left.</small>					
<p>You have been selected as the medical certifier for the death record of [REDACTED]</p> <p>Promptly complete, sign, date and fax to <b>1-855-864-9936</b>.</p> <p>If you encounter issues using the above number, please try 1-608-234-5400.</p>					
DECEDENT'S NAME: [REDACTED]			DATE OF BIRTH: [REDACTED]		
DATE & TIME PRONOUNCED: [REDACTED]		AGE: [REDACTED]		SEX: [REDACTED]	
PLACE OF DEATH: [REDACTED]					
PHYSICIAN LICENSE NO. [REDACTED]	MEDICAL CERTIFIER'S MAILING ADDRESS [REDACTED]		CITY [REDACTED]	STATE [REDACTED]	ZIP CODE [REDACTED]
DATE OF DEATH		AUTOPSY PERFORMED?		DID TOBACCO/ALCOHOL USE CONTRIBUTE TO DEATH?	
<input type="checkbox"/> Actual <input type="checkbox"/> Estimated		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
TIME OF DEATH (MM/DD/YYYY)		<input type="checkbox"/> Actual <input type="checkbox"/> Estimated		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
PREGNANCY STATUS: complete only if decedent is female (statistical use only - will not appear on certificate)					
<input type="checkbox"/> Not pregnant within the past year		<input type="checkbox"/> Pregnant at the time of death		<input type="checkbox"/> Natural <input type="checkbox"/> Homicide	
<input type="checkbox"/> Not pregnant, but pregnant within 42 days of death		<input type="checkbox"/> Unknown if pregnant within last year		<input type="checkbox"/> Accident <input type="checkbox"/> Undetermined	
<input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year prior to death				<input type="checkbox"/> Suicide <input type="checkbox"/> Pending	
PART I. CAUSE OF DEATH - (chain of events leading directly to death) - Enter the diseases or complications that caused death.					
a. [REDACTED]			Interval Between Onset and Death		
b. [REDACTED]					
c. [REDACTED]					
d. [REDACTED]					
PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in Part I.					
I attest the information I have provided is accurate to the best of my knowledge. I understand that the provided information, unless otherwise noted, will appear on the certified copy of the death record.					
<small>NOTE: A cause of death that indicates any type of trauma or poisoning (in any part of the cause), sudden unexpected death or unknown cause of death must be signed by the Coroner or Medical Examiner of jurisdiction. A certificate signed by the treating medical provider will be rejected. Contact the State Vital Records Office at DPHSR.VitalRecords@wisconsin.gov with any questions. Use "COD" in the subject line. By July 1, 2013, the medical certifier must complete the cause of death and return it to the funeral director within 7 days of the date of death.</small>					
PRINT LEGIBLY - CERTIFIER'S NAME, TITLE, AND LICENSE NUMBER					
SIGNATURE - Certifier			SIGN IN THE BOX BELOW		
[REDACTED]			[REDACTED]		
			Date Signed (MM/DD/YYYY)		

# Different Faxed Attestations Received

**FAX ATTESTATION FOR MEDICAL CERTIFICATION**  
 State of Wisconsin, Department of Health Services, Division of Public Health, State Vital Records Office

TO: [REDACTED] TRACKING NUMBER: [REDACTED]  
 FROM: KRAUSE FUNERAL HOME INC DATE AND TIME SENT: [REDACTED]  
 PHONE NUMBER OF SENDER: [REDACTED]

You have been selected as the medical certifier for the death record of [REDACTED].  
 Promptly complete, sign, date and fax to **1-855-864-9936**.  
 If you encounter issues using the above number, please try 1-800-231-5100.

DECEDENT'S NAME: [REDACTED] DATE OF BIRTH: [REDACTED]  
 DATE & TIME PRONOUNCED: [REDACTED] AGE: [REDACTED] SEX: [REDACTED]  
 PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED]  Actual  Estimated  
 TIME OF DEATH: [REDACTED]  Actual  Estimated

PREVIOUSLY PREGNANT:  Yes  No

CAUSE OF DEATH: a. Hypertensive Left Heart S. dysfunction  
 b. [REDACTED]  
 c. [REDACTED]  
 d. [REDACTED]

PREVIOUSLY PREGNANT

SIGNATURE - Certifier: [REDACTED] SIGN IN THE BOX BELOW  
 Date Signed: [REDACTED]

**FAX ATTESTATION FOR MEDICAL CERTIFICATION**  
 State of Wisconsin, Department of Health Services, Division of Public Health, State Vital Records Office

TO: KELOEY [REDACTED] TRACKING NUMBER: [REDACTED]  
 FROM: KRAUSE FUNERAL HOME INC DATE AND TIME SENT: [REDACTED]  
 PHONE NUMBER OF SENDER: [REDACTED]

You have been selected as the medical certifier for the death record of [REDACTED].  
 Promptly complete, sign, date and fax to **1-855-864-9936**.  
 A courtesy copy of the medical certification will be faxed to you for your final review after the record is completed.

The medical certifier must complete and/or correct all of the information below.

DECEDENT'S NAME: [REDACTED] DATE OF BIRTH: [REDACTED]  
 DATE & TIME PRONOUNCED: [REDACTED] AGE: [REDACTED] SEX: [REDACTED]  
 PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED]  Actual  Estimated  
 TIME OF DEATH: [REDACTED]  Actual  Estimated

PREGNANCY STATUS:  Not pregnant within the past year  
 Not pregnant, but pregnant within 42 days of death  
 Not pregnant, but pregnant 43 days to 1 year prior to death

CAUSE OF DEATH: a. Pulmonary Edema  
 b. End-Stage Alcoholic Cirrhosis  
 c. [REDACTED]  
 d. [REDACTED]

Interval Between Onset and Death: a. <1 day  
 b. unknown  
 c. [REDACTED]  
 d. [REDACTED]

OTHER SIGNIFICANT CONDITIONS: Wernicke Encephalopathy, Gastrointestinal Hemorrhage, Intracerebral Volume Depletion

SIGNATURE - Certifier: [REDACTED] SIGN IN THE BOX BELOW  
 Date Signed: [REDACTED]

**FAX ATTESTATION FOR MEDICAL CERTIFICATION**  
 State of Wisconsin, Department of Health Services, Division of Public Health, State Vital Records Office

TO: [REDACTED] TRACKING NUMBER: [REDACTED]  
 FROM: KRAUSE FUNERAL HOME INC DATE AND TIME SENT: [REDACTED]  
 PHONE NUMBER OF SENDER: [REDACTED]

You have been selected as the medical certifier for the death record of [REDACTED].  
 Promptly complete, sign, date and fax to **1-855-864-9936**.  
 If you encounter issues using the above number, please try 1-800-234-8400.

DECEDENT'S NAME: [REDACTED] DATE OF BIRTH: [REDACTED]  
 DATE & TIME PRONOUNCED: [REDACTED] AGE: [REDACTED] SEX: [REDACTED]  
 PLACE OF DEATH: [REDACTED]

DATE OF DEATH: [REDACTED]  Actual  Estimated  
 TIME OF DEATH: [REDACTED]  Actual  Estimated

PREGNANCY STATUS:  Not pregnant within the past year  
 Not pregnant, but pregnant within 42 days of death  
 Not pregnant, but pregnant 43 days to 1 year prior to death

CAUSE OF DEATH: a. Alzheimer's disease  
 b. [REDACTED]  
 c. [REDACTED]  
 d. Onychomycosis

Interval Between Onset and Death: [REDACTED]

OTHER SIGNIFICANT CONDITIONS: B12 deficiency, vitamin D deficiency, ONYCHOMYCOSIS, high blood pressure but not hypertensive

SIGNATURE - Certifier: [REDACTED] SIGN IN THE BOX BELOW  
 Date Signed: [REDACTED]

Poor Faxing  
 Quality (Multiple  
 Attempts)

Doctor  
 Changed

Illegible Writing  
 & Incorrect  
 Spelling

# Current Death Reporting Models

## Electronically Signing Doctor

- Select doctor from a drop down and information is already in system
- Assistant can enter information into system
- Doctor proofs and signs information
- Legible and accurate



# Faxed vs Electronic Attestation

**FAX ATTESTATION FOR MEDICAL CERTIFICATION**  
 State of Wisconsin, Department of Health Services, Division of Public Health, State Vital Records Office

TO: [REDACTED] TRACKING NUMBER: [REDACTED]  
 FROM: [REDACTED] KRAUSE FUNERAL HOME INC DATE AND TIME SENT: [REDACTED]  
 PHONE NUMBER OF SENDER: [REDACTED]

This fax is intended only for use of the person or entity to which it is addressed. It contains confidential information. If you are not the intended recipient, you are notified that any review, use, copying, dissemination or distribution is strictly prohibited. Please call the sender phone number, above left.

You have been selected as the medical certifier for the death record of [REDACTED].  
 Promptly complete, sign, date and fax to **1-855-864-9936**.  
 If you encounter issues using the above number, please try 1-608-234-5400.

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**DECEDENT'S NAME:** [REDACTED] **DATE OF BIRTH:** [REDACTED]  
**DATE & TIME PRONOUNCED:** [REDACTED] **AGE:** [REDACTED] **SEX:** [REDACTED]  
**PLACE OF DEATH:** [REDACTED]

**PHYSICIAN LICENSE NO.:** [REDACTED] **MEDICAL CERTIFIER'S MAILING ADDRESS:** [REDACTED] **CITY:** [REDACTED] **STATE:** [REDACTED] **ZIP CODE:** [REDACTED]

**DATE OF DEATH:** [REDACTED]  Actual  Estimated **AUTOPSY PERFORMED?**  Yes  No **DO TOBACCO/ALCOHOL USE CONTRIBUTE TO DEATH?** (statistical use only - will not appear on certificate)  
 [REDACTED]  Yes  No  Probably  Unknown

**TIME OF DEATH (2000-7000):** [REDACTED]  Actual  Estimated  Yes  No  Probably  Unknown

**PREGNANCY STATUS - complete only if decedent is female (statistical use only - will not appear on certificate)**  
 Not pregnant within the past year  Pregnant at the time of death  Unknown if pregnant within last year  
 Had pregnant, but pregnant within 42 days of death  Unknown if pregnant within last year  Not pregnant, but pregnant 43 days to 1 year prior to death

**MANNER OF DEATH**  
 Natural  Homicide  Accident  Undetermined  Suicide  Pending

**PART I. CAUSE OF DEATH (Chain of Events leading directly to death) - Enter the diseases or complications that caused death.**

a. Acute hypoxic respiratory failure

b. Aspiration pneumonia

c. Dysphagia

d.

**PART II. OTHER SIGNIFICANT CONDITIONS** contributing to death but not resulting in the underlying cause given in Part I.

I attest the information I have provided is accurate to the best of my knowledge. I understand that the provided information, unless otherwise noted, will appear on the certified copy of the death record.

**NOTE:** A cause of death that is listed on any type of form is not binding for any part with a certifier, unless explained. Death or unknown cause of death must be signed by the Coroner or Medical Examiner of jurisdiction. A certified copy of the original will be sent for all deaths. Contact the State Vital Records Office at 715.737.6000 or ds@wisconsin.gov with any questions. Use "COD" in the subject line. By law (s. 49.18 (2)), the medical certifier must complete the cause of death and return it to the record director within 5 days with a date of death.

**PRINT LEGIBLY - CERTIFIER'S NAME, TITLE, AND LICENSE NUMBER**  
 (If different from information printed above)

**SIGNATURE - Certifier SIGN IN THE BOX BELOW** ↓

**Date Signed (MM/DD/YYYY)**

**Record Identifier**

Decedent's Full Name: [REDACTED] Date Pronounced Dead: [REDACTED] County of Death: MILWAUKEE Record Status: REGISTERED

**Actual or Estimated Date and Time of Death**

Date of Death: [REDACTED] Date of Death (A = Actual or E = Estimated): A  
 Time of Death (Military): [REDACTED] Time of Death (A = Actual or E = Estimated?): A

**Other Information**

Autopsy?  No Tobacco Use Contribute to Death?  Did Alcohol Use Contribute to Death?  Pregnancy Status: NOT APPLICABLE

**Cause of Death**

Manner of Death: NATURAL

--- PART I --- (If reporting more than one condition per line, separate each condition with a semi-colon.)

A. Immediate Cause (Final disease or condition resulting in Death) ACUTE PERITONITIS Approximate Interval - Onset to Death: HOURS

**List Conditions Leading to the Immediate Cause ---**

B. Due to or as a Consequence of RUPTURED DUODENAL ULCER Approximate Interval - Onset to Death: UNKNOWN

C. Due to or as a Consequence of [REDACTED] Approximate Interval - Onset to Death: [REDACTED]

D. Due to or as a Consequence of [REDACTED] Approximate Interval - Onset to Death: [REDACTED]

--- PART II --- (If reporting more than one condition per line, separate each condition with a semi-colon.)

**Other Significant Conditions Contributing to Death**  
 CIRRHOSIS; CARDIOMEGALY; CORONARY ARTERY DISEASE

Typed and legible  
 (can still lead to  
 human error)

E-Signer – less  
 human error, only  
 1 person entering

# Current Issues Involving Uniform Death Reporting

- Burial vs Cremation
- Steps for applying for cremation permit
  - Doctor's signature
  - Cremation Viewing by Medical Examiner
  - No time frame for receiving cremation permit
- Doctor vs Medical Examiner Discrepancies

# Basics Of Requesting a Permit

## Faxing for a Cremation Permit

### Milwaukee County

Need Cover Sheet

Need Abstract

Need Attestation

### Waukesha County

Need Cover Sheet

Need Attestation

### ANY other County

Cremation Release Form off of SVRIS

Must have Cause of Death filled out

Write in person requesting cremation – Informant Info

Signed by the Director

Final Dispo signed by the Director (Ozaukee ONLY)

\*\*\*See example\*\*\*

\*If this is a Medical Examiner case in Milwaukee or Waukesha, you do **NOT** need to wait for Cause of Death to be filled out. Once we know the ME is signing the death certificate, you will not get a fax attestation, so fax a cover sheet and the abstract to the ME right away.

# Medical Examiner Fees

<b>ME Fees 2022</b>	
<b>MILWAUKEE COUNTY 414-223-1200</b>	
Death Certificate	\$153.00
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$357.00
Transportation of Body	\$153.00
Disinterment Permit	\$50.00
Body Storage	\$35.00
<b>WAUKESHA COUNTY 262-548-7575</b>	
Death Certificate	\$85.00
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$265.00
Transportation of Body	\$204
Disinterment Permit	\$65.00
Body Storage After 1st Day	\$50 /Day
Cremation Trip Charge	\$50.00 each
<b>WASHINGTON COUNTY 262-335-4460</b>	
Death Certificate	\$108.00
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$263.00
Transportation of Body	\$273.00
Disinterment Permit	\$76.00
Body Storage	\$45/day
<b>OZAUKEE COUNTY 262-238-8455</b>	
Death Certificate	\$100.00
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$200.00
Transportation of Body	\$150.00
Disinterment Permit	\$75.00
Body Storage Per Day	\$50.00
Use of Ozaukee County Morgue	\$500.00
Bag Fee	\$100.00
<b>RACINE COUNTY 262-636-3303</b>	
Death Certificate	\$82.00
Cremation Permit: Will waive for Human Service only with written verification from Human Service office Waived for 17yrs and under	\$219.00
Transportation of Body	N/A
Disinterment Permit	\$82.00
Body Storage	N/A

<b>KENOSHA COUNTY 262-653-3869</b>	
Death Certificate	\$167.00
Removal of Body from Scene of Death	\$195.00
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$306.00
Transportation of Body	\$186.00
Disinterment Permit	\$65.00
Bio-Seal (per case)	\$200.00
Body Storage	\$50/ day
<b>DODGE COUNTY 920-386-3941</b>	
Death Certificate	\$50.00
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$175.00
Transportation of Body	
Disinterment Permit	\$100.00
Body Storage	
<b>WALWORTH COUNTY 262-741-4729</b>	
Death Certificate	No Charge
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$250.00
Transportation of Body	No Charge
Disinterment Permit	No Charge
Body Storage	N/A
<b>JEFFERSON COUNTY 920-674-7119</b>	
Death Certificate	\$25
Cremation Permit: Will waive for Human Service only with written verification from Human Service office	\$212.00
Transportation of Body	No Charge
Disinterment Permit	\$50
Body Storage	N/A

# Requesting a Cremation Permit

**CREMATION RELEASE**  
OFFICE OF THE CORONER/MEDICAL EXAMINER OF WASHINGTON COUNTY  
Consent Case Number

**DECEDENT DEMOGRAPHIC**

**DECEASED PERSONAL INFORMATION**

**MANUFACTURE OF DEATH**

**CREMATION RELEASE APPLICANT AND FUNERAL DIRECTOR**

**CREMATION RELEASE AUTHORIZATION**

Washington  
County

**CREMATION RELEASE**  
OFFICE OF THE CORONER/MEDICAL EXAMINER OF OZAUKEE COUNTY  
Consent Case Number

**DECEDENT DEMOGRAPHIC**

**DECEASED PERSONAL INFORMATION**

**MANUFACTURE OF DEATH**

**CREMATION RELEASE APPLICANT AND FUNERAL DIRECTOR**

**CREMATION RELEASE AUTHORIZATION**

Ozaukee  
County

Waukesha County Medical Examiner's Office  
315 W. Milwaukee Road  
Waukesha, WI 53188  
Phone: (262) 548-7575 FAX: (262) 596-8079  
\*\*\*CREMATION REQUEST FORM\*\*\*

A cremation permit is also required before a permit is issued, as required by law.

COVID POSITIVE?  Yes  No

Waukesha  
County

**PRELIMINARY INFORMATION FORM**  
MILWAUKEE COUNTY MEDICAL EXAMINER'S OFFICE  
313 West Highland  
Milwaukee, WI 53225  
(414) 223-2300 FAX: (414) 223-1217

All attempts will be made to provide some **PLEASE PRINT:**

**FAX ATTESTATION FOR MEDICAL CERTIFICATION**  
State of Wisconsin, Department of Health Services, Division of Public Health, State Vital Records Office

**FROM:** [Name] RAJASE FURNERAL HOME INC [Address] [City] [State] [Zip Code]

**TO:** [Name] RAJASE FURNERAL HOME INC [Address] [City] [State] [Zip Code]

**DATE AND TIME SENT:** [Date] [Time]

**PHONE NUMBER OF SENDER:** [Phone Number]

**TRACING NUMBER:** [Tracing Number]

**DATE AND TIME SENT:** [Date] [Time]

**YOU HAVE BEEN SELECTED AS THE MEDICAL CERTIFIER FOR THE DEATH RECORD OF [Name].**

**Promptly complete, sign, date and fax to 1-855-864-9936.**

**If you encounter issues with the above number, please try 1-800-224-5400.**

**DECEDENT'S NAME:** [Name] **DATE OF BIRTH:** [Date]

**DATE & TIME PRONOUNCED:** [Date] [Time] **SEX:** [Sex]

**PLACE OF DEATH:** [Location] **TYPE OF DEATH:** [Type]

**RELATIONSHIP TO DECEDENT:** [Relationship]

**ADDRESS:** [Address] **CITY:** [City] **STATE:** [State] **ZIP CODE:** [Zip Code]

**PHONE NUMBER:** [Phone Number]

**CREMATION INFORMATION**

**Direct Cremation:**  Yes  No **La or In-urn:**  Yes  No

**Was an autopsy performed:**  Yes  No

**Crematory Name:** [Name] **Address:** [Address] **City:** [City] **State:** [State] **Zip Code:** [Zip Code]

**Do cremains need to be ready by a specific date:**  Yes  No

**IF ANY & OTHER SIGNIFICANT CONDITIONS:** [Text]

**PRINT & SIGN IN THE BOX BELOW**

**Signature:** [Signature] **Print Name:** [Name] **Print Title:** [Title]

**FAX ATTESTATION FOR MEDICAL CERTIFICATION**  
State of Wisconsin, Department of Health Services, Division of Public Health, State Vital Records Office

**FROM:** [Name] RAJASE FURNERAL HOME INC [Address] [City] [State] [Zip Code]

**TO:** [Name] RAJASE FURNERAL HOME INC [Address] [City] [State] [Zip Code]

**DATE AND TIME SENT:** [Date] [Time]

**PHONE NUMBER OF SENDER:** [Phone Number]

**TRACING NUMBER:** [Tracing Number]

**DATE AND TIME SENT:** [Date] [Time]

**YOU HAVE BEEN SELECTED AS THE MEDICAL CERTIFIER FOR THE DEATH RECORD OF [Name].**

**Promptly complete, sign, date and fax to 1-855-864-9936.**

**If you encounter issues with the above number, please try 1-800-224-5400.**

**DECEDENT'S NAME:** [Name] **DATE OF BIRTH:** [Date]

**DATE & TIME PRONOUNCED:** [Date] [Time] **SEX:** [Sex]

**PLACE OF DEATH:** [Location] **TYPE OF DEATH:** [Type]

**RELATIONSHIP TO DECEDENT:** [Relationship]

**ADDRESS:** [Address] **CITY:** [City] **STATE:** [State] **ZIP CODE:** [Zip Code]

**PHONE NUMBER:** [Phone Number]

**CREMATION INFORMATION**

**Direct Cremation:**  Yes  No **La or In-urn:**  Yes  No

**Was an autopsy performed:**  Yes  No

**Crematory Name:** [Name] **Address:** [Address] **City:** [City] **State:** [State] **Zip Code:** [Zip Code]

**Do cremains need to be ready by a specific date:**  Yes  No

**IF ANY & OTHER SIGNIFICANT CONDITIONS:** [Text]

**PRINT & SIGN IN THE BOX BELOW**

**Signature:** [Signature] **Print Name:** [Name] **Print Title:** [Title]

Milwaukee  
County

**WISCONSIN STATISTICAL ABSTRACT**  
MILWAUKEE COUNTY MEDICAL EXAMINER'S OFFICE  
313 West Highland  
Milwaukee, WI 53225  
(414) 223-2300 FAX: (414) 223-1217

**NAME OF DECEDENT:** [Name]

**HOME ADDRESS:** [Address]

**CITY:** [City] **STATE:** [State] **ZIP CODE:** [Zip Code]

**DATE OF BIRTH:** [Date]

**DATE OF DEATH:** [Date]

**DEATH CERTIFICATE SIGNED BY:** [Name]

**LOCATION OF DEATH:** [Location]

**NAME AND LOCATION OF FUNERAL HOME:** [Name] [Address]

**NAME OF FUNERAL DIRECTOR:** [Name]

**NAME OF PERSON REQUESTING CREMATION:** [Name]

**RELATIONSHIP TO DECEDENT:** [Relationship]

**ADDRESS:** [Address]

**CITY:** [City] **STATE:** [State] **ZIP CODE:** [Zip Code]

**PHONE NUMBER:** [Phone Number]

**VIEW AT WHICH LOCATION:**  Yes  No

**IF BODY AT THIS LOCATION:**  Yes  No

**When cremating:**  Yes  No

**This form does not constitute or imply any information on:**

**COVID 19 POSITIVE**

# Cremation Permit Differences By County

9414 223 1237

Milwaukee County Medical Examiner  
933 W. Highland Avenue  
Milwaukee, WI 53233  
(414) 223-1200 Fax (414) 223-1237

Case Number: [REDACTED]

**Release To Cremate**

Name of Deceased: [REDACTED] Date of Death: [REDACTED] Time of Death: [REDACTED] BYR Date: [REDACTED]

Home Address: [REDACTED] Place of Death: [REDACTED]

**DEATH CERTIFICATE DATA**

Death Certificate Signed By: [REDACTED] Date Signed: [REDACTED]

**REQUESTOR INFORMATION**

Name of Person Requesting Cremation: [REDACTED] Mailing Address: [REDACTED]

Phone: [REDACTED] Relation to Deceased: [REDACTED] Funeral Home: [REDACTED]

**Office of the Medical Examiner**  
315 W. Industrial Blvd.  
Waukegan, WI 53188-2022  
(262) 548-7375  
FAX (262) 876-8079  
Waukegan County, Wisconsin  
Cremation Release

**This is to certify that in accordance with Wisconsin state statute 979.10, this office is and made personal inquiry into the cause and manner of death of the person named opinion that no further examination or judicial inquiry concerning the same is next occur after:**

07/30/2022  
02:20:00

8/2/2022

(Milwaukee County Medical Examiner's Office) (Date Issued)

**NOTE: THIS DOCUMENT DOES NOT OVERRIDE THE WISHES OF THE NEXT REGARDING THE FINAL DISPOSITION OF THE REMAINS.**

NAME OF DECEASED: [REDACTED]

ADDRESS: [REDACTED]

AGE: [REDACTED] AGE IF <1 YEAR: [REDACTED] DATE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED] DATE DEATH RECORD SENT: [REDACTED]

DEATH RECORD SIGNED BY: [REDACTED]

CAUSE OF DEATH: [REDACTED]

ATTENDING PHYSICIAN: [REDACTED]

FUNERAL DIRECTOR: Krause-Brookfield (262) 432-8300

NAME OF PERSON REQUESTING CREMATION: [REDACTED]

ADDRESS: [REDACTED]

PHONE: [REDACTED] RELATION TO DECEASED: [REDACTED]

CREMATORY: Krause

PLACE OF DEATH: [REDACTED]

OTHER INFORMATION: [REDACTED]

**This is to certify that I have viewed the body and made personal inquiry into the cause and manner of death of the person named above as accords with a 979.10 of Wisconsin statute and that I am of the opinion that no further examination or judicial inquiry concerning the same is necessary and that permission to cremate is hereby authorized after:**

None Month, Day, Year

ISSUED [REDACTED] Signature of M.E./Deputy

2/3

**CREMATION RELEASE**  
OFFICE OF THE CORONER/MEDICAL EXAMINER OF WASHINGTON COUNTY  
Coroner/ME Case Number: [REDACTED]

**DECEDENT DEMOGRAPHIC**

Decedent's Current Legal Name - First Middle Last Suffix [REDACTED]

Sex [REDACTED] Date Pronounced Dead [REDACTED] Time Pronounced Dead (approx) [REDACTED] Date of Birth (approx) [REDACTED] Age at Death [REDACTED] Years [REDACTED] Months [REDACTED] Days [REDACTED] Hours [REDACTED]

Medical Death: [REDACTED] Cause of Death: [REDACTED] Other Cause of Death: [REDACTED] Decedent's Residence: [REDACTED] Hospice Facility: [REDACTED] CBPP: [REDACTED]

Residence Care App: [REDACTED] Adult Family Home (AFH): [REDACTED] Other: [REDACTED]

County of Death: [REDACTED] State of Death: [REDACTED] Country of Death: [REDACTED] City: [REDACTED] Village: [REDACTED] Township: [REDACTED] Check One: [REDACTED] [REDACTED] [REDACTED]

If Applicable, Facility Name: [REDACTED] Street Address: [REDACTED] ZIP Code: [REDACTED]

Decedent's Residence (Country/State): [REDACTED] County of Residence: [REDACTED] City/Village/Township of Residence: [REDACTED] Check One: [REDACTED] [REDACTED] [REDACTED]

Residence Address: [REDACTED] ZIP Code: [REDACTED]

**MANNER AND CAUSE OF DEATH**

Coroner Type: [REDACTED] Coroner/Medical Examiner [REDACTED] License Number: [REDACTED]

Coroner's Mailing Address (Street, City, State, ZIP Code): [REDACTED]

Coroner's Phone Number: [REDACTED] Coroner's Fax Number: [REDACTED]

Manner of Death: [REDACTED] Natural [REDACTED] Accidental [REDACTED] Suicide [REDACTED] Homicide [REDACTED] Undetermined [REDACTED] Pending [REDACTED]

Completed by FAX: [REDACTED]

Part I - Cause of Death: [REDACTED] Interval to Between Onset and Death: [REDACTED] WEEKS

Part II - Other Significant Conditions Contributing to Death: [REDACTED]

**CREMATION RELEASE APPLICANT AND FUNERAL DIRECTOR**

Name of Applicant Requesting the Cremation: [REDACTED] Relationship to Decedent: [REDACTED] Applicant's Mailing Address: [REDACTED]

Funeral Home Name: [REDACTED] Funeral Home Mailing Address: [REDACTED]

KRAUSE FUNERAL HOME INC 9000 W CAPITOL DR, MILWAUKEE, WI 53222

Funeral Director's Full Name: [REDACTED] Funeral Director's Signature: [REDACTED] FO Phone Number: [REDACTED]

**DECEDENT'S BODY IDENTIFIED BY**

Check One: [REDACTED] Applicant for Cremation Release [REDACTED] Funeral Director [REDACTED] Relationship to Decedent: [REDACTED]

Phone Number: [REDACTED] Mailing Address: [REDACTED]

**CREMATION RELEASE AUTHORIZATION**

Name and Address of Crematory: [REDACTED] Hour: [REDACTED] Cremation May Occur

**Consentable Disease Alert:** Is there any communicable disease or condition documented in the Coroner/Medical Examiner case file for the decedent (named on this form which indicates that isolation techniques (cover and above universal precautions) should be used for preparation and body handling during the cremation)? [REDACTED] No [REDACTED] Yes, If 'Yes', specify the condition and precautions to be used [REDACTED]

Foreign Foreign Object Alert: Does the decedent have any external esophageal/bronchial device or any other foreign object? [REDACTED] No [REDACTED] Yes, If 'Yes', specify the condition and precautions to be used [REDACTED]

Name and Title of Coroner/ME: [REDACTED] Date Signed: [REDACTED]

**This is to certify that I have viewed the body and made personal inquiry into the cause and manner of death of the decedent named on this form, that I am of the opinion that no further examination or judicial inquiry concerning the same is necessary and that permission to cremate is hereby authorized after:**

None Month, Day, Year

Signature of Coroner/ME: [REDACTED] Date Signed: [REDACTED]

**Any person who knowingly and willfully obstructs the coroner or medical examiner in the execution of their duties shall be guilty of a Class B misdemeanor. Any person who knowingly and willfully obstructs the coroner or medical examiner in the execution of their duties shall be guilty of a Class B misdemeanor.**

**CREMATION RELEASE**  
OFFICE OF THE CORONER/MEDICAL EXAMINER OF OZAUKEE COUNTY  
Coroner/ME Case Number: [REDACTED]

**DECEDENT DEMOGRAPHIC**

Decedent's Current Legal Name - First Middle Last Suffix [REDACTED]

Sex [REDACTED] Date Pronounced Dead [REDACTED] Time Pronounced Dead (approx) [REDACTED] Date of Birth (approx) [REDACTED] Age at Death [REDACTED] Years [REDACTED] Months [REDACTED] Days [REDACTED] Hours [REDACTED]

Medical Death: [REDACTED] Cause of Death: [REDACTED] Other Cause of Death: [REDACTED] Decedent's Residence: [REDACTED] Hospice Facility: [REDACTED] CBPP: [REDACTED]

Residence Care App: [REDACTED] Adult Family Home (AFH): [REDACTED] Other: [REDACTED]

County of Death: [REDACTED] State of Death: [REDACTED] Country of Death: [REDACTED] City: [REDACTED] Village: [REDACTED] Township: [REDACTED] Check One: [REDACTED] [REDACTED] [REDACTED]

If Applicable, Facility Name: [REDACTED] Street Address: [REDACTED] ZIP Code: [REDACTED]

Decedent's Residence (Country/State): [REDACTED] County of Residence: [REDACTED] City/Village/Township of Residence: [REDACTED] Check One: [REDACTED] [REDACTED] [REDACTED]

Residence Address: [REDACTED] ZIP Code: [REDACTED]

**MANNER AND CAUSE OF DEATH**

Coroner Type: [REDACTED] Coroner/Medical Examiner [REDACTED] License Number: [REDACTED]

Coroner's Mailing Address (Street, City, State, ZIP Code): [REDACTED]

Coroner's Phone Number: [REDACTED] Coroner's Fax Number: [REDACTED]

Manner of Death: [REDACTED] Natural [REDACTED] Accidental [REDACTED] Suicide [REDACTED] Homicide [REDACTED] Undetermined [REDACTED] Pending [REDACTED]

Completed by FAX: [REDACTED]

Part I - Cause of Death: [REDACTED] Interval to Between Onset and Death: [REDACTED] WEEKS

Part II - Other Significant Conditions Contributing to Death: [REDACTED]

**CREMATION RELEASE APPLICANT AND FUNERAL DIRECTOR**

Name of Applicant Requesting the Cremation: [REDACTED] Relationship to Decedent: [REDACTED] Applicant's Mailing Address: [REDACTED]

Funeral Home Name: [REDACTED] Funeral Home Mailing Address: [REDACTED]

KRAUSE FUNERAL HOME INC 9000 W CAPITOL DR, MILWAUKEE, WI 53222

Funeral Director's Full Name: [REDACTED] Funeral Director's Signature: [REDACTED] FO Phone Number: [REDACTED]

**DECEDENT'S BODY IDENTIFIED BY**

Check One: [REDACTED] Applicant for Cremation Release [REDACTED] Funeral Director [REDACTED] Relationship to Decedent: [REDACTED]

Phone Number: [REDACTED] Mailing Address: [REDACTED]

**CREMATION RELEASE AUTHORIZATION**

Name and Address of Crematory: [REDACTED] Hour: [REDACTED] Cremation May Occur

**Consentable Disease Alert:** Is there any communicable disease or condition documented in the Coroner/Medical Examiner case file for the decedent (named on this form which indicates that isolation techniques (cover and above universal precautions) should be used for preparation and body handling during the cremation)? [REDACTED] No [REDACTED] Yes, If 'Yes', specify the condition and precautions to be used [REDACTED]

Foreign Foreign Object Alert: Does the decedent have any external esophageal/bronchial device or any other foreign object? [REDACTED] No [REDACTED] Yes, If 'Yes', specify the condition and precautions to be used [REDACTED]

Name and Title of Coroner/ME: [REDACTED] Date Signed: [REDACTED]

**This is to certify that I have viewed the body and made personal inquiry into the cause and manner of death of the decedent named on this form, that I am of the opinion that no further examination or judicial inquiry concerning the same is necessary and that permission to cremate is hereby authorized after:**

None Month, Day, Year

Signature of Coroner/ME: [REDACTED] Date Signed: [REDACTED]

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# Benefits of Consistent Reporting

- Removes uncertainty in timelines and methods of reporting
- Provides a uniform set of rules for all parties
- Levels expectations to families

More efficient statewide death reporting begins with uniform county reporting. Having one method of reporting at the county level increases the success of death reporting at a state level.