



**SOUTHWESTERN
INSTITUTE OF FORENSIC SCIENCES
AT DALLAS**

2355 N. Stemmons Freeway
Dallas, Texas 75207

Telephone (214) 920-5900
FAX (214) 920-5908

Office of the Medical Examiner

DECEASED INFANT/CHILD BODY DISPOSITION REQUEST AND WAIVER

I, _____, do hereby certify that I have the right to control the disposition of the remains of _____ as specified in Section 711.002 of the Health and Safety Code, and

I further attest that (*check one*):

- ☐ I do not have financial resources sufficient to accept responsibility for the disposition of the remains, OR
- ☐ I am refusing to accept responsibility for the disposition of the remains.

Therefore, I am requesting that the Dallas County Office of the Medical Examiner (DCME) take responsibility for the disposition of the remains as specified in Section 694.002 of the Health and Safety Code*. By this request, I grant unto the DCME full rights to dispose of the remains by cremation and inter the remains at a vendor cemetery. By this request, I relinquish all rights and claims regarding hereon described decedent, by any person whatsoever, and direct that in accepting the responsibility for disposition of the remains that the DCME shall not incur any liability, and that no claim shall arise against that institution in any matter.

**Section 694.002(b) of the Health and Safety Code states that "the commissioners court shall consider any information, including the religious affiliation of the deceased pauper, provided by a person listed in Section 711.002 (a)" of the Health and Safety Code. I hereby acknowledge that I have been informed of my right to provide information for consideration by the commissioners court, and I make the following choice in this regard (check one):*

- ☐ *I wish to provide information for consideration by the Commissioners Court (attach information)*
- ☐ *I decline my right to provide information for consideration by the Commissioners Court.*

Printed Name – Legal Next of Kin

Relationship to Decedent

Signature – Legal Next of Kin

Date

(f-45) 04/25



OFFICE OF THE
MEDICAL EXAMINER

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214-920-5900

FETAL DEATH CERTIFICATE INFORMATION FORM

LEGAL NAME OF DECEASED (First, Middle, Last) <i>(Optional – at the discretion of the parents)</i>		DATE OF DELIVERY (mm/dd/yyyy)		TIME OF DELIVERY	
SEX	NAME OF HOSPITAL OR BIRTHING CENTER (if not institution, give street address)			FACILITY NPI:	
MOTHER'S CURRENT LEGAL NAME (First, Middle, Last)				MOTHER'S DATE OF BIRTH:	
MOTHER'S NAME Prior to First Marriage (First, Middle, Last)				BIRTHPLACE (State, Territory, or Foreign Country)	
Mother's Residence – STATE		COUNTY		CITY, TOWN, or LOCATION	
STREET ADDRESS or RURAL LOCATION		APT NO.		ZIP CODE	INSIDE CITY LIMITS? ☐ YES ☐ NO
FATHER'S NAME (First, Middle, Last, and Suffix)		FATHER'S DATE OF BIRTH:		BIRTHPLACE (State, Territory, or Foreign Country)	
MOTHER'S EDUCATION <i>(Check the box that best describes the highest degree or level of school completed at the time of delivery)</i> ☐ 8 th grade or less ☐ 9 th – 12 th grade, no diploma ☐ High school graduate or GED completed ☐ Some college credit, but no degree ☐ Associates degree (e.g. AA, AS) ☐ Bachelor's degree (e.g. BA, AB, BS) ☐ Master's degree (e.g. MA, MS, Meng, Med, MSW, MBA) ☐ Doctorate (e.g. PhD or EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)		MOTHER of HISPANIC ORIGIN? <i>(Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if decedent is not Spanish/Hispanic/Latina.)</i> ☐ No, not Spanish, Hispanic /Latina ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, Other Spanish/Hispanic/Latina (Specify): _____		MOTHER'S RACE <i>(Check one or more races to indicate what the mother considers herself to be)</i> ☐ White ☐ Black or African American ☐ American Indian or Alaska Native (Name of the enrolled or Principal tribe): _____ ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (specify): _____ ☐ Native American ☐ Guamanian/Chamorro ☐ Samoan ☐ Other Pacific Islander (specify): _____	

PREGNANCY HISTORY																													
LIVE BIRTHS:	NOW LIVING:	NUMBER: _____	☐ NONE	NOW DEAD: NUMBER: _____ ☐ NONE																									
CIGARETTE SMOKING Before and During Pregnancy for each time period Enter the number of cigarettes or the number of packs of cigarettes smoked. If NONE, ENTER "O" <u>Average number of cigarettes or packs of cigarettes smoked per day:</u> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;"></td> <td style="width: 10%; text-align: center;"># of cigarettes</td> <td style="width: 10%; text-align: center;">OR</td> <td style="width: 10%; text-align: center;"># of packs</td> <td style="width: 40%;"></td> </tr> <tr> <td>Three months before pregnancy</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">OR</td> <td style="text-align: center;">_____</td> <td></td> </tr> <tr> <td>First three months of pregnancy</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">OR</td> <td style="text-align: center;">_____</td> <td></td> </tr> <tr> <td>Second three months of pregnancy</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">OR</td> <td style="text-align: center;">_____</td> <td></td> </tr> <tr> <td>Third trimester of pregnancy</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">OR</td> <td style="text-align: center;">_____</td> <td></td> </tr> </table>				# of cigarettes	OR	# of packs		Three months before pregnancy	_____	OR	_____		First three months of pregnancy	_____	OR	_____		Second three months of pregnancy	_____	OR	_____		Third trimester of pregnancy	_____	OR	_____		Date Last Normal Menses Began (mm/dd/yyyy): _____ Did Mother get WIC food for herself during this pregnancy? ☐ YES ☐ NO Mother Married? <i>(At delivery, conception, or anytime between)</i> ☐ YES ☐ NO Mother transferred for maternal medical or fetal indications for this delivery? ☐ YES ☐ NO IF Yes, enter the name of facility mother transferred from: _____	
	# of cigarettes	OR	# of packs																										
Three months before pregnancy	_____	OR	_____																										
First three months of pregnancy	_____	OR	_____																										
Second three months of pregnancy	_____	OR	_____																										
Third trimester of pregnancy	_____	OR	_____																										
SOURCE OF PRENATAL CARE <i>(Check all that apply)</i> ☐ HOSPITAL CLINIC ☐ PRIVATE PHYSICIAN ☐ NONE ☐ OTHER(SPECIFY): _____ ☐ PUBLIC HEALTH CLINIC ☐ MIDWIFE ☐ UNKNOWN			RISK FACTORS IN THIS PREGNANCY <i>(Check all that apply)</i> DIABETES ☐ Prepregnancy <i>(Diagnosis prior to this pregnancy)</i> ☐ Gestational <i>(Diagnosis in this pregnancy)</i> HYPERTENSION ☐ Prepregnancy <i>(Chronic)</i> ☐ Gestational <i>(PIH, preeclampsia)</i> ☐ ECLAMPSIA ☐ PREGNANCY RESULTED FROM INFERTILITY TREATMENT (IF YES, CHECK ALL THAT APPLY) ☐ FERTILITY – <i>enhancing drugs, artificial insemination, or intrauterine insemination</i> ☐ ASSISTED REPRODUCTIVE TECHNOLOGY <i>(e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))</i> ☐ PREVIOUS PRETERM BIRTH ☐ OTHER PREVIOUS POOR PREGNANCY OUTCOME <i>(including perinatal death, small-for-gestational age/intrauterine growth restricted birth)</i>																										
MOTHER HEIGHT: _____ FEET/ INCHES	MOTHER'S PREGNANCY WEIGHT: _____	MOTHER'S WEIGHT AT DELIVERY: _____																											
PRENATAL CARE: ☐ NO PRENATAL CARE DATE OF FIRST VISIT (mm/dd/yyyy): _____ DATE OF LAST VISIT (mm/dd/yyyy): _____ NUMBER OF PRENATAL VISIT: _____			☐ MOTHER HAD PREVIOUS CESAREAN DELIVERY – If yes, how many _____ ☐ Antiretrovirals Administered During Pregnancy or At Delivery ☐ NONE OF THE ABOVE																										
INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY <i>(Check all that apply)</i>																													
☐ GONORRHEA ☐ CHLAMYDIA ☐ GROUP B STREPTOCOCCUS ☐ PARVOVIRUS ☐ SYPHILIS ☐ LISTERIA ☐ CYTOMEGALOVIRUS ☐ TOXOPLASMOSIS				☐ NONE OF THE ABOVE ☐ OTHER (SPECIFY): _____																									

The information requested on this form will be used to complete the death certificate. Please print this information to ensure the spelling is correct. Any areas left blank will be filled as unknown and an amendment to the death certificate will be necessary to correct this at the family's expense. Please complete as much of this information as possible.

If you would like to claim personal property that may be recovered by DCME, please call 214-920-5900 Opt.1