



**PRELIMINARY INFORMATION FORM  
MILWAUKEE COUNTY MEDICAL EXAMINER'S OFFICE  
933 West Highland  
Milwaukee, WI 53233  
(414) 223-1200 FAX (414) 223-1237**

*All attempts will be made to provide same day service for requests received by 8:00am.  
PLEASE PRINT OR TYPE CLEARLY*

Name of Deceased: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Date of Death \_\_\_\_\_ Time of Death (military) \_\_\_\_\_

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

Location of Death: \_\_\_\_\_

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

Name of Funeral Director: \_\_\_\_\_ Phone: \_\_\_\_\_

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Name of Person Requesting Cremation: \_\_\_\_\_

Relationship to Deceased: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

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

Is Body at this Location Now: Yes \_\_\_\_ No \_\_\_\_ If "No", then when \_\_\_\_\_

Where cremating: \_\_\_\_\_

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