MEDICAL EXAMINER

DEKALB COUNTY

INQUIRY REPORT REQUEST FORM

Date: ____________________

Deceased Name: ____________________________________

Date of Birth (if known) ____________________________________

Date of Death (if known) ____________________________________

Case Number (if known) ____________________________________

Your Name: ____________________________________

Address: ____________________________________

City & State: __________________________ Zip: _____________

Relationship to Deceased: __________________________

Telephone Number Where You Can Be Contacted: ____________________________________

Preferred Method of Delivery: (Select one)

☐ Email (provide address below):

____

☐ Mail to Same Address as Listed Above

☐ Different Address (provide below):

Name: ____

Address: ____

City & State: __________________________ Zip: _____________

☐ Check box if you want to pick the report up instead of mailing

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