

Place of disaster: _____ **PM No:** _____

Nature of disaster: _____

Date of disaster: Day Month Year

Male Female Unknown

a = Data not available

b = Attachment

c = Further info on page Sup. Info. (700's)

ADMINISTRATIVE DATA (checklist of operations in the mortuary)				Date	a	b	c
150	Body part	No 1 <input type="checkbox"/>	Yes (specify): 2 <input type="checkbox"/> _____				
155	Photographs taken	No 1 <input type="checkbox"/>	Yes by: 2 <input type="checkbox"/> _____				
160	Exhibits	No 1 <input type="checkbox"/>	Yes by: 2 <input type="checkbox"/> _____				
165	Prints taken from	No 1 <input type="checkbox"/>	Not Possible 2 <input type="checkbox"/>	Yes by: 3 <input type="checkbox"/> _____			
	01 Finger(s)	No 1 <input type="checkbox"/>	Not Possible 2 <input type="checkbox"/>	Yes by: 3 <input type="checkbox"/> _____			
	02 Palm(s)	No 1 <input type="checkbox"/>	Not Possible 2 <input type="checkbox"/>	Yes by: 3 <input type="checkbox"/> _____			
	03 Foot/feet	No 1 <input type="checkbox"/>	Not Possible 2 <input type="checkbox"/>	Yes by: 3 <input type="checkbox"/> _____			
170	Examination	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify): 3 <input type="checkbox"/> _____			
	01 External examination	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify): 3 <input type="checkbox"/> _____			
	02 Partial autopsy	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify): 3 <input type="checkbox"/> _____			
	03 Full autopsy	No 1 <input type="checkbox"/>	Yes - See separate report 2 <input type="checkbox"/>				
	04 Pathologist name						
	Street / No. Postcode / Town State / Country Phone / Email						
175	Dental examination	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify in field 615) 3 <input type="checkbox"/>			
	01 Completed	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify in field 615) 3 <input type="checkbox"/>			
	02 Odontologist name						
	Street / No. Postcode / Town State / Country Phone / Email						
180	Samples taken	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	DNA 3 <input type="checkbox"/>	Tox (if required) 4 <input type="checkbox"/>		
	01 By pathologist Reference to 545	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	DNA 3 <input type="checkbox"/>	Tox (if required) 4 <input type="checkbox"/>		
	02 By odontologist Reference to 610	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	DNA 3 <input type="checkbox"/>	Tox (if required) 4 <input type="checkbox"/>		

CHECKLIST OF CONTENTS	Enclosed complete	Not available	Remarks
Administrative Data (fields 1xx)			
Effects (fields 3xx)			
Body description (fields 4xx)			
Pathology (fields 5xx)			
Odontology (fields 6xx)			
Supporting information (fields 7xx)			
Appendix (fields 8xx) (optional)			

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EFFECTS								a	b	c			
300	Clothing Items	No:	1	Type	2	Colour	3	Label	4	Material			
		Head and neck 101 Headcover 102 Scarf 103 Tie 199 Other Upper part of the body and arms 201 Blouse 202 Braces 203 Brassiere 204 Cardigan 205 Coat 206 Gloves 207 Overcoat 208 Pullover 209 Shirt 210 T-shirt 211 Undershirt 212 Waistcoat 299 Other Lower part of the body and legs 301 Belt 302 Shorts 303 Skirt 304 Socks 305 Stockings 306 Swimming attire 307 Tights 308 Trousers 309 Underpants 399 Other The whole of the body 401 Body suit 402 Dress 403 Religious/Cultural/Traditional 404 Uniform 499 Other In case of using "x99 Other" describe the kind of item in column "1 Type".											
305	Footwear	No:	1	Type	2	Colour	3	Label	4	Material			
		01 Boots 02 Open footwear 03 Shoes 99 Other Describe the kind of footwear in column "1 Type", e.g. sports shoes, sandals											

Only use these colours: Black, Blue, Brown, Green, Grey, Orange, Pink, Purple, Red, White, Yellow, Unknown.

Registered by	Duty Title	:	<i>Signature / Date</i>
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EFFECTS								a	b	c					
310 Watch 01 Digital wristwatch 02 Analog wristwatch 03 Digital/analog w. 04 If wristwatch, worn on 05 Watch strap/chain 06 Watch, other type	No: 1	Make	2	Model	3	Colour	4	Material	5	Inscription					
	Left		Right		Outside		Inside								
	1 <input type="checkbox"/>		2 <input type="checkbox"/>		3 <input type="checkbox"/>		4 <input type="checkbox"/>								
	Leather		Metal		Rubber		Other (specify):								
	1 <input type="checkbox"/>		2 <input type="checkbox"/>		3 <input type="checkbox"/>		4 <input type="checkbox"/>								
	Where worn: _____														
315 Glasses 01 Frame 02 Lenses (glass) 03 Shape of lenses 04 Lenses material/type 05 Where found	1	Make	2	Model	3	Colour	4	Material	5	Inscription					
	Self tinting		Tinted		3 <input type="checkbox"/> Yes (specify):										
	1 <input type="checkbox"/>		2 <input type="checkbox"/> No												
	Round		Oval		Square		Half		Rimless		Full rim				
	1 <input type="checkbox"/>		2 <input type="checkbox"/>		3 <input type="checkbox"/>		4 <input type="checkbox"/>		5 <input type="checkbox"/>		6 <input type="checkbox"/>				
	Glass		Polycarbonate		Bi-focal		Progressive								
1 <input type="checkbox"/>		2 <input type="checkbox"/>		3 <input type="checkbox"/>		4 <input type="checkbox"/>									
Specify: _____															
320 Contact lenses	No		Yes (if coloured specify):												
	1 <input type="checkbox"/>		2 <input type="checkbox"/>												
325 Hearing aids 01 Left 02 Right	No		Yes (specify):				Serial No:								
	1 <input type="checkbox"/>		2 <input type="checkbox"/>												
	No		Yes (specify):				Serial No:								
	1 <input type="checkbox"/>		2 <input type="checkbox"/>												
330 External prostheses	No		Yes (specify):						Serial No:						
	1 <input type="checkbox"/>		2 <input type="checkbox"/>												
335 Jewellery 01 Anklet 02 Bracelets 03 Earclips 04 Earrings 05 Neck chains 06 Necklace 07 Nose ring 08 Pendant on chain 09 Wedding ring 10 Other rings 99 Other In case of using "99 Other" describe the kind of item in column "1 Type".	No: 1	Type	2	Colour	3	Material	4	Inscription	5	Where worn					

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EFFECTS							a	b	c
340 Identity documents	No:	1 Nationality	2 Number	3 Details	4 Biometrics	5 Chip			
	01 Bank cards								
	02 Driving licence								
	03 Identity card								
	04 Passport								
	99 Other								
	In case of using "99 Other" describe the kind of item in column "3 Details".								
345 Effects	No:	1 Make	2 Model	3 Colour	4 Material	5 Serial No.	6 Markings		
	01 Badges/keys								
	02 Bum bag								
	03 Currency								
	04 Diary/agenda								
	05 Purse								
	06 Ticket								
	07 Wallet								
	99 Other								
	In case of using "99 Other" describe the kind of item in column "2 Model".								
350 Electronic devices	No:	1 Make	2 Model	3 Colour	4 Material	5 Serial No.	6 Markings		
	01 Camera								
	02 Mobile phone								
	03 Music player								
	04 SIM								
	05 Tablet/handheld								
	06 Video								
	99 Other								
	In case of using "99 Other" describe the kind of item in column "2 Model".								

Only use these colours: Black, Blue, Brown, Green, Grey, Orange, Pink, Purple, Red, White, Yellow, Unknown.

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BODY DESCRIPTION (external)		a	b	c
402	State of the body	Complete 1 <input type="checkbox"/>	Incomplete 2 <input type="checkbox"/>	
404	Specific details	No: 1 Scars	2 Piercings	3 Tattoos
	Head and neck 01 Head 02 Neck			
	Torso 03 Torso front 04 Torso back 05 Genitalia 06 Buttocks			
	Upper limbs 07 Right upper arm 08 Left upper arm 09 Right forearm 10 Left forearm 11 Right hand 12 Left hand			
	No: 4 Skin marks	5 Malformations	6 Amputations	
	Lower limbs 13 Right thigh 14 Left thigh 15 Right knee 16 Left knee 17 Right lower leg 18 Left lower leg 19 Right foot 20 Left foot			
408	Height	Min _____ cm / Max _____ cm	Min _____ ft _____ in / Max _____ ft _____ in	
412	Weight	Min _____ kg / Max _____ kg	Min _____ lb / Max _____ lb	
416	Build	Slight 1 <input type="checkbox"/>	Medium 2 <input type="checkbox"/>	Large 3 <input type="checkbox"/>
420	Hair of the head	Natural 1 <input type="checkbox"/>	Extensions 2 <input type="checkbox"/>	Hairpiece 3 <input type="checkbox"/>
	01 Type			Wig 4 <input type="checkbox"/>
	02 Length			Implants 5 <input type="checkbox"/>
	03 Dyed colour			Short <6 cm / 2.4 in 1 <input type="checkbox"/>
				Medium <12 cm / 4.7 in 2 <input type="checkbox"/>
				Long >12 cm / 4.7 in 3 <input type="checkbox"/>
				Shaved 4 <input type="checkbox"/>
				None/unknown 1 <input type="checkbox"/>
				Streaked 2 <input type="checkbox"/>
				Blond 3 <input type="checkbox"/>
				Brown 4 <input type="checkbox"/>
				Black 5 <input type="checkbox"/>
				Red 6 <input type="checkbox"/>
				Grey 7 <input type="checkbox"/>
				White 8 <input type="checkbox"/>
				Mixed grey 9 <input type="checkbox"/>
				Other (specify): 10 _____
	04 Natural colour			Blond 1 <input type="checkbox"/>
				Brown 2 <input type="checkbox"/>
				Black 3 <input type="checkbox"/>
				Red 4 <input type="checkbox"/>
				Grey 5 <input type="checkbox"/>
				White 6 <input type="checkbox"/>
				Mixed grey 7 <input type="checkbox"/>
				Other (specify): 8 _____
	05 Baldness			Partial 1 <input type="checkbox"/>
				Total 2 <input type="checkbox"/>
				Forehead 3 <input type="checkbox"/>
				Sides 4 <input type="checkbox"/>
				Tonsure 5 <input type="checkbox"/>
	06 Distinctive feature(s)	Describe (and use page Sup. Info. (700's) for details): _____		

Registered by	Duty Title : _____	Signature / Date
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BODY DESCRIPTION (external)			a	b	c
424 Eyebrows	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
428 Eyes	Blue	Grey	Green	Brown	
01 Colour (Left and Right)	1 <input type="checkbox"/> <input type="checkbox"/> L R	2 <input type="checkbox"/> <input type="checkbox"/> L R	3 <input type="checkbox"/> <input type="checkbox"/> L R	4 <input type="checkbox"/> <input type="checkbox"/> L R	
	Black	Hazel	Maroon	Pink	
	5 <input type="checkbox"/> <input type="checkbox"/> L R	6 <input type="checkbox"/> <input type="checkbox"/> L R	7 <input type="checkbox"/> <input type="checkbox"/> L R	8 <input type="checkbox"/> <input type="checkbox"/> L R	
02 Distinctive feature(s)	Cross-eyed	Squint-eyed	Artificial eye	Other (specify):	
	1 <input type="checkbox"/> <input type="checkbox"/> L R	2 <input type="checkbox"/> <input type="checkbox"/> L R	3 <input type="checkbox"/> <input type="checkbox"/> L R	5 <input type="checkbox"/>	
432 Nose	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
436 Facial hair	Shaved	Moustache	Goatee	Whiskers	Full beard
01 Type	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	Blond	Brown	Black	Red	Other (specify on page 700's)
02 Colour	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	6 <input type="checkbox"/>
	Grey	White	Mixed grey	Other (specify):	8 <input type="checkbox"/>
	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	
440 Ears	Attached	Pierced - specify number of piercings			
01 Ear lobes/pierced	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	3 <input type="checkbox"/> Left	4 <input type="checkbox"/> Right	
	No	Yes (describe and use page Sup. Info. (700's) for details):			
02 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
444 Mouth/teeth	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
448 Lips	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
452 Chin	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
456 Neck	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
460 Hands/nails	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
464 Feet/nails	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
468 Body/public hair	No	Yes (describe and use page Sup. Info. (700's) for details):			
01 Distinctive feature(s)	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
472 Circumcision	No	Yes			
	1 <input type="checkbox"/>	2 <input type="checkbox"/>			
476 Ancestry	European	African	Asian	Other	
	1 <input type="checkbox"/> White	2 <input type="checkbox"/> Black	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
	Mixed (specify):				
	5 <input type="checkbox"/>				

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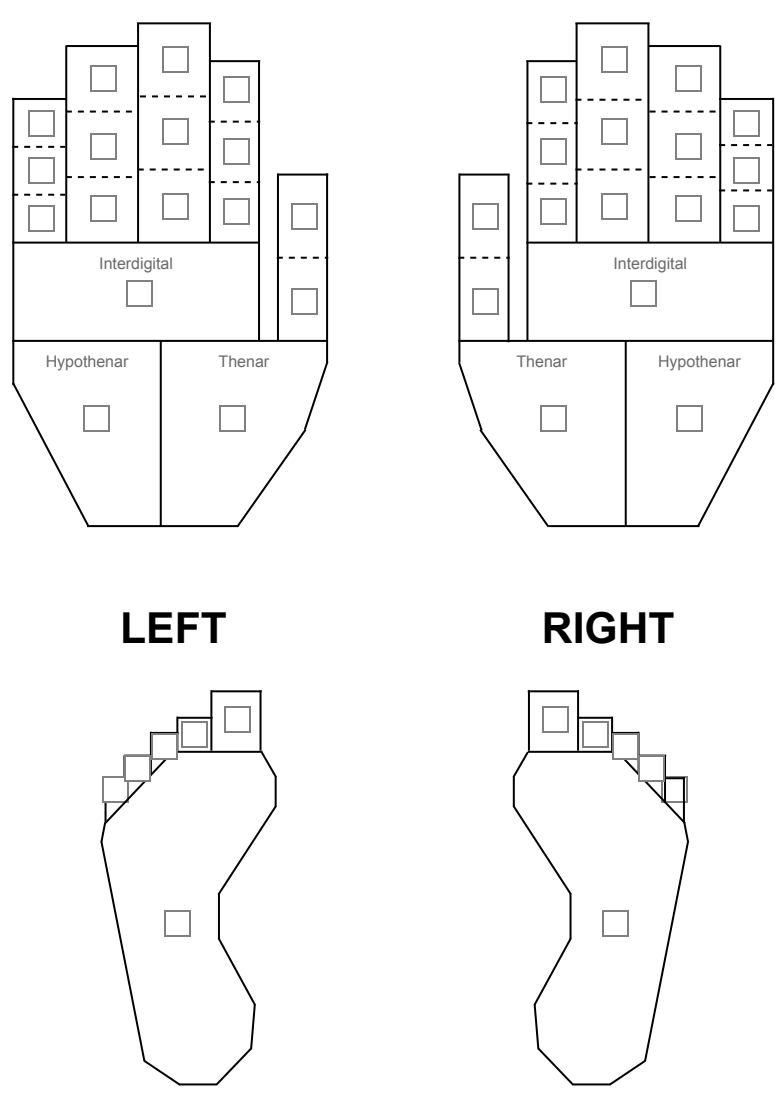
Date of disaster: Day Month Year

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BODY DESCRIPTION (fingerprint information)		a	b	c
484	Skin type prints retrieved from	<i>Epidermis</i> 1 <input type="checkbox"/>	<i>Dermis</i> 2 <input type="checkbox"/>	
488	Print development technique	<i>Washed and printed</i> 1 <input type="checkbox"/> <i>Epidermal glove</i> 3 <input type="checkbox"/> <i>Other (specify):</i> 5 <input type="checkbox"/> _____	<i>Boiling water technique</i> 2 <input type="checkbox"/> <i>Silicon based casting agent</i> 4 <input type="checkbox"/>	
492	Prints recorded using	<i>Black powder & adhesive label</i> 1 <input type="checkbox"/> <i>Photograph</i> 3 <input type="checkbox"/>	<i>Ink</i> 2 <input type="checkbox"/> <i>Other (specify):</i> 4 <input type="checkbox"/> _____	
496	Prints retrieved from	 <p style="text-align: center;">LEFT RIGHT</p> <p style="text-align: center;">SHADE AREAS PRINTS RETRIEVED FROM</p>		

<p>Registered by Duty Title : _____</p> <p>Name : _____</p> <p>Address : _____</p> <p>Phone / Email : _____</p>	<p>Signature / Date _____</p>
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PATHOLOGY		a	b	c
510 Internal examination	No: 1 <i>Specify</i>			
	Head			
	01 Brain			
	02 Neck			
	03 Skull			
	04 Other			
	Chest			
	10 Heart/vessels			
	11 Lungs			
	12 Thorax/ribs/sternum			
	13 Other			
	Abdomen			
	20 Appendix			
	21 Intestines			
	22 Stomach			
	23 Other			
	Other internal organs			
	30 Adrenals/pancreas/ Spleen			
	31 Genitalia			
	32 Kidneys/ureters/ Bladder			
	33 Liver/gall bladder			
	Skeleton/soft tissue			
	40 Left lower limb			
	41 Left upper limb			
	42 Pelvis			
	43 Right lower limb			
	44 Right upper limb			
	45 Other bones			
46 Soft tissue, other locations				
47 Vertebral column				
Various				
50 Demonstrable pathological condition (e.g. heart disease, cancer etc.)				
51 Healed fractures				
52 Operations				
In women				
60 Births				
61 Hysterectomy				
62 Intrauterine contra- ceptive devices				
63 Pregnancy				
515 Implants	No: 1 <i>Specify</i>	2	<i>Serial No.</i>	
	01 Breast			
	02 Pacemaker			
	03 Insulin pump			
	04 Other surgical implants			

Registered by	Duty Title	:	<i>Signature / Date</i>
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PATHOLOGY		a	b	c
520	Prostheses	No 1 <input type="checkbox"/>	Yes (specify): 2 <input type="checkbox"/> _____	
525	Other artificial aids	No 1 <input type="checkbox"/>	Yes (specify): 2 <input type="checkbox"/> _____	
535	Sex	Male 1 <input type="checkbox"/>	Female 2 <input type="checkbox"/>	Undetermined 3 <input type="checkbox"/> Reason: _____
540	Estimated age	01 Age (Fill either year or month) Min _____ year / Max _____ year 02 Method used Min _____ month / Max _____ month Specify: _____		
545	DNA specimens taken	Specimen No. _____		
	Type	Bone 1 <input type="checkbox"/>	Teeth 2 <input type="checkbox"/>	Muscle 3 <input type="checkbox"/>
	Swab-card spotted with:	Buccal cells 6 <input type="checkbox"/>	Blood 7 <input type="checkbox"/>	Other (specify): 5 <input type="checkbox"/> _____ Tissue 8 <input type="checkbox"/>
	State	Fresh 1 <input type="checkbox"/>	Slight 2 <input type="checkbox"/> decomp.	Moderate 3 <input type="checkbox"/> decomp.
545	DNA specimens taken	Specimen No. _____		
	Type	Bone 1 <input type="checkbox"/>	Teeth 2 <input type="checkbox"/>	Muscle 3 <input type="checkbox"/>
	Swab-card spotted with:	Buccal cells 6 <input type="checkbox"/>	Blood 7 <input type="checkbox"/>	Other (specify): 5 <input type="checkbox"/> _____ Tissue 8 <input type="checkbox"/>
	State	Fresh 1 <input type="checkbox"/>	Slight 2 <input type="checkbox"/> decomp.	Moderate 3 <input type="checkbox"/> decomp.
545	DNA specimens taken	Specimen No. _____		
	Type	Bone 1 <input type="checkbox"/>	Teeth 2 <input type="checkbox"/>	Muscle 3 <input type="checkbox"/>
	Swab-card spotted with:	Buccal cells 6 <input type="checkbox"/>	Blood 7 <input type="checkbox"/>	Other (specify): 5 <input type="checkbox"/> _____ Tissue 8 <input type="checkbox"/>
	State	Fresh 1 <input type="checkbox"/>	Slight 2 <input type="checkbox"/> decomp.	Moderate 3 <input type="checkbox"/> decomp.
545	DNA specimens taken	Specimen No. _____		
	Type	Bone 1 <input type="checkbox"/>	Teeth 2 <input type="checkbox"/>	Muscle 3 <input type="checkbox"/>
	Swab-card spotted with:	Buccal cells 6 <input type="checkbox"/>	Blood 7 <input type="checkbox"/>	Other (specify): 5 <input type="checkbox"/> _____ Tissue 8 <input type="checkbox"/>
	State	Fresh 1 <input type="checkbox"/>	Slight 2 <input type="checkbox"/> decomp.	Moderate 3 <input type="checkbox"/> decomp.
550	Further ID information			

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ODONTOLOGY					a	b	c	
610	Material present for examination	<i>Check</i>		<i>Specimen taken</i>				
	01 Jaws with teeth	<input type="checkbox"/> Upper	<input type="checkbox"/> Lower					
	02 Jaws without teeth	<input type="checkbox"/> Upper	<input type="checkbox"/> Lower					
	03 Teeth only	FDI No's:						
	04 Fragments							
05 Other								
615	Dental images available	1 Digital	2 State number of	3 Non digital	4 State number of			
	01 PA	<input type="checkbox"/>		<input type="checkbox"/>				
	02 BW	<input type="checkbox"/>		<input type="checkbox"/>				
	03 OPG	<input type="checkbox"/>		<input type="checkbox"/>				
	04 CT	<input type="checkbox"/>		<input type="checkbox"/>				
	05 Other radiographs	<input type="checkbox"/>		<input type="checkbox"/>				
	06 Photographs	<input type="checkbox"/>		<input type="checkbox"/>				
625	Supplementary details							
	01 Condition of the body							
	02 Other details							

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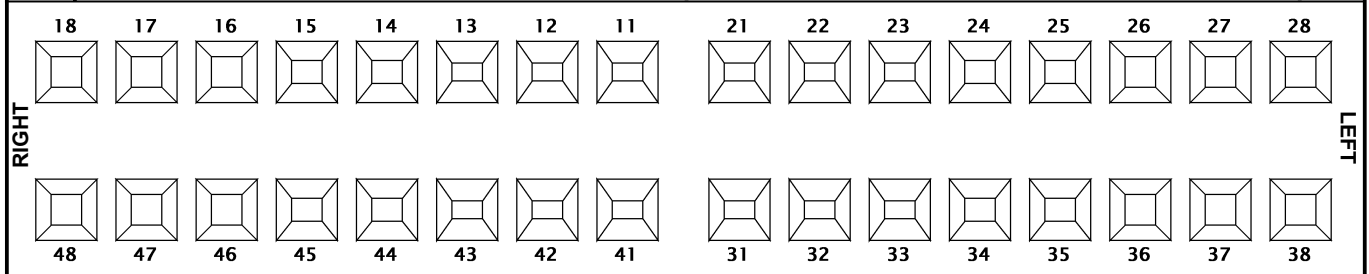
b = Attachment

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ODONTOLOGY

630 Dental findings (for primary teeth change specific FDI code)

11			21
12			22
13			23
14			24
15			25
16			26
17			27
18			28



48			38
47			37
46			36
45			35
44			34
43			33
42			32
41			31

635 Specific data 01 Specify	1 <input type="checkbox"/> Crowns	2 <input type="checkbox"/> Pontics	3 <input type="checkbox"/> Implants	a	b	c
	4 <input type="checkbox"/> Dentures	5 <input type="checkbox"/> Other				
640 Other findings 01 Specify	1 <input type="checkbox"/> Occlusion	2 <input type="checkbox"/> Tooth wear	3 <input type="checkbox"/> Periodontal status			
	4 <input type="checkbox"/> Supernumeraries	5 <input type="checkbox"/> Stains	6 <input type="checkbox"/> Other			
645 Type of dentition 01 Dentition	1 <input type="checkbox"/> Primary dentition	2 <input type="checkbox"/> Mixed dentition	3 <input type="checkbox"/> Permanent dentition			
647 Estimated age 01 Age (Fill either year or month)	Min _____ year	Max _____ year	Min _____ month	Max _____ month		
650 Quality check FOd 1	Date:	Signature:				
	FOd 1 Name:					
FOd 2 (If available)	Date:	Signature:				
	FOd 2 Name:					

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805 APPENDIX DNA				a	b	c
810	Typing Laboratory	Name: _____ Email: _____ Address: _____ City: _____ Date of sample: _____				
815	Laboratory Standards	Accredited according to: _____ Not accredited 1 <input type="checkbox"/>				
820	STR kit(s) used	Name(s) of kit(s) used: _____				
825	DNA	Human Remains 1	Human Remains 2			
	VWA					
	TH01					
	D21S11					
	FGA					
	D8S1179					
	D3S1358					
	D18S51					
	Amelogenin					
	TPOX					
	CSF1PO					
	D13S317					
	D7S820					
	D5S818					
	D16S539					
	D2S1338					
	D19S433					
	Penta D					
	Penta E					
	D1S1656					
	D2S441					
	D10S1248					
	D22S1045					
	D12S391					
	SE33					
	D6S1043					
Add any information not represented of the markers above, using c-column/page 700's Supporting information.						
830	Additional DNA profile page (805-825) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes					

Registered by Duty Title : _____ Name : _____ Address : _____ Phone / Email : _____	Signature / Date _____
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Place of disaster: _____

PM No: _____

Nature of disaster: _____

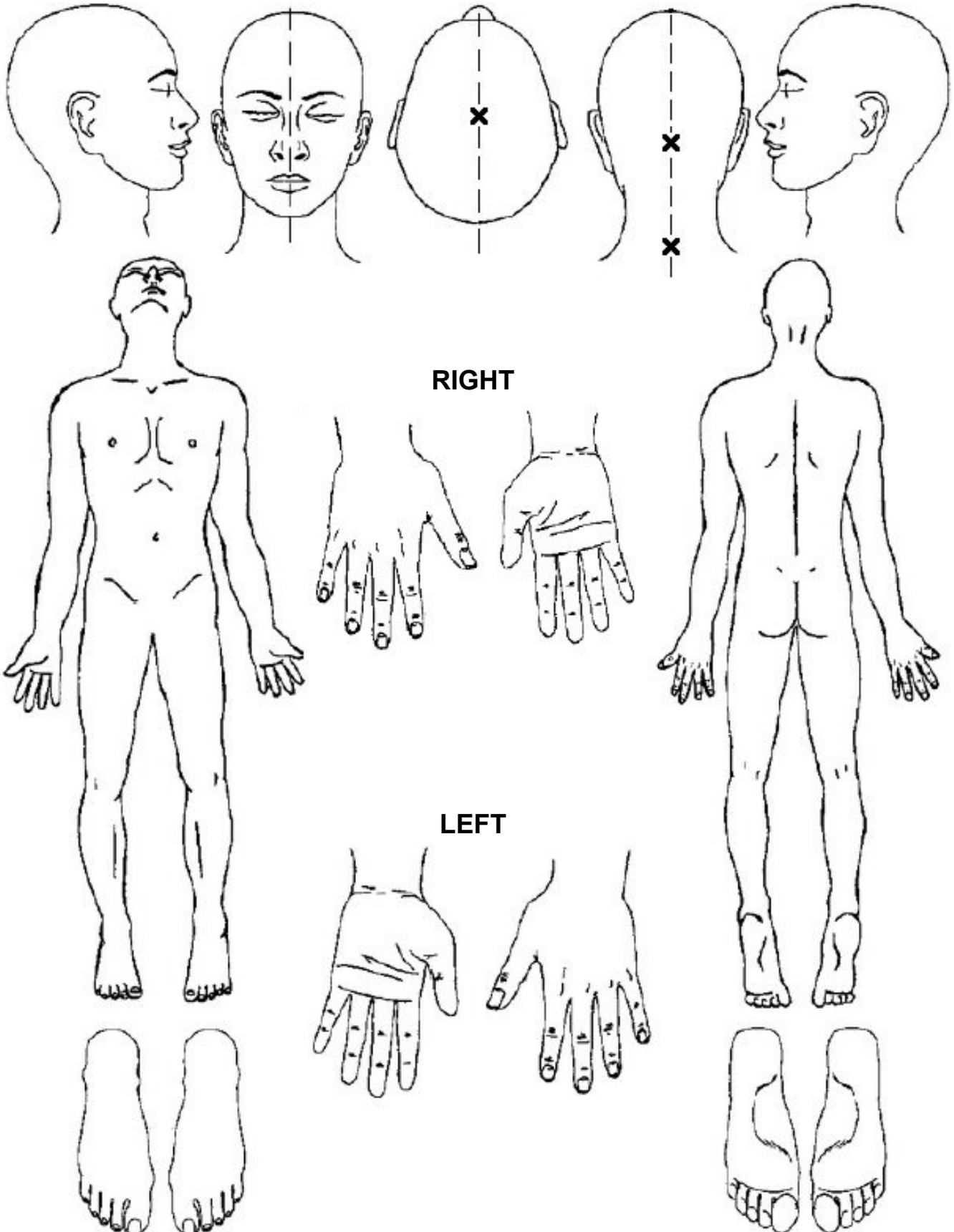
Date of disaster: Day Month Year

Male

Female

Unknown

835 APPENDIX BODY SKETCH (for optional use)



Place of disaster: _____

PM No: _____

Nature of disaster: _____

Date of disaster: Day Month Year

Male

Female

Unknown

840 APPENDIX SKELETON SKETCH (for optional use)

