



Midwest Medical Examiner's Office

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A. Quinn Strobl M.D. Chief Medical Examiner

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Accredited by



NEXT OF KIN AUTHORIZATION FOR REMOVAL

As the legal next of kin of _____, who died _____, in _____ County,
(Decedent's name) (Date of death) (County of Death)

I, _____, authorize _____ to care for and remove
(NOK printed name) (Name of Funeral Home)

the above named decedent from the Midwest Medical Examiner's Office for the purpose of funeral arrangements, embalming, shipping, cremation, burial or other means of final disposition.

Signature: _____ Relationship to decedent: _____
(Next-of Kin) (Date)

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This portion to be completed by the Funeral Home:

I, _____ with _____ received this
(Print name) (Name of Funeral Home)

completed authorization from the above named person on _____ at _____.
(Date) (Time)

Signature of funeral home employee accepting this form _____

****Please complete this form and leave it, at the time of removal, along with any other necessary documentation**