

Food and Drug Administration  
Center for Food Safety and Applied Nutrition  
Office of Special Nutritionals

ARMS#

13096



8 - OTHER

**000001**

REPORT OF DEATH

NAME: [REDACTED] ADDRESS: [REDACTED]

Admission Date: 7/12/98 Date/hour of death: 7/12/98 1135 Room: [REDACTED]

Age: 37 (M) S W D Nurse or Doctor present: Dr [REDACTED]

Relative notified: husband Present: (yes/no) Phone: [REDACTED]

Personal Effects, valuables (list) NONE Clothing: NONE

Effects taken by: [REDACTED] Relationship: [REDACTED] Signature: [REDACTED]

Chief clinical cause of death: Full arrest R/D P.E.

Contributory: 6 mo - post partum Duration: [REDACTED]

There was disease contracted or injury sustained? NO

Did an operation precede death? NO Nature and dates of operations: [REDACTED]

Dr [REDACTED] Signature of Physician

CORONER'S CASES

DOA X Coroner notified at 1230 time 7-12-98 date

Other [REDACTED] Name of coroner [REDACTED]

Instructions: [REDACTED]

[REDACTED]

RELEASE OF BODY

Release body to: SEE MEDICAL RECORD Date: [REDACTED] Time: [REDACTED] Name of Undertaker: [REDACTED]

Undertaker's Signature: [REDACTED] Next of Kin Signature: [REDACTED]

000002

[REDACTED]

[REDACTED]

REPORT OF AUTOPSY

[REDACTED]

DECEDENT: [REDACTED]

DATE OF BIRTH:

[REDACTED]

DATE/TIME OF DEATH

JULY 12, 1998, 1135 HOURS

PLACE OF DEATH:

[REDACTED]

DATE/TIME OF AUTOPSY:

JULY 13, 1998, 1000 HOURS

ASSISTING:

AUTOPSY ASSISTANT

FORENSIC PATHOLOGIST:

M. D.

CAUSE OF DEATH:

- A. CARDIAC ARRHYTHMIA (SECONDS) DUE TO
- B. PROFOUND HYPOKALEMIA (DAYS) DUE TO
- C. ELECTROLYTE IMBALANCE SECONDARY TO DIETING (UNKNOWN)

MANNER:

NATURAL

[REDACTED]

M. D.

FORENSIC PATHOLOGIST

THE DOCUMENT TO WHICH THIS CERTIFICATE IS ATTACHED IS A FULL, TRUE AND CORRECT COPY OF THE RECORDS ON FILE IN THE OFFICE OF THE CORONER OF THE

[REDACTED]

ATTEST [REDACTED]

BY [REDACTED] DEPUTY

## REPORTED DEATH CIRCUMSTANCES

She was complaining on July 11 of sharp anterior pelvic pain. These persisted throughout much of the day. Recently she was taking Metabolife, a dietary supplement for 2 to 3 days. Additionally, further information disclosed that at some time in the last year she was taking "Phen-Fen" a weight loss medication. She no other serious illnesses or health complaints. She was complaining of feeling tired the evening prior to her sudden collapse and had a recent delivery 6 months ago for her fourth child.

## EXTERNAL EXAMINATION

The unembalmed body is that of a 37 year old Caucasoid female. She is overweight and has a measured height of 5 feet 7 inches and a scaled weight of 220 pounds.

1. Head hair is light brown. Eye coloration is not discernible. There has been corneal transplant harvest.
2. Upper and lower jaws have natural teeth in good condition.
3. Clothing items are brought with her. She is otherwise, swathed in a hospital sheet.
4. Marks, scars and tattoos:
  - a. There are no external tattoos.
  - b. There are no apparent scars that are of surgical significant. She has ear lobe pierce marks.
5. Recent medical artifacts:
  - a. Extending from the left external nares is a "Levine" tube.
  - b. In the right and left sides of the neck are bilateral intravenous catheters. Each is taped to the skin.
  - c. Defibrillator paddle marks are present on the right upper anterior chest and lower lateral chest.
  - d. Needle puncture marks are in the left front bend of the elbow, bilateral groin area.
  - e. Extending from the right corner of the mouth is an oral endotracheal tube at the 24 cm mark.
6. Injuries and external abnormalities:
  - a. The body has residual rigor in the larger joints. Both lower extremities from the hip and to include the pelvic areas show harvest transplant surgical incisions sutured. There has been prior retrieval of bone and tendon material.

b. The body is pale.

7. Identification devices:

- a. A Coroner's Identification tag by Investigator [REDACTED] is attached to the left great toe.

### INTERNAL EXAMINATION

The body is opened using the Y-shaped incision. The head is opened using a transverse coronal incision extending from mastoid to mastoid. Significant internal findings disclose:

1. Organ weights in grams:

- |                            |                           |
|----------------------------|---------------------------|
| a. Brain 1425 grams.       | h. Left kidney 200 grams. |
| b. Heart 350 grams.        | i. Right adrenal 7 grams. |
| c. Right lung 650 grams.   | j. Left adrenal 8 grams.  |
| d. Left lung 610 grams.    | k. Pancreas 200 grams.    |
| e. Liver 2650 grams.       | l. Thymus 25 grams.       |
| f. Spleen 390 grams.       | m. Thyroid 20 grams.      |
| g. Right kidney 200 grams. | n. Uterus 225 grams.      |

2. The brain is dusky. Meningeal congestion is profound. Anterior frontal subgale petechiae are present together with bilateral mastoid air sinus hemorrhages.

3. Lungs bilaterally are collapsed within the respective chest spaces. These are limp, congested and show dark purple homogeneous coloration throughout.

4. Liver, spleen, and kidneys are congested.

5. The uterus shows residual postpartum effect. The endometrium is red-tinged. The bilateral adnexa show physiological structures.

6. The liver has yellow patchiness throughout. Additionally, cholesterolosis is seen within the gall bladder.

### SYSTEMIC DESCRIPTION

**A. CENTRAL NERVOUS SYSTEM-** The brain is otherwise unremarkable. There is diminution of cerebral spinal fluid. Separating the dura shows no underlying fractures. Atheromatous changes within the vessels are not seen. The brain is symmetrical to include cerebellar hemispheres.

**B. CARDIOVASCULAR SYSTEM-** Pericardial surfaces are smooth, free of petechial hemorrhages and show no abnormal fluid collections. The heart has the usual external configuration and is acutely dilated with liquid blood. The myocardium is unremarkable. There are no anomalous vessels and valves as well as coronary arteries are free of atheromatous material. The aorta is totally smooth throughout. Great vessels to include pulmonary arteries, superior and inferior vena cavae are unremarkable.

**C. RESPIRATORY SYSTEM-** Bruising and injury of the soft tissues of the mouth and throat are not noted. The hyoid bone is intact. Larynx is patent with walls intact. The endotracheal tube extends to above the carina. Trachea and bronchi are free of lesions and obstruction. Pleural surfaces are smooth and there are no abnormal fluid collections. The lungs are as previously described.

**D. GASTROINTESTINAL SYSTEM-** The esophagus has a collapsed tubular lumen. The stomach has well retained gastric rugae. Less than 20 ml of bloody fluid has adhered to the gastric surface. Small and large intestines are unremarkable and the appendix is present.

**E. HEPATOBILIARY SYSTEM-** Liver configuration appears swollen, soft. The gall bladder has no stones. There are no impacted stones in the cystic duct or common duct.

**F. SPLEEN AND LYMPHATICS-** The spleen has a slate grey blue capsule. The magenta parenchyma is almost semidiffuent. Lymph node bearing areas show no adenopathy. Thymic tissue is soft tan-pink.

**G. URINARY SYSTEM-** Kidneys bilaterally are unremarkable. Renal pelves are moderately fatty replaced and symmetrical ureters enter the collapsed bladder, free of urine.

**H. GENITAL SYSTEM-** The breasts bilaterally are fatty replaced. There is no extrusion of fluid from the small amount of residual fibrous tissue. The uterus is symmetrical. The cervix is patent, smooth. Bilateral adnexa have corpora lutea and other physiological structures. The uterus shows no intraluminal peculiarities within the fundus. The vaginal vault has no trauma to it.

**I. ENDOCRINE SYSTEM-** Pituitary, thyroid and adrenals have neither masses, hemorrhage nor other peculiarities. The pancreas is soft, tan-pink, multilobulated.

**J. MUSCULOSKELETAL SYSTEM-** Axial and appendicular systems display neither fractures, nor callus formations. Skeletal muscles are soft red-brown and bilaterally symmetrical.

## **MICROSCOPIC EXAMINATION**

**A. CENTRAL NERVOUS SYSTEM-** Tissues to include pons, cerebral, cerebellar hemispheres disclose no obviously discernible peculiarity.

**B. CARDIO VASCULAR SYSTEM-** Myocardial tissue to include mitral valve and left ventricle show no myocardial fibrosis or acute infarction. Rare tiny vessels have intraluminal endothelial proliferation.

**C. RESPIRATORY SYSTEM-** Multiple pulmonary tissues show profound pulmonary edema and congestion. More than five tissue pieces are examined and vessels showing medial hypertrophy and plexiform vascular changes with endothelial proliferation are not demonstrated. Trichrome stains also fail to reveal the presence of these vascular changes.

**D. GASTROINTESTINAL SYSTEM-** Not examined.

**E. HEPATOBILIARY SYSTEM-** Liver tissue discloses mild focal fatty change.

**F. SPLEEN AND LYMPHATICS-** Splenic tissue discloses congestion and some depletion of the lymphoid tissue.

**G. URINARY SYSTEM-** Kidney tissue show focal ischemic change. Rare sclerotic glomeruli are not present.

**H. GENITAL SYSTEM-** Uterine tissue shows no peculiarities.

**I. ENDOCRINE SYSTEM-** Pancreatic tissue is autolyzed and there is no hemorrhagic or acute inflammatory process in the tissue examined. Adrenal tissue has profound decrease in the cortical layer, especially the outer glomerulosa.

**NOTE:** Trichrome stains are tested for control and they are adequate. None of the tissues show DIC, chorionic cells, foreign debris and no multi nucleate giant cells.

Selected tissue samples are retained for microscopic analysis.

*Microscopic tissue samples are retained at the Coroner's Division for a period of one (1) year from the date of autopsy.*

#### **TOXICOLOGY SPECIMENS**

Specimens obtained include blood (2) vitreous (1) which are submitted to [REDACTED] for analysis.

**000007**

*Toxicology samples are retained for a period of one (1) year from the date of autopsy.*

#### **PHOTOGRAPHS**

No photographs are obtained.

#### **X-RAY EXAMINATION**

No radiographs are obtained.

#### **SIGNIFICANT NEGATIVE FINDINGS**

The significant negative findings disclose:

- a. No evidence of trauma or violence that would account for or directly contribute to death.
- b. No obviously discernible evidence for a septic process that would warrant alerting the Health Department.

#### **ANATOMICAL DIAGNOSES**

- I. Hypokalemic clinical lab studies (premortem serum).
- II. Acute congestive changes with:
  - A. Congestion of brain, lungs, liver, spleen and kidneys.
  - B. Fatty change, liver, mild.
- III. Cholesterolosis, gall bladder.
- IV. Exogenous obesity.
- V. History of weight reduction medication and dietary supplement.

  
July 16, 1998

**000008**



ORIGINAL  
COPY

**Coroner's Report**

Case No: [REDACTED]

In the matter of the Death of: [REDACTED]

Aliases: N/A

Date of Death : July 12, 1998  
Time of Death: 1135 hours

Date Reported : July 12, 1998  
Time Reported: 1230 hours

**DECEDENT IDENTIFYING DATA:**

Height: 67 inches  
Weight: 220 pounds  
Hair: Lt. Brown  
Eyes: Unavailable  
Race: Caucasian  
Sex: Female  
Age: 37 years  
Birth Date: [REDACTED]  
Birth State: [REDACTED]

Marital Status: Married  
Social Security No. [REDACTED]  
Residence [REDACTED]  
Street Address: [REDACTED]  
City, State: [REDACTED]  
County: [REDACTED]  
Occupation: Branch Manager  
Employer: [REDACTED]

**PLACE OF DEATH**

Reported By: [REDACTED] RN  
Type of Premises: Hospital  
Street Address: [REDACTED]  
City, State: [REDACTED]  
In City Limits: Yes

**NEXT OF KIN**

Name, Relationship: [REDACTED]  
Street Address: [REDACTED]  
City, State: [REDACTED]  
Notified: Yes

**DISPOSITION OF REMAINS**

Funeral Director: [REDACTED]  
Release Ordered By: [REDACTED]  
Disposition: Cremation/Burial  
Location: [REDACTED]

000009

SEP 18 1998

**INJURY DATA:**

Date: None  
 Time: -----  
 At Work: -----  
 Type of Injury: -----  
 Type of Premises: -----  
 Place: -----

**CAUSE OF DEATH**

Primary: Cardiac Arrhythmia  
 Due to: Profound Hypokalemia  
 Due to: Electrolyte Imbalance, Secondary to Dieting  
 Due to: None  
 Other Significant Conditions: None

Autopsy/Attendance Certificate: Autopsy  
 Date Performed/Signed: July 13, 1998  
 Surgeon/Attending Physician: [REDACTED], M.D.

**OTHER EXAMINATIONS:**

Toxicology: Yes Refer to Toxicology Report for results  
 Dental: No  
 X-Rays: No  
 Finger Prints: Yes

**WITNESSES:**

- 1. —
- 2. —
- 3. —

Investigating Agency: None  
 Investigating Officer: -----

**PROPERTY**

Items Taken: None  
 Seized By: -----  
 Released to: -----  
 Date Released: -----

INVESTIGATION SUMMARY

On July 12, 1998 at 1230 hours, a call was received from Mr. [REDACTED] RN, of the [REDACTED] Emergency Department, reporting the death of [REDACTED] WFA, age 37, due to apparent natural causes. No evidence of trauma or foul play was noted by the hospital staff.

Investigation revealed that the decedent arrived at [REDACTED] on July 12, 1998 at 1110 hours via [REDACTED] Ambulance, after being found unresponsive at home by her husband, [REDACTED], the hospital's [REDACTED]. Upon arrival, the decedent was in full cardiopulmonary arrest. Mrs. [REDACTED] had been earlier intubated at the residence by paramedics. Advanced cardiac life-support measures proved unsuccessful with death pronounced by Dr. [REDACTED] at 1135 hours. Mr. [REDACTED] stated that the decedent had no history of serious illness and/or recent health complaints, other than being "tired" the evening prior. Her primary medical physician was Dr. [REDACTED] who had been contacted by the hospital staff. No serious medical history could be provided by Dr. [REDACTED]. The decedent was not taking any prescription medication(s).

However, Mr. [REDACTED] added that Dr. [REDACTED] believed that the decedent may have expired as a result of a saddle pulmonary embolus. The decedent had recently given birth, approximately 4 to 6 months earlier, and the decedent's demise may be related to postpartum complications. Search of old medical records revealed that a blood chemistry lab panel being performed, February 5, 1998, on the decedent due to possible gestational diabetes. The decedent's blood glucose measured 77 (normal range 70 to 110).

At 1315 hours, I called the [REDACTED] residence and spoke with [REDACTED], who stated that the decedent had gotten up this morning to make pancakes for the couple's four children, ages 8, 6, 4 and 5 months. At approximately 1000 hours, the decedent left the kitchen and went to the bathroom. Mr. [REDACTED] began to finish making pancakes, when his children noticed no answer by Mrs. [REDACTED] from the bathroom. Mr. [REDACTED] checked on the decedent's welfare and found her collapsed on the bathroom floor, lying on her left side. The decedent was cyanotic with some fluid coming from the decedent's nose. Mr. [REDACTED] stated that the decedent had rested comfortably, the night before.

However, the afternoon of July 11, 1998, the [REDACTED] were driving from [REDACTED] to [REDACTED] to go department store shopping, when Mrs. [REDACTED] complained of "sharp pains" from the anterior pelvic region. The pains were persistent much of the day; however, the decedent did not complain any further. Mr. [REDACTED] added that during the decedent's last pregnancy with the couple's 5 month old daughter, [REDACTED] born February 17, 1998 at [REDACTED], the decedent suffered from "blood clots" and similar abdominal pains. All four children were born vaginally with no complications, other than delayed delivery of the placenta, during birth of [REDACTED]. The remainder of the placenta was expelled by Mrs. [REDACTED] a few days later, according to Mr. [REDACTED].

The decedent was not taking any prescription and/or over the counter medications. However, due to Mrs. [REDACTED] being obese (approximately 250 pounds), she and Mr. [REDACTED] began to use "Metabolife" dietary supplement for the past two to three days. Mrs. [REDACTED] took two tablets for each of the past two days, except for July 12, 1998.

On July 13, 1998 at 1300 hours, I informed Mr. [REDACTED] of the preliminary autopsy findings. Mr. [REDACTED] stated that the decedent had actually taken the Metabolife supplement for the past week of the decedent's life, averaging three (3) tablets per day. The decedent and Mr. [REDACTED] had also used the "Phen/Fen" or phentermine/fenfluramide dietary supplement plan from April 1996 to June 1997. Mrs. [REDACTED] stopped taking the Phen/Fen, just after becoming pregnant with their last child.

**000011**

After conducting an investigation into the death of [REDACTED] I find the mode of death to be due to natural causes.

**TYPE OF DEATH: NATURAL**

Date: September 6, 1998

By: [REDACTED]  
[REDACTED] **DEPUTY CORONER**

Date: September 14, 1998

By: [REDACTED]  
[REDACTED] **Chief Coroner Investigator**

September 6, 1998  
[REDACTED]

Directors



M. D.  
D.  
D.  
M. T.



MKL# [Redacted]

COPY

TOXICOLOGY REPORT  
FAX REPORT

Name: [Redacted]

Submitting Agency: [Redacted]

Date Collected: 7/13/99  
Time Collected: 10:30  
Case Number: [Redacted]

Date Received: 7/14/99  
Time Received: 10:30  
Collected By: [Redacted]

RESULTS

INTERPRETATION

OTHER TESTING

|              |            |
|--------------|------------|
| BUN          | 16 mg/dl   |
| CREATININE   | 0.3 mg/dl  |
| GLUCOSE      | 30 mg/dl   |
| ELECTROLYTES |            |
| CHLORIDE     | 129 meq/l  |
| POTASSIUM    | >10 meq/l  |
| SODIUM       | >200 meq/l |

000013

SEP 18 1999

Verifying Scientist: [Redacted]

Report Date: 07/29/99



[Redacted] 8/03/98

Directors

TOXICOLOGY REPORT  
FAX REPORT

COPY

Name: [REDACTED]

Submitting Agency: [REDACTED]

Date Collected: 7/13/98  
Time Collected: 10:30  
Case Number: [REDACTED]

Date Received: 7/14/98  
Time Received: 10:30  
Collected By: [REDACTED]

RESULTS

INTERPRETATION

DRUG SCREEN

DRUG SCREEN

SOURCE

VITREOUS

OPIATES

Negative

> 75 ng/ml

BENZODIAZEPINES

Negative

> 25 ng/ml

COCAINE (METABOLITE)

Negative

> 75 ng/ml

PHENCYCLIDINE

Negative

> 6.25 ng/ml

AMPHETAMINES

Negative

> 250 ng/ml

BARBITURATES

Negative

> 50 ng/ml

CANNABINOIDS

Negative

> 25 ng/ml

000014

Certifying Scientist: [REDACTED]

Report Date: 07/15/98

07/15/98

Directors

TOXICOLOGY REPORT  
FAX REPORT

Name: [REDACTED]  
2 BOTTLES

Submitting Agency: [REDACTED]

Date Collected: 7/13/98  
Time Collected: 10:30  
Case Number: [REDACTED]

Date Received: 7/14/98  
Time Received: 10:30  
Collected By: [REDACTED]

RESULTS

INTERPRETATION

DRUG SCREEN  
BLOOD

|                      |          |              |
|----------------------|----------|--------------|
| OPIATES              | Negative | > 75 ng/ml   |
| BENZODIAZEPINES      | Negative | > 25 ng/ml   |
| COCAINE (METABOLITE) | Negative | > 75 ng/ml   |
| PHENCYCLIDINE        | Negative | > 6.25 ng/ml |
| AMPHETAMINES         | Negative | > 250 ng/ml  |
| BARBITURATES         | Negative | > 50 ng/ml   |
| CANNABINOIDS         | Negative | > 25 ng/ml   |

CONFIRMATION

BLOOD ALCOHOL = 0.00 % > 0.08% BY GC

PROCEDURE

COMMENTS

BLOOD ALCOHOL ALCOHOL PRESENT AT GREATER THAN 0.02%  
LEGAL LIMIT 0.08% FOR MOTOR VEHICLE OPERATION

I CERTIFY, UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF [REDACTED] THAT THE ATTACHED BLOOD/URINE ANALYSIS WAS PERFORMED DURING THE REGULAR COURSE OF MY DUTIES, AND IS A TRUE AND CORRECT COPY THEREOF. I FURTHER CERTIFY THAT I AM QUALIFIED TO PERFORM THESE ANALYSIS PURSUANT TO TITLE 17 OF THE [REDACTED] CODE OF REGULATION, AND THAT THE EQUIPMENT USED IN ARRIVING AT THE RESULTS WAS IN PROPER WORKING ORDER AT THE TIME I PERFORMED THIS ANALYSIS.

000015

Certifying Scientist: [REDACTED]

Report Date: 07/20/98

7/20/98



### CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| STATE FILE NUMBER   |  | LOCAL REGISTRATION NUMBER                            |  |
| 1. NAME OF DECEDENT (FIRST, MIDDLE, LAST)   |  | 2. SEX   |  |
| 3. DATE OF BIRTH (MM/DD/CCYY)   |  | 4. AGE (YEARS, MONTHS, DAYS)                         |  |
| 5. SOCIAL SECURITY NO.  |  | 6. DATE OF DEATH (MM/DD/CCYY)                        |  |
| 7. MARRIAGE STATUS  |  | 8. EDUCATION—GRADE COMPLETED                         |  |
| 9. RACE   |  | 10. USUAL EMPLOYER                                   |  |
| 11. TYPE OF BUSINESS  |  | 12. YEARS IN OCCUPATION                              |  |
| 13. CITY  |  | 14. COUNTY   |  |
| 15. STATE OF BIRTH  |  | 16. ZIP CODE   |  |
| 17. NAME & RELATIONSHIP   |  | 18. MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS) |  |
| 19. NAME OF SURVIVING SPOUSE (LAST, FIRST, MIDDLE)  |  | 20. DATE OF MARRIAGE                                 |  |
| 21. NAME OF FATHER (LAST, FIRST, MIDDLE)  |  | 22. DATE OF BIRTH                                    |  |
| 23. NAME OF MOTHER (LAST, FIRST, MIDDLE)  |  | 24. DATE OF BIRTH                                    |  |
| 25. DATE (MM/DD/CCYY) AND PLACE OF FINAL RESIDENCE  |  | 26. LICENSE NO.                                      |  |
| 27. TYPE OF DEPENDENCY  |  | 28. SIGNATURE OF FURNERAL DIRECTOR                   |  |
| 29. NAME OF FURNERAL DIRECTOR   |  | 30. DATE (MM/DD/CCYY)                                |  |
| 31. PLACE OF DEATH  |  | 32. SIGNATURE OF LOCAL REGISTRAR                     |  |
| 33. STREET ADDRESS (STREET AND NUMBER OR LOCATION)  |  | 34. DATE (MM/DD/CCYY)                                |  |
| 35. DEATH WAS CAUSED BY (LIST ONE CAUSE ONLY FOR A.D.A.C. AND ICD-10)                                       |  | 36. DEATH REPORTED TO CORONER                        |  |
| 37. IMMEDIATE CAUSE   |  | 38. CHOCY PERFORMED                                  |  |
| 39. DUE TO (B)  |  | 39. AUTOPSY PERFORMED                                |  |
| 40. DUE TO (C)  |  | 40. WED IN DETERMINED CASE                           |  |
| 41. DUE TO (D)  |  |  |  |
| 42. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE (SPEC IN 35)                |  |  |  |
| 43. WAS OPERATION PERFORMED FOR ANY CORONER'S CASE? (YES/NO)  |  |  |  |
| 44. I CERTIFY THAT THIS OPINION OF DEATH OCCURRED AT THE HOME, DATE AND PLACE STATED FROM THE DANER STATED. |  | 45. SIGNATURE AND TITLE OF CERTIFIER                 |  |
| 46. SIGNATURE OF PHYSICIAN  |  | 47. DATE (MM/DD/CCYY)                                |  |
| 48. TYPE OF DEATH   |  | 49. HOUR   |  |
| 49. ACCIDENT  |  | 50. PLACE OF INJURY                                  |  |
| 51. SIGNATURE OF CORONER OR DEPUTY CORONER  |  | 52. DATE (MM/DD/CCYY)                                |  |
| 53. STATE REGISTRAR   |  | 54. FAX AUTH.  |  |

000016

CERTIFIED COPY OF VITAL RECORDS  
DATE ISSUED

**Memorandum to ARMS # 13096**

Date: 7 Jun 99

**COPY**

From: Medical Officer, Clinical Research and Review Staff, Office of Special Nutritionals, HFS-452

Subject: Medical Records Placed in Permanent Storage.

The following types and amounts of records (more than 20 pages total) were place in permanent storage on this date because they were not considered essential for interpretation of this adverse event.

| Approx Pages | Type of Records   |
|--------------|---|
|              | Nursing notes   |
|              | Dietitian notes   |
|              | Respiratory therapy/occupational therapy/physical therapy notes                 |
|              | Clergy notes  |
|              | Medication records  |
|              | Physician's orders  |
|              | Vital signs, fluids, input/output records                                       |
|              | Ventilator records  |
| 11           | Hospital administrative records (e.g., insurance information, living will, etc) |
| 1/4"         | 1990 Records of pregnancy, delivery & perinatal                                 |
| 18           | 1992 " " " " " "  |
| 1/2"         | 1993 " " " " " "  |
| 5            | 1994 Evaluation for tubal pregnancy   |
| 1"           | 1998 Records of pregnancy, delivery, perinatal                                  |

K. Chesman for LAlove.

**000017**