

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AUTOPSY NO. \_\_\_\_\_  
SEX \_\_\_\_\_ RACE: \_\_\_\_\_ Case No. \_\_\_\_\_  
HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ EYE \_\_\_\_\_ HAIR \_\_\_\_\_

