

DISASTER VICTIM IDENTIFICATION (DVI)

HOW TO USE THE PINK POST-MORTEM (PM) FORM

Please write legibly.

I. RULES TO BE OBSERVED ON THE DISASTER SITE

No body should be moved before its location has been recorded.

All personal effect that undoubtedly belonged to a deceased individual should be collected and kept with the body or parts of the body of that individual. Any other effects should be recorded as unidentified and kept separately in the first instance.

A moisture resistant number card should be attached to each body or unidentified part of a body to ensure that it cannot get lost.

II. GENERAL INSTRUCTIONS

The PM form is designed for listing all obtainable data about a dead body that may assist in its identification in order to compare that data with the information obtained at the place of residence of the possible victim or missing person and recorded on the yellow ante-mortem form.

IMPORTANT: Record all data that can be obtained, since it is impossible to know what information will be supplied at the victim's place of residence for comparison purposes.

The layout of the form is intended to correspond to the actual sequence of events, and allows a simultaneous examination of effects, body, and teeth.

Where provided, use the appropriate figures for description.

EXAMPLE: Section C1: Fill in the figures "0203" in the "No." column at item 24 to designate a pullover and describe the material, etc. in the space provided for this information.

Wherever appropriate, boxes that can simply be marked with a cross are provided. Please use as many of them as possible. This will facilitate electronic processing of the information and also make it possible to handle reports compiled in a foreign language without translation (the Interpol Member States all use the same forms). For this reason, the layout is the same for the AM and PM forms.

III. SPECIFIC INSTRUCTIONS

- Section B Recovery of body from site: Fill in this form during recovery from the site of the disaster and add the number from the number-board attached to the body or part of the body.
- Sections C1 to C3 Photograph the body first, then remove any clothing and jewellery from the body.
- C1 - clothing and shoes
C2 - personal effects
C3 - jewellery
- Sections D1 to D5 While the effects are examined and described.
- D1 to D3 - physical description of the dead body.
- D4 - record any distinguishing marks (tattoos, etc.)
- D5 - record any fingerprint information.
- Sections E1 to F2 a medical examination is performed
- E1 to E3 - list all data obtained by an internal examination that may assist in identification.
- E4 - DNA profiles
- F1 & F2 - dental data (cf. instructions on the back of Section F1)
- Sections G Record any further information that may assist in identification, and/or continue with your description from a previous section (C to F) if there is not enough space.

If an identification is made, complete a "Victim Identification Report" in accordance with the instructions.

DEAD BODY		No: _____
Nature of disaster :	----- <i>Barcode</i>	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>

CHECKLIST OF OPERATIONS IN THE MORTUARY		Date	Remarks
Photographs	<i>With clothes</i> <input type="checkbox"/> <i>Without clothes</i> <input type="checkbox"/> Full size - front, back Head <i>Front</i> <input type="checkbox"/> <i>From left</i> <input type="checkbox"/> <i>From right</i> <input type="checkbox"/>		
Fingerprints	<input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Not Possible</i> <input type="checkbox"/> <i>Yes</i> Finger <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Not Possible</i> <input type="checkbox"/> <i>Yes</i> Palm of the hand		
Autopsy	<input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> Medicolegal examin. <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>X-rays</i> <input type="checkbox"/> <i>Photo</i> Full autopsy Pathologist name Address/Phone		
Dental examination	<input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>X-rays</i> <input type="checkbox"/> <i>Photo</i> Completed <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>X-rays</i> <input type="checkbox"/> <i>Photo</i> Jaws removed Odontologist name Address/Phone		
Samples	<input type="checkbox"/> <i>Taken</i> <input type="checkbox"/> <i>Sent for analysis</i> <input type="checkbox"/> <i>Result enclosed</i> (cf. E2 item 73) <input type="checkbox"/> <i>DNA profiles ordered</i>		

CHECK LIST OF CONTENTS		Enclosed complete	Enclosed in part	Issued to Name	Date	Returned Date	Remarks
B	Recovery from scene						
C1	Clothing and Foot wear						
C2	Personal Effects						
C3	Jewellery						
D1	Physical description						
D2	Physical desc. cont.						
D3	Physical desc. cont.						
D4	Body sketch						
D5	Fingerprint information						
E1	Internal examination						
E2	Medical conclusions						
E3	Skeleton sketch						
E4	DNA						
F1	Dental findings						
F2	Dental findings cont.						
G	Further information						

DEAD BODY	No: _____
Nature of disaster : _____	<i>Barcode</i>
Place of disaster : _____	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>
Date of disaster : <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	

a = Data not available b = Photo c = Further information on page G

RECOVERY OF BODY FROM SCENE			a	b	c
20	Apparent age	Min _____ Max _____ Txt: _____			
21	Date - and place where the body was found	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year			
	01 Map reference/GPS	Coordinates: _____ / _____			
	02 Photographs	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Digital 4 <input type="checkbox"/> Film 5 <input type="checkbox"/> Other /Specify: _____			
22	State of the body	Complete <input type="checkbox"/> Incomplete <input type="checkbox"/> Presentable <input type="checkbox"/> No 4 <input type="checkbox"/> Yes Body part(describe) <input type="checkbox"/> _____			
		1 Damaged 2 Burnt 3 Decomp. 4 Skelet. 5 Missing 6 Loose			
	01 Head				
	1A Neck / Throat				
	02 Right arm				
	03 Left arm				
	04 Right hand				
	05 Left hand				
	06 Body front				
	07 Body back				
	08 Right leg				
	09 Left leg				
	10 Right foot				
	11 Left foot				
22 A	Important ID information				
23	Person - finding the body				
	If an ID-team is involved - name officer in charge				
	Any other person - Name Address Phone/E-mail Occupation				

Registered by	Signature / Date
Duty Title : _____	
Name : _____	
Address : _____	
Phone/E-mail : _____	

DEAD BODY

Nature of disaster : _____ **No:** _____
Barcode

Place of disaster : _____ **Male** **Female** **Sex unknown**

Date of disaster : *Day* *Month* *Year*

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CLOTHING AND FOOT WEAR						a	b	c
24 Clothing Items	No:	1 Material	2 Colour	3 Type	4 Label	5 Size		
	01 Head and neck							
	0101 Hat							
	0102 Scarf							
	0103 Tie							
	0199 Other							
	02 Upper part of the body and arms							
	0201 Overcoat							
	0202 Coat							
	0203 Pullover							
	0204 Shirt							
	0205 Waistcoat							
	0206 Vest							
	0207 Dress							
	0208 Cardigan							
	0209 Blouse							
	0210 Petticoat							
	0211 Chemise							
	0212 Brassiere							
0213 Braces								
0214 Gloves								
0215 Jacket								
0299 Other								
03 Lower part of the body and legs								
0301 Trousers (men)								
0302 Underpants								
0303 Trousers (women)								
0304 Skirt								
0305 Panties								
0306 Girdle								
0307 Corset								
0308 Stockings								
0309 Tights								
0310 Socks								
0311 Belt								
0312 Belt buckle								
0313 Shorts								
0314 Swimming attire								
0399 Other								
04 The whole of the body								
0401 Flying suit								
0402 Boiler suit								
0403 Trouser suit								
0499 Other								
In case of using "xx99 Other" describe the kind of item in column "3 Type".								
25 Foot wear	No:	1 Material	2 Colour	3 Type	4 Label	5 Size		
	01 Shoes							
	1A Open footwear							
03 Boots								
99 Other								
Describe the kind of Foot wear in column "3 Type", eg Sport shoes Sandals								

Registered by Duty Title : _____
 Name : _____
 Address : _____
 Phone/E-mail : _____

Signature / Date _____

DEAD BODY		No: _____
Nature of disaster :	----- Barcode	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>

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PERSONAL EFFECTS		a	b	c
26 Watch 00 Wearing watch 01 Digital 02 Analog 03 Digital/Analog 04 If wrist watch worn on 05 Watch strap/chain 06 Watch, other type	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	No: 1 Material 2 Colour 3 Design 4 Brand 5 Inscription			
	Left Right Outside Inside			
	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>			
	Leather Metal Other (specify):			
	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>			
27 Glasses 00 Wearing glasses 01 Frame 02 Lenses (glass) 03 Lenses/Shape 3A Lens type 04 Contact lenses	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	1 Material 2 Colour 3 Design 4 Brand 5 Inscription			
	Tinted			
	1 <input type="checkbox"/> No 2 <input type="checkbox"/> yes (specify): _____			
	Strength - Left/Right			
	3 <input type="checkbox"/> L 4 <input type="checkbox"/> R			
28 Identity Papers 00 Carrying ID-papers 01 Passport 02 Driving licence 03 Credit cards 04 Identity card 05 Donor card 06 Travellers cheques 07 Personal cheques 08 Health card 99 Other	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	No: 1 Type 2 Photograph 3 Fingerprint 4 Blood type			
29 Effects 00 Carrying effects 01 Wallet 02 Purse 03 Money belt 04 Badges/keys 05 Currency 06 Mobile phone 07 PDA 08 Sim card 09 Ticket 10 Camera/Video 99 Other	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	No: 1 Material 2 Colour 3 Design 4 Brand 5 Markings			

Registered by Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date
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DEAD BODY		No: _____
Nature of disaster :	----- <i>Barcode</i>	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>

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PHYSICAL DESCRIPTION (at mortuary)						a	b	c
31	State of the body	Complete 1 <input type="checkbox"/>	Incomplete 2 <input type="checkbox"/>	Presentable 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Yes	Body part(describe) 5 <input type="checkbox"/>			
		1 Damaged	2 Burnt	3 Decomp.	4 Skelet.	5 Missing	6 Loose	
		01 Head						
		1A Neck / Throat						
		02 Right arm						
		03 Left arm						
		04 Right hand						
		05 Left hand						
		06 Body front						
		07 Body back						
		08 Right leg						
		09 Left leg						
	10 Right foot							
	11 Left foot							
Indicate specific details on body sketch, page D4.								
31	Estimated age	Min _____	Max _____	Method used ? _____				
32	Height	Min/cm _____	Max/cm _____	Method used ? _____				
33	Weight	Min/kg _____	Max/kg _____	Method used ? _____				
34	Build	Light 1 <input type="checkbox"/>	Medium 2 <input type="checkbox"/>	Heavy 3 <input type="checkbox"/>				
	01 Bodily constitution							
	02 Head form, front <small>(02-03 see Silhouette sketch)</small>	Oval 1 <input type="checkbox"/>	Pointheaded 2 <input type="checkbox"/>	Pyramidal 3 <input type="checkbox"/>	Circular 4 <input type="checkbox"/>	Rectangular 5 <input type="checkbox"/>	Quadrangular 6 <input type="checkbox"/>	
03 Head form, profile	Shallow 1 <input type="checkbox"/>	Medium 2 <input type="checkbox"/>	Deep 3 <input type="checkbox"/>					
35	Race	Caucasoid 1 <input type="checkbox"/>	Mongoloid 2 <input type="checkbox"/>	Negroid 3 <input type="checkbox"/>	Type: _____			
	01 Group							
02 Complexion	Light 1 <input type="checkbox"/>	Medium 2 <input type="checkbox"/>	Dark 3 <input type="checkbox"/>					
36	Hair of the head	Natural 1 <input type="checkbox"/>	Artificial 2 <input type="checkbox"/>	Hair-piece 3 <input type="checkbox"/>	Wig 4 <input type="checkbox"/>	Braided 5 <input type="checkbox"/>	Implanted 6 <input type="checkbox"/>	
	01 Type							
	02 Length	Short<6cm 1 <input type="checkbox"/>	Medium<12cm 2 <input type="checkbox"/>	Long>12cm 3 <input type="checkbox"/>	Shaved 4 <input type="checkbox"/>			
	03 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"/>	
	04 Shade of colour	Light 1 <input type="checkbox"/>	Medium 2 <input type="checkbox"/>	Dark 3 <input type="checkbox"/>	Turning grey 4 <input type="checkbox"/>	Dyed 5 <input type="checkbox"/>	Streaked 6 <input type="checkbox"/>	
	05 Thickness	Thin 1 <input type="checkbox"/>	Medium 2 <input type="checkbox"/>	Thick 3 <input type="checkbox"/>				
	06 Style	Straight 1 <input type="checkbox"/>	Wavy 2 <input type="checkbox"/>	Curly 3 <input type="checkbox"/>	Parted 4 <input type="checkbox"/> Left	5 <input type="checkbox"/> Right	6 <input type="checkbox"/> Middle	
	07 Baldness	Beginning 1 <input type="checkbox"/>	Advanced 2 <input type="checkbox"/>	Total 3 <input type="checkbox"/>	Forehead 4 <input type="checkbox"/>	Sides 5 <input type="checkbox"/>	Tonsure 6 <input type="checkbox"/>	
08 Other	(specify): _____							

Registered by Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date _____
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DEAD BODY		No: _____
Nature of disaster :	----- <i>Barcode</i>	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>

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PHYSICAL DESCRIPTION (cont.)							a	b	c		
37	Forehead	<i>Low</i>	<i>Medium</i>	<i>High</i>	<i>Narrow</i>	<i>Medium</i>	<i>Wide</i>				
		01 Height / Width <small>(01-02 see Silhouette sketch)</small>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> /	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>			
	02 Inclination	<i>Protruding</i>	<i>Vertical</i>	<i>Receding/slightly or clearly</i>							
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> S	4 <input type="checkbox"/> C						
38	Eyebrows	<i>Straight</i>	<i>Arched</i>	<i>Joining</i>	<i>Thin</i>	<i>Medium</i>	<i>Thick</i>				
		01 Shape / Thickness	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> /	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>			
	02 Peculiarities	<i>Plucked</i>	<i>Tattooed</i>								
		1 <input type="checkbox"/>	2 <input type="checkbox"/>								
39	Eyes	<i>Blue</i>	<i>Grey</i>	<i>Green</i>	<i>Brown</i>	<i>Black</i>					
		01 Colour	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>				
		02 Shade	<i>Light</i>	<i>Medium</i>	<i>Dark</i>	<i>Mixed</i>					
			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>					
	03 Distance between eyes	<i>Small</i>	<i>Medium</i>	<i>Large</i>							
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>							
	04 Peculiarities	<i>Cross-eyed</i>	<i>Squint-eyed</i>	<i>Artificial eye</i>							
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> Left	4 <input type="checkbox"/> Right						
40	Nose	<i>Small</i>	<i>Medium</i>	<i>Large</i>	<i>Pointed</i>	<i>Roman</i>	<i>Alcoholics</i>				
		01 Size / Shape	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> /	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>			
		02 Peculiarities	<i>Marks of spectacles</i>		<i>Misshapen</i>	<i>Other(specify):</i>					
		1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	3 <input type="checkbox"/>	4 <input type="checkbox"/>						
	03 Curve / Angle <small>(03 see Silhouette sketch)</small>	<i>Concave</i>	<i>Straight</i>	<i>Convex</i>	<i>Turned down</i>	<i>Horizontal</i>	<i>Turned up</i>				
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> /	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
41	Facial hair	<i>No beard</i>	<i>Moustache</i>	<i>Goatee</i>	<i>Whiskers</i>	<i>Full beard</i>					
		01 Type	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>				
	02 Colour	<i>Blond</i>	<i>Brown</i>	<i>Black</i>	<i>Red</i>	<i>Grey</i>	<i>White</i>				
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
42	Ears	<i>Small</i>	<i>Medium</i>	<i>Large</i>	<i>Close-set</i>	<i>Medium</i>	<i>Protruding</i>				
		01 Size / Angle	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> /	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>			
	02 Ear lobes / Pierced <small>(02 see Silhouette sketch)</small>	<i>Attached</i>	<i>Pierced - specify number of piercings</i>								
		1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes /	3 <input type="checkbox"/> Left	5 <input type="checkbox"/> Right						
43	Mouth	<i>Small</i>	<i>Medium</i>	<i>Large</i>	<i>Other (specify):</i>						
	01 Size / Other	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> /	4 <input type="checkbox"/>						
44	Lips	<i>Thin</i>	<i>Medium</i>	<i>Thick</i>	<i>Made up</i>	<i>Other (specify):</i>					
	01 Shape / Other	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> /	4 <input type="checkbox"/>	5 <input type="checkbox"/>					
45	Teeth (cf. page F1/F2)	<i>Natural</i>	<i>Untreated</i>	<i>Treated</i>	<i>Crowns</i>	<i>Bridges</i>	<i>Implants</i>				
		01 Conditions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>			
		02 Gaps / Missing teeth	<i>Gaps between front teeth</i>		<i>Missing teeth</i>		<i>Toothless</i>				
		1 <input type="checkbox"/> Upper	2 <input type="checkbox"/> Lower	3 <input type="checkbox"/> Upper	4 <input type="checkbox"/> Lower	5 <input type="checkbox"/> Upper	6 <input type="checkbox"/> Lower				
	03 Dentures	<i>Part.upper</i>	<i>Part.lower</i>	<i>Full upper</i>	<i>Full lower</i>	<i>ID-number(specify):</i>					
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>					
46	Smoking habits	<i>No</i>	<i>Teeth</i>	<i>Lips</i>	<i>Moustache</i>	<i>Finger / Hands</i>					
	01 Stains found	1 <input type="checkbox"/>	2 <input type="checkbox"/> /	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/> Left	6 <input type="checkbox"/> Right				

Registered by	Duty Title : _____	Signature / Date
	Name : _____	
	Address : _____	
	Phone/E-mail : _____	

DEAD BODY		No: _____
Nature of disaster :	----- Barcode	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>

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PHYSICAL DESCRIPTION (cont.)							a	b	c				
47	Chin	<i>Small</i>	<i>Medium</i>	<i>Large</i>	<i>Receding</i>	<i>Medium</i>	<i>Protruding</i>						
		01 Size / Inclination 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>						
	02 Shape	<i>Pointed</i> 1 <input type="checkbox"/>	<i>Round</i> 2 <input type="checkbox"/>	<i>Angular</i> 3 <input type="checkbox"/>	<i>Cleft chin</i> 4 <input type="checkbox"/>	<i>Groove</i> 5 <input type="checkbox"/>							
48	Neck	<i>Short</i>	<i>Medium</i>	<i>Long</i>	<i>Thin</i>	<i>Medium</i>	<i>Thick</i>						
		01 Length / Shape 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>						
	02 Peculiarities	<i>Goitre</i> 1 <input type="checkbox"/>	<i>Prominent Adams apple</i> 2 <input type="checkbox"/>	<i>Collar / Shirt No</i> 4 <input type="text"/>	<i>Circumference</i> 6 <input type="text"/> in cm								
49	Hands	<i>Slender</i>	<i>Medium</i>	<i>Broad</i>	<i>Small</i>	<i>Medium</i>	<i>Large</i>						
		01 Shape / Size 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>						
	02 Nail length	<i>Short</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>Long</i> 3 <input type="checkbox"/>									
	03 Peculiarities	<i>Bitten short</i> 1 <input type="checkbox"/>	<i>Manicured</i> 2 <input type="checkbox"/>	<i>Painted</i> 3 <input type="checkbox"/>	<i>Artificial</i> 4 <input type="checkbox"/>	<i>Nicotine</i> 5 <input type="checkbox"/> Left	6 <input type="checkbox"/> Right						
50	Feet	<i>Slender</i>	<i>Medium</i>	<i>Broad</i>	<i>Flatfooted</i>	<i>Arched</i>	<i>Length in cm</i>						
		01 Shape / Size 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="text"/>						
	02 Condition / Nail	<i>Bunion</i> 1 <input type="checkbox"/>	<i>Corn</i> 2 <input type="checkbox"/>	<i>Painted</i> 3 <input type="checkbox"/>	<i>Defective</i> 4 <input type="checkbox"/>								
	03 Peculiarities	<i>(Specify):</i> _____											
51	Body hair	<i>None</i>	<i>Slight</i>	<i>Medium</i>	<i>Pronounced</i>								
		01 Extent 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>								
	02 Colour	<i>Blond</i> 1 <input type="checkbox"/>	<i>Brown</i> 2 <input type="checkbox"/>	<i>Black</i> 3 <input type="checkbox"/>	<i>Red</i> 4 <input type="checkbox"/>	<i>Grey</i> 5 <input type="checkbox"/>	<i>White</i> 6 <input type="checkbox"/>						
52	Pubic hair	<i>None</i>	<i>Slight</i>	<i>Medium</i>	<i>Pronounced</i>	<i>Shaved</i>							
		01 Extent 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>							
	02 Colour	<i>Blond</i> 1 <input type="checkbox"/>	<i>Brown</i> 2 <input type="checkbox"/>	<i>Black</i> 3 <input type="checkbox"/>	<i>Red</i> 4 <input type="checkbox"/>	<i>Grey</i> 5 <input type="checkbox"/>	<i>White</i> 6 <input type="checkbox"/>						
53	Specific details	No:	1 Scars/Piercing	2 Skin marks	3 Tattoo marks	4 Malformations	5 Amputations						
		01 Head											
		1A Neck / Throat											
		02 Right arm											
		03 Left arm											
		04 Right hand											
		05 Left hand											
		06 Body - front											
		07 Body - back											
		08 Right leg											
		09 Left leg											
		10 Right foot											
11 Left foot													
----- Indicate specific details on body sketch, page D4.													
54	Circumcision	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes											
55	Other peculiarities												

Registered by	Duty Title : _____	Signature / Date
	Name : _____	
	Address : _____	
	Phone/E-mail : _____	

DEAD BODY

No: _____

Barcode

Nature of disaster : _____

Place of disaster : _____

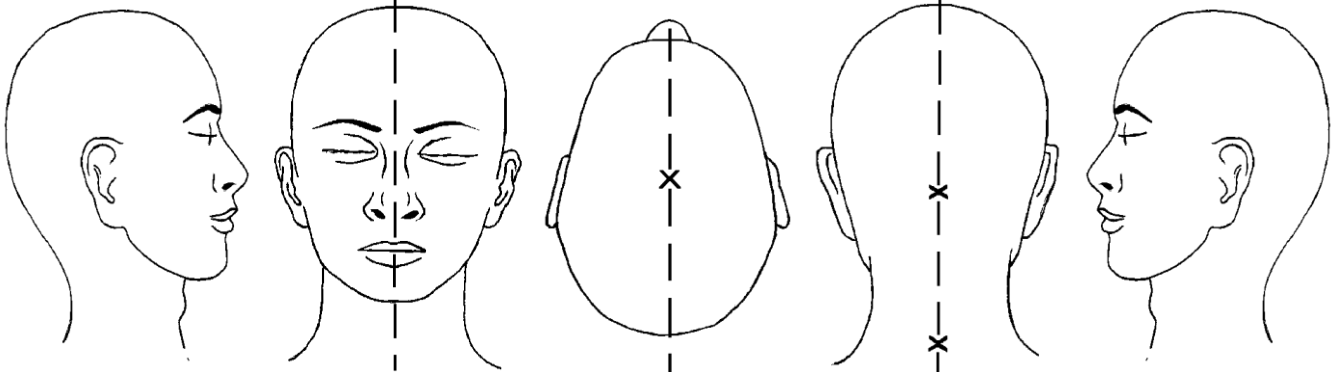
Date of disaster : Day Month Year

Male

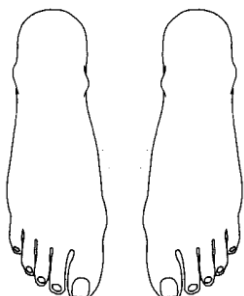
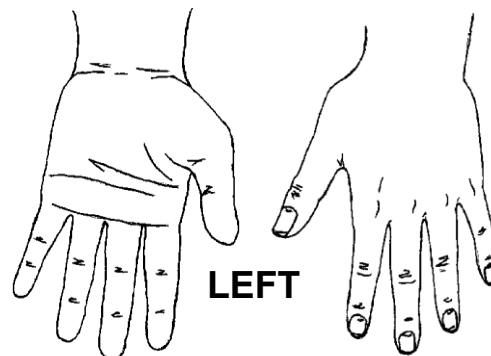
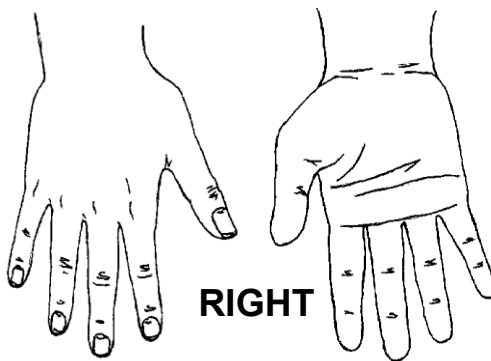
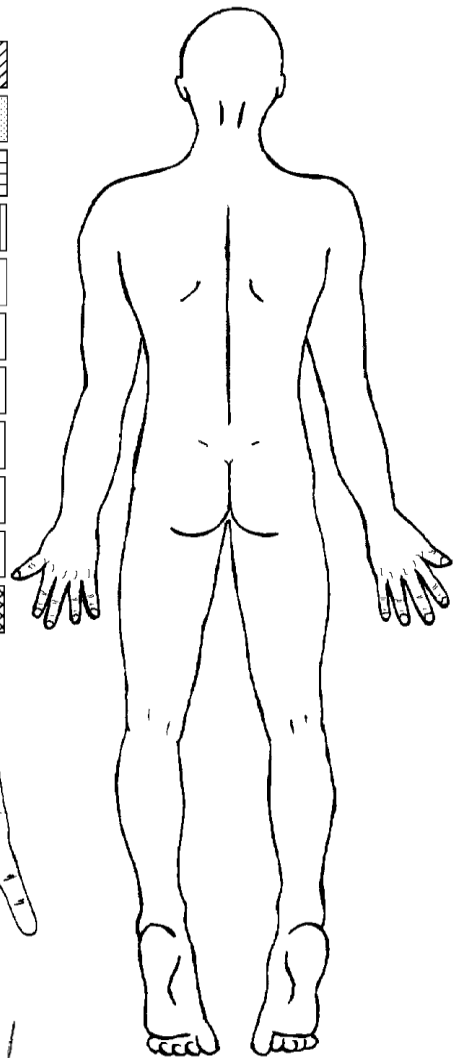
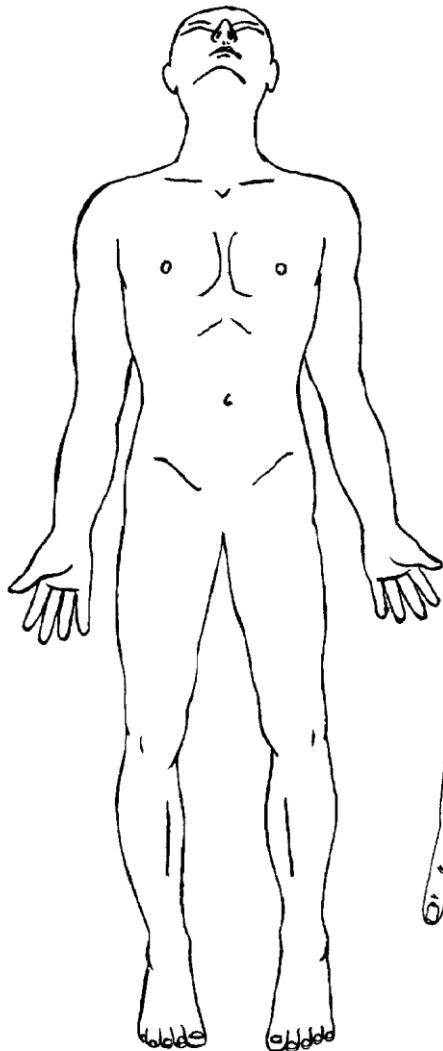
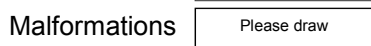
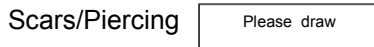
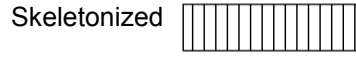
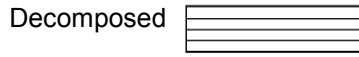
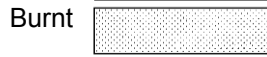
Female

Sex unknown

BODY SKETCH (described in item 22 and/or 31, 53)



Mark on charts



DEAD BODY		No: _____
Nature of disaster :	----- Barcode	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>

a = Data not available b = Photo c = Further information on page G

FINGERPRINT INFORMATION		a	b	c
01	Skin type fingerprints retrieved from	1 <input type="checkbox"/> EPIDERMIS 2 <input type="checkbox"/> DERMIS		
02	Fingerprint development technique	1 <input type="checkbox"/> Boiling water technique 2 <input type="checkbox"/> Epidermal glove 3 <input type="checkbox"/> Casting agent, eg Microsil, Aquasil 4 <input type="checkbox"/> Other: _____		
03	Fingerprints recorded using	1 <input type="checkbox"/> Black powder 2 <input type="checkbox"/> Ink 3 <input type="checkbox"/> Photograph 4 <input type="checkbox"/> Other: _____		
04	Prints retrieved from			

Registered by Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date : _____
--	--------------------------

DEAD BODY	No: _____
Nature of disaster : _____	<i>Barcode</i>
Place of disaster : _____	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>
Date of disaster : <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	

a = Data not available / Indefinable b = Photo c = Injuries and further information on page G d = X-rays

INTERNAL EXAMINATION - Full autopsy		<input type="checkbox"/> No <input type="checkbox"/> Yes - autopsy No:		a	b	c	d
60	Head 01 Head 1A Skull 1B Brain 02 Neck	No:					
61	Chest 01 Thorax/Ribs/Sternum 02 Lungs 03 Heart/Vessels						
62	Abdomen 01 Stomach 02 Intestines 03 Appendix						
63	Other internal organs 01 Adrenals/pancreas /Spleen 02 Liver/Gall bladder 03 Kidneys/Ureters/Bladder 04 Genitalia-male 05 Genitalia-female 06 Hysterectomy						
64	Skeleton/Soft tissue 01 Vertebral column 02 Pelvis 03 Limbs-right arm 04 Limbs-left arm 05 Limbs-right leg 06 Limbs-left leg 07 Other Bones 08 Soft tissue, other locations						
65	Various 01 Pregnancies 02 Healed fractures 03 Operations 04 Demonstrable pathological condition (e.g. heart disease, cancer etc.)						
	IMPLANT: 05 Intrauterine contraceptive devices	Metal 1 <input type="checkbox"/> Plastic 2 <input type="checkbox"/>	Describe: _____				
	06 Other implants	Metal 1 <input type="checkbox"/> Plastic 2 <input type="checkbox"/>	Describe: _____				

Continued item no 71 (Item 66 - 70 in form AM only)

Registered by Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date
--	------------------

DEAD BODY		No: _____
Nature of disaster :	----- <i>Barcode</i>	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>

MEDICAL CONCLUSIONS

71	Sex	<i>Male</i> 1 <input type="checkbox"/>	<i>Female</i> 2 <input type="checkbox"/>	<i>Undetermined</i> 3 <input type="checkbox"/>	<i>Reason of decision</i>
72	Estimated age	<i>Min</i> _____ , <i>Max</i> _____			<i>Method used</i>
73	Samples taken	<i>Purpose</i>		<i>Place of storage</i>	<i>Result</i>
	01 Stomach contents	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	02 Urine	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	03 Blood-heart	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	04 Blood-peripheral	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	05 Blood-elsewhere	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	06 Bile	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	07 Vitreous humour L	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	08 Vitreous humour R	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	09 Other fluids	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	10 Symphysis pubis	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	11 Hair	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	12 Tissue dry	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	13 Tissue in formalin	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	14 DNA-specimens	1 <input type="checkbox"/> <i>No</i>	2 <input type="checkbox"/> <i>Yes</i>		
	Where were the DNA samples taken from	<i>Specify:</i>			
	Number of DNA samples taken	<i>Specify:</i>			
74	Other clues for identification	1 <input type="checkbox"/> <i>No</i> 2 <input type="checkbox"/> <i>Yes (describe)</i>			
75	Other medical findings				

Continued item no 83 (Item 76 - 82 in form AM only)

Registered by	Signature / Date
Duty Title :	
Name :	
Address :	
Phone/E-mail :	

DEAD BODY

No: _____

Nature of disaster : _____

Barcode

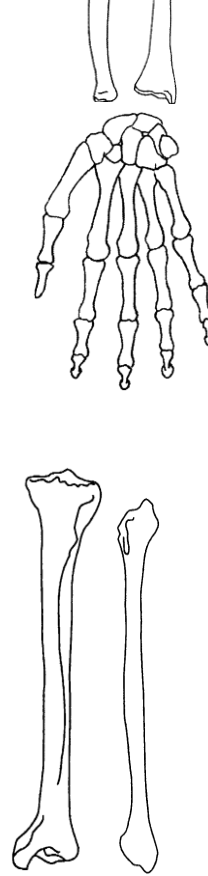
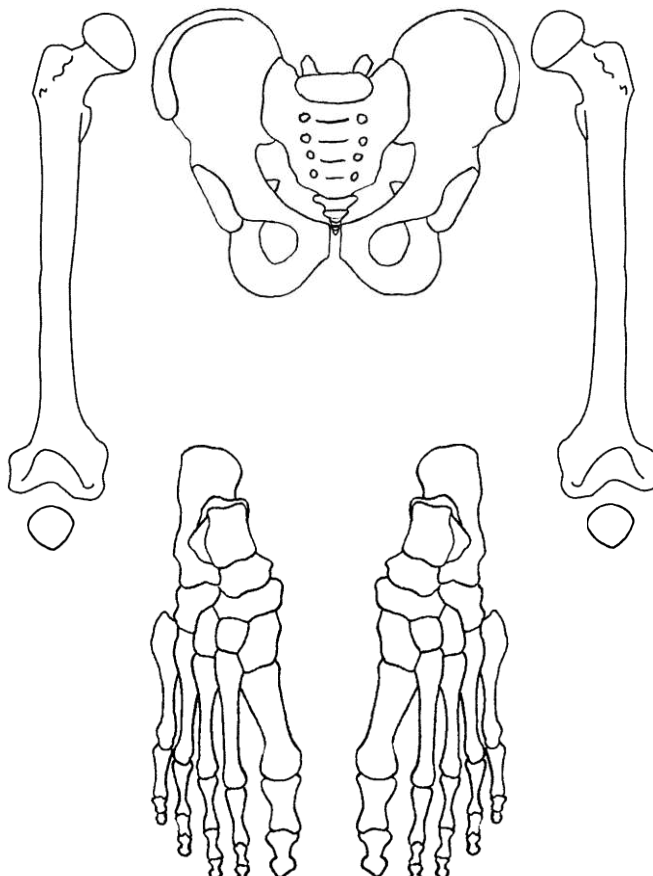
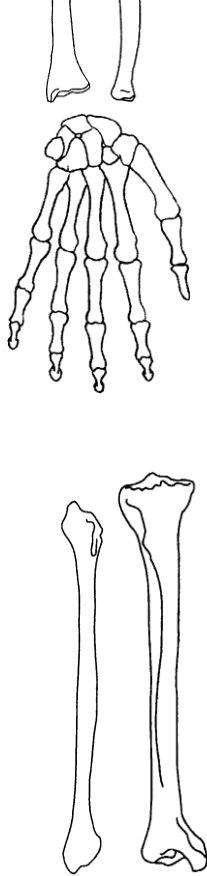
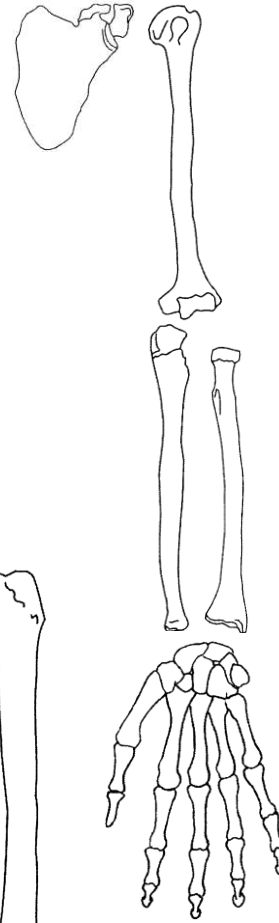
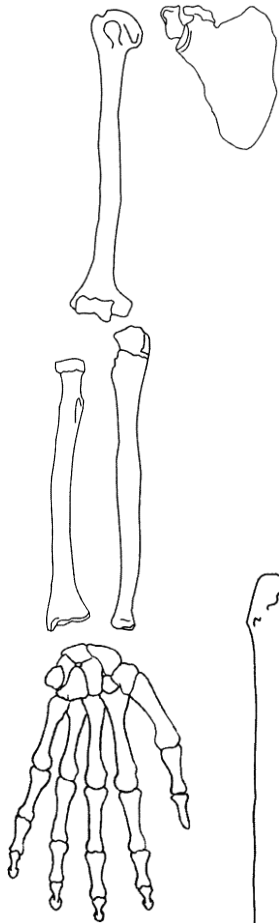
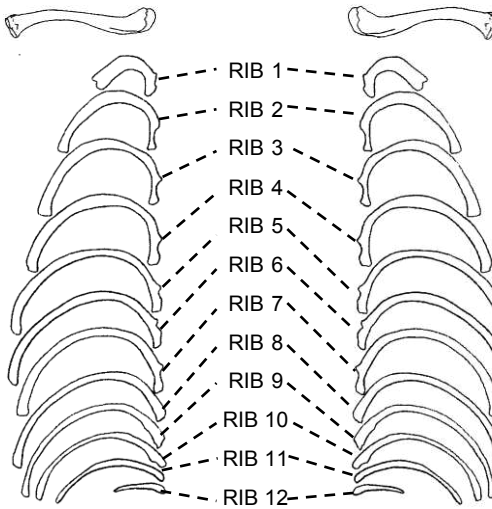
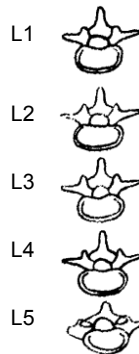
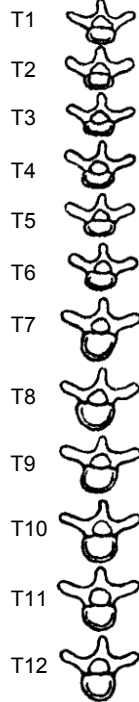
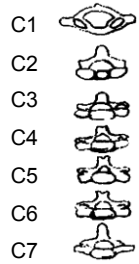
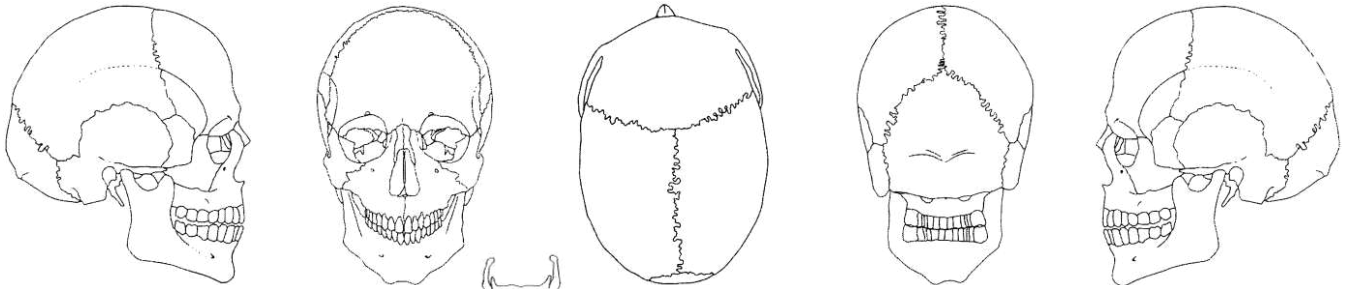
Place of disaster : _____

Date of disaster : Day Month Year

Male

Female

Sex unknown



DEAD BODY		No: _____
Nature of disaster :	-----	<i>Barcode</i>
Place of disaster :	-----	Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown <input type="checkbox"/>
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	

c = Further information on page G

DNA						c	
93	1. Sample	Received (date):					
		Label:					
		Type:					
		Condition:					
	2. Sample	Received (date):					
		Label:					
		Type:					
		Condition:					
	3. Sample	Received (date):					
		Label:					
		Type:					
		Condition:					
	4. Sample	Received (date):					
		Label:					
		Type:					
		Condition:					
94	DNA profiles	1. Sample	2. Sample	3. Sample	4. Sample		
	D3S1358						
	VWA						
	D16S539						
	D2S1338						
	Amelogenin						
	D8S1179						
	D21S11						
	D18S51						
	D19S433						
	TH01						
	FGA						
	TPOX						
	CSF1PO						
	D13S317						
	D7S820						
	D5S818						
	Penta D						
	Penta E						
	FES						
	F13A1						
	F13B						
	SE33						
	CD4						
	GABA						
95	Checked by	Date: _____				Signature: _____	

Registered by Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date : _____
--	--------------------------

DEAD BODY		No: _____
Nature of disaster :	-----	<i>Barcode</i>
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> <i>Day</i> <input type="text"/> <input type="text"/> <i>Month</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>Year</i>	<input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i> <input type="checkbox"/> <i>Sex unknown</i>

DENTAL FINDINGS

83	Recovery			
	Site of recovery Recovery No. Date Police Agency Address Phone/E-mail DENTAL EXAMINATION Requested by (date) Performed at (date)			
84	Remains recovered	PM material present for examination, describe specimens collected.		
	Exhibits:	<i>Check</i>	<i>Specimen taken</i>	<i>Stored at</i>
	01 Jaws with teeth	<i>Upper:</i> <input type="checkbox"/>	<i>Lower:</i> <input type="checkbox"/>	
	02 Jaws without teeth	<i>Upper:</i> <input type="checkbox"/>	<i>Lower:</i> <input type="checkbox"/>	
	03 Teeth only	<i>FDI #s:</i>		
	04 Fragments			
	05 Other			
85	Supplementary details			
	Condition of the body Condition of the jaws Injuries to - oral soft tissue - jaws - teeth Possible cause(s) of injuries Other details			

Registered by	Duty Title : Name : Address : Phone/E-mail :	Signature / Date
----------------------	---	------------------

The INTERPOL Victim Identification Form, Sections F1 and F2

GENERAL INFORMATION

The INTERPOL Victim Identification Form consists of several sections - divided into two groups:

- 1) YELLOW FORMS for listing latest known data concerning a missing person;
- 2) PINK FORMS for listing all findings concerning a dead body.

Identification of a dead body may become possible if data listed on the pink forms concerning this body can be compared with, and shown to match, data listed on the yellow forms concerning one particular missing person. If an identification is made, the experts involved will complete an Identification-Report - as a prerequisite to issuing a death certificate and releasing the body for burial.

The identification of a dead body may be accomplished in several ways, depending upon the type of data used. The INTERPOL Victim Identification Form has been set up in such a way, that sections listing the same type of data are marked with the same capital letter in the upper right-hand corner. For dental identification, the forms to use are Sections F1 and F2 (yellow), and Sections F1 and F2 (pink); because of the specialized vocabulary, they must be filled in by a forensically trained dentist.

INSTRUCTIONS FOR USE - SECTION F1 AND F2 PM (pink)

These forms are designed for listing all dental information collected during the dental examination of an unknown dead body (or remains thereof).

In Section F1, make sure that the reference number is clearly shown - and that the sex is clearly indicated (boxes at the top). Fill in all the details requested further down. Under "Supplementary Details", list any information at hand that may serve to explain the results obtained from the dental investigation, eg. where and when the body was found (co-ordinates), its condition (drowned, burned, skeleton), your own working conditions, presumed identity.

In Section F2, all dental findings related to the dead body must be listed. After having established full access to both jaws and cleaned all remaining teeth, describe in the spaces provided - tooth by tooth, at the right upper jaw with tooth 18, ending in the right lower jaw with tooth 48 - all treatment and other conditions found. Indicate surfaces by using Capital-Letter System: M = mesial, O = occlusal, D = distal, V = vestibular, L = lingual; if other abbreviations are used, please explain them in one of the boxes further down. (NOTE: there must be a notation for every tooth (or corresponding jaw area) recovered as part of the body!)- Next, sketch on the dental chart the location and extent of all fillings and other conditions found. For color distinction, use black for amalgam, red for gold, and green for tooth-colored material. For teeth missing ante mortem, put large cross (X) over the appropriate tooth square; for teeth missing postmortem (open socket), encircle the tooth number over/under the corresponding tooth square; for jaws sections not recovered, leave unmarked. Make sure that sketch and text tally. All X-rays taken in connection with the oral autopsy must be listed (type, date of exposure, teeth concerned). Supplementary examination may include photographic, microscopic, scanning electron microscopic (SEM), or metallographic examination of teeth and/or restoration removed from the body. Finally, and evaluation of age should always be given, either your own clinical estimate or, if teeth have been removed for this purpose, the method used and the result.

Once Section F2 has been completed, type your name, address and telephone number (or use your professional stamp) in the box at the bottom of Section F1. Finally, enter the date of completion above your personal signature. Remember - this is a legal document, so keep a full copy for your own file.

DEAD BODY		No: _____
Nature of disaster :	----- Barcode	
Place of disaster :	-----	
Date of disaster :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Sex unknown	

86	DENTAL FINDINGS for permanent teeth (Note primary teeth specifically)	
11		21
12		22
13		23
14		24
15		25
16		26
17		27
18		28

18	17	16	15	14	13	12	11		21	22	23	24	25	26	27	28
RIGHT									LEFT							
48	47	46	45	44	43	42	41		31	32	33	34	35	36	37	38
48		38														
47		37														
46		36														
45		35														
44		34														
43		33														
42		32														
41		31														

87	Specific description of Crowns, bridges, dentures and implants	
88	Further findings Occlusion, attrition, anomalies, smoker, periodontal status, supernumeraries, etc.	
89	Radiographs taken of Type and region	
90	Supplementary examination	
91	Estimated age	Min _____ / Max _____ Method used ?
96	Quality Check FOd 1 FOd 2 (If required)	Date: _____ Signature: _____ FOd 1 Name: _____ Date: _____ Signature: _____ FOd 2 Name: _____

F2 Prepared by	Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date
-----------------------	---	------------------

DEAD BODY

No: _____

Nature of disaster : _____

Barcode

Place of disaster : _____

Male

Female

Sex unknown

Date of disaster : Day Month Year

FURTHER INFORMATION (if referring to data given on a previous page, please indicate item number)

92

[Empty area for further information]

VICTIM IDENTIFICATION FORM

SILHOUETTE SKETCH

Please choose the appropriate sketches and mark items on D1 and D2

34 02 Head form, front (Shape of head from front)



1 Oval



2 Pointheaded



3 Pyramidal



4 Circular



5 Rectangular



6 Quadrangular

03 Head form, profile (Shape of head from side)



1 Shallow

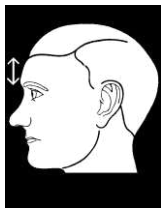


2 Medium

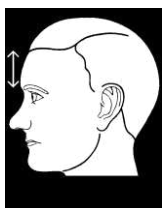


3 Deep

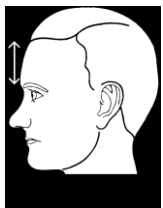
37 01 Forehead - Height/Width



1 Low



2 Medium



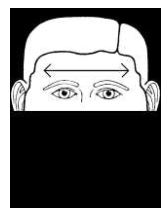
3 High



4 Narrow

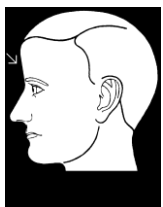


5 Medium



6 Wide

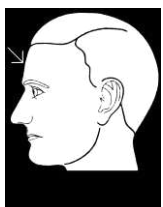
02 Forehead - Inclination



1 Protruding



2 Vertical



3 Receding



4 Receding clearly

40 03 Nose - Curve/Angle



1 Concave



2 Straight



3 Convex



4 Turned down



5 Horizontal



6 Turned up

42 02 Ear lobes



1 Not attached



2 Attached