1965-66, 1966-67

BIENNIAL REPORT

of the

CHIEF MEDICAL EXAMINER-CORONER

THOMAS T. NOGUCHI, M.D.

Chief Medical Examiner-Coroner

County of Los Angeles

COUNTY OF LOS ANGELES

BIENNIAL REPORT

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CHIEF MEDICAL EXAMINER-CORONER

FISCAL YEARS

JULY 1, 1965 - JUNE 30, 1966
JULY 1, 1966 - JUNE 30, 1967

BOARD OF SUPERVISORS

FRANK G. BONELLI, CHAIRMAN, 1966-1967

BURTON W. CHACE
ERNEST E. DEBS
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CHIEF ADMINISTRATIVE OFFICER

BURTON W. CHACE, CHAIRMAN,
COMMITTEE for the CORONER

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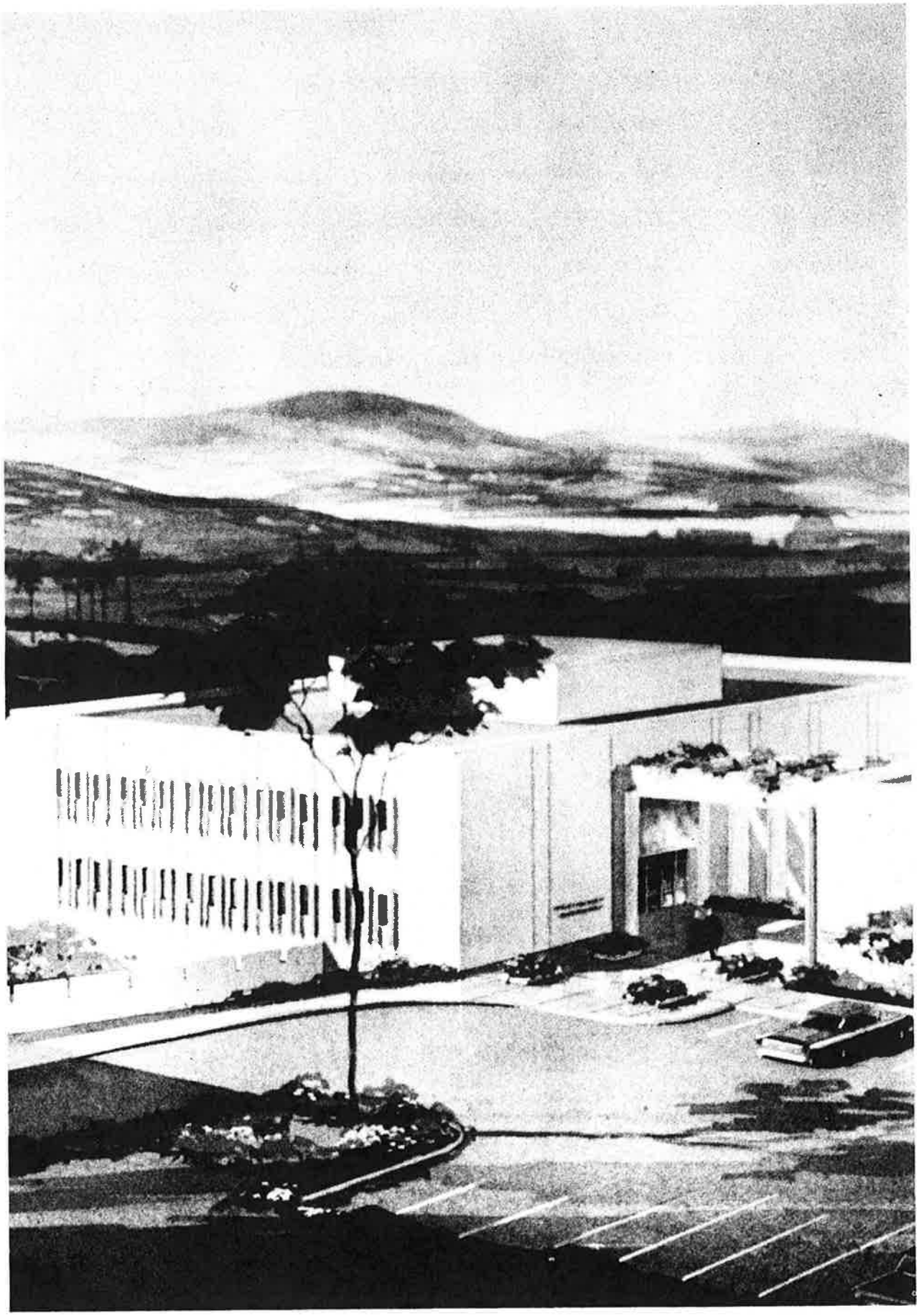

Proposed new Chief Medical Examiner-Coroner's Building

COUNTY OF LOS ANGELES

DEPARTMENT OF CHIEF MEDICAL EXAMINER – CORONER

HALL OF JUSTICE, LOS ANGELES, CALIFORNIA 90012

THOMAS T. NOGUCHI, M. D.
CHIEF MEDICAL EXAMINER-CORONER

Honorable Board of Supervisors
County of Los Angeles
Hall of Administration
500 W. Temple Street
Los Angeles, California 90012

Gentlemen:

Herein is presented a report for the biennium 1965-66 and 1966-67. As you know, the period covered by this report predates my appointment to the position of Chief Medical Examiner-Coroner. It is my opinion, however, that the material in this report reflects accurately the activities of this department during the last biennium.

During the 1965-67 biennium this department established an in-service training program for forensic pathologists. This program has the approval of the American Medical Association and is designed to train full-time pathologists with methods and procedures in forensic pathology.

The in-service training program for Coroner's Investigators was established late in the 1963-65 biennium. During these last two years we were able to enjoy the advantages of that program. Coroner's Investigators are trained to be particularly sensitive to the medical aspects of death and the evidence pertaining thereto. It is our hope that this program can be continued. Our ultimate objective is to utilize Coroner's Investigators on every case within the jurisdiction of this office.

I look forward to serving the people of Los Angeles County by constantly seeking the improvement and advancement of a modern medical examiner system.

Respectfully submitted,

Thomas T. Noguchi, M.D.

Thomas T. Noguchi, M.D.
Chief Medical Examiner-Coroner

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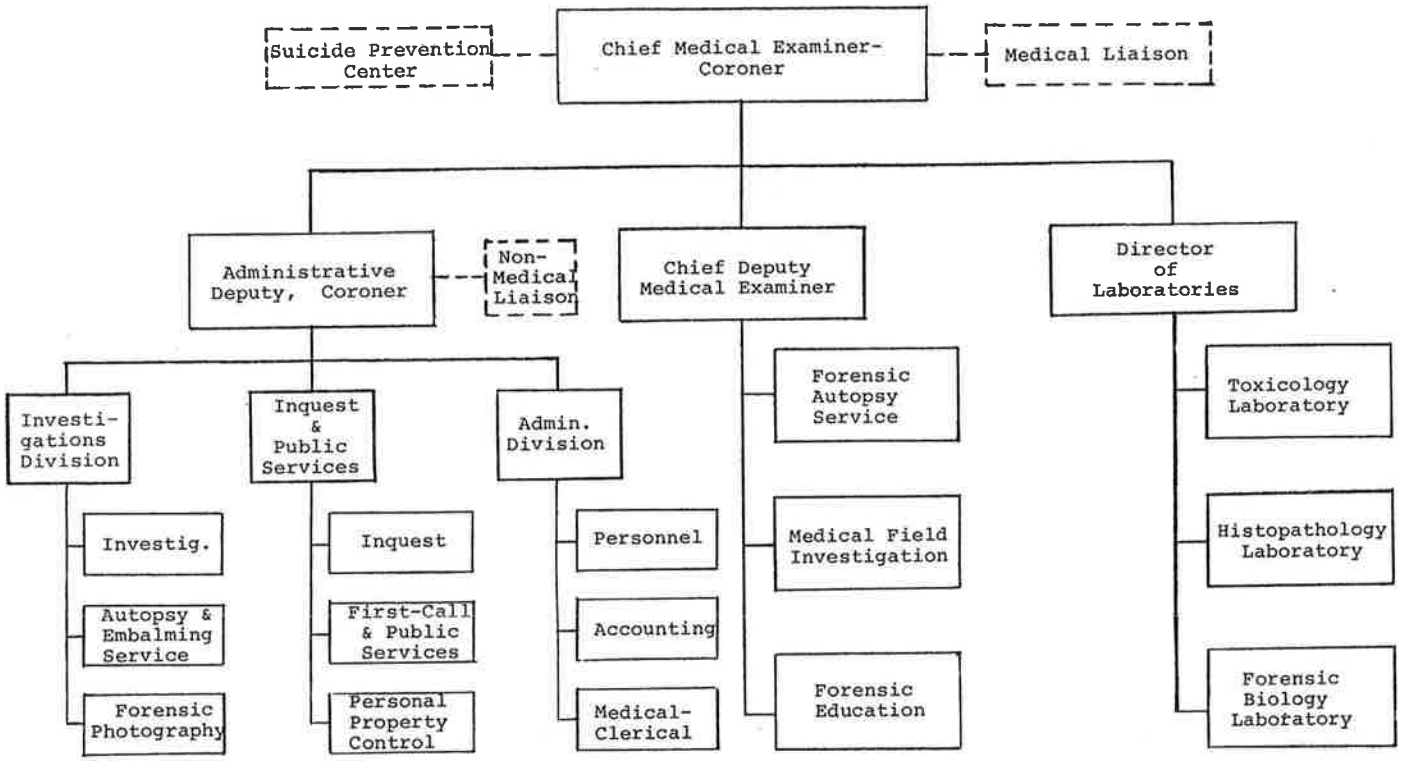

Suicide Prevention Center
Chief Medical Examiner-Coroner
Medical Liaison
Administrative Deputy, Coroner
Non-Medical Liaison
Chief Deputy Medical Examiner
Director of Laboratories
Investi-gations Division
Inquest & Public Services
Admin. Division
Forensic Autopsy Service
Toxicology Laboratory
Investig.
Autopsy & Embalming Service
Forensic Photography
Inquest
First-Call & Public Services
Personal Property Control
Personnel
Accounting
Medical-Clerical
Medical Field Investigation
Forensic Education
Histopathology Laboratory
Forensic Biology Laboratory

ORGANIZATIONAL STRUCTURE

During the 1966-67 fiscal year, management surveys were conducted which resulted in a reorganization of certain functional areas with this department. The chart delineates the major areas of functional control.

Within the framework of this structure, this department expects to systemize procedures and controls to the end that more effective service can be offered the public. A systems concept will provide more effective information feedback and lead to the development of even better management tools.

FINANCIAL STATEMENT

Expenditure*

	1965-66	1966-67
Salaries and employee benefits	$808,186.	$883,319.
Services and supplies	76,996.	80,610.
Fixed assets	3,678.	14,014.
	$888,861.	$977,943.

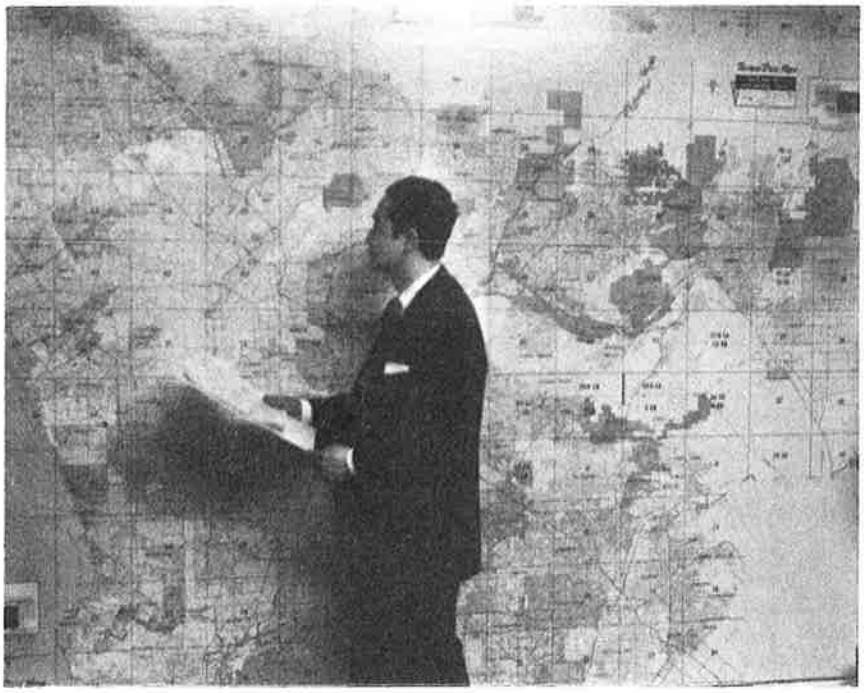
Income

	1965-66	1966-67
Embalming fees	$173,512.	$162,848.
Sale of documents	8,878.	9,468.
Witness fees	515.	370.
Transportation refunds	1,198.	1,564.
	$184,105.	$174,251.

*Cost per capita -- $0.129 (based on Los Angeles County Regional Planning Commission estimate of population - January 1, 1968.

OFFICE OF THE CHIEF MEDICAL EXAMINER-CORONER

The Chief Medical Examiner-Coroner is responsible for investigating and determining the circumstances, manner and cause of all sudden, unexpected, or unusual deaths in the County of Los Angeles. During the 1965-67 biennium, there were 109,121 deaths recorded in Los Angeles County. Of this total 25,515 deaths, or 25.4 percent, were within the jurisdiction of the Chief Medical Examiner-Coroner and investigated by this office.



During this report period 11,009 deaths were investigated and handled in our central facilities located in the Hall of Justice. The remaining 14,506 deaths were handled at those private mortuaries who act as representatives of the Chief Medical Examiner-Coroner.

Table No. 1

NUMBER OF CASES INVESTIGATED

	1965-66	1966-67	Total
In central examining facilities	5,608	5,401	11,009
In other than central examining facilities	7,520	6,986	14,506
	13,128	12,387	25,515

With the increasing case load, and the complexity of modern pathological methods, this office finds it difficult to meet the minimal requirements of our responsibility to the citizens in Los Angeles County. Modern facilities are imperative if we are to fulfill our legal obligations in this sensitive area of public service.

REPORTABLE DEATHS TO THE CORONER

The Government Code of the State of California, Section 27491, directs the Coroner to inquire into and determine the circumstances, manner and cause of the following deaths which are immediately reportable to the Coroner:

1. Without medical attendance.
2. Wherein the deceased has not been attended by a physician within 10 days prior to death.
3. Where the attending physician is unable to state the cause of death.
4. Known or suspected homicides.
5. Known or suspected suicides.
6. Where the deceased died as a result of an accident.
7. Related to or following known or suspected self-induced or criminal abortion.
8. Therapeutic misadventures.
9. Accidental poisoning (food, chemical, drugs, therapeutic agents.)
10. Poison deaths.
11. Drowning, fire, hanging, gunshot, stabbing, cutting, strangulation, exposure, heat prostration, alcoholism, drug addiction, aspiration deaths, and suffocation.
12. Occupational diseases or occupational hazards.
13. Known or suspected contagious diseases constituting a public hazard.
14. All deaths of unattended persons.
15. Under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another.

CHIEF DEPUTY MEDICAL EXAMINER

The Chief Deputy Medical Examiner is responsible to the Chief Medical Examiner-Coroner for the Medical Division. Two medical service programs are conducted by this division; Forensic Autopsy Service and Forensic Medicine Education.

Forensic Autopsy Service

The post-mortem medical investigation is conducted by doctors of medicine in a specialized branch of pathology. The service rendered by the Deputy Medical Examiners can reveal facts which may direct attention to hazardous conditions of employment, the existence of disease or the commission of a crime. The post-mortem examinations are conducted in our Hall of Justice facility and at mortuaries who act as representatives for the Coroner.

Forensic Medicine Education

The Senior Deputy Medical Examiner on each shift is responsible for conducting a training program designed to acquaint new Deputy Medical Examiners with the methods and procedures of the Chief Medical Examiner-Coroner's Office.

This program will encompass a review of the gross autopsy findings in assigned cases, preparation of the medical report, the format of the autopsy protocol, and exposure to the other records relating to a coroner's case. This educational program utilizes specialists in related fields, such as neuropathologists, forensic toxicologists and human behavioral scientists.

ADMINISTRATIVE DEPUTY, CORONER

The Administrative Deputy, Coroner, is responsible to the Chief Medical Examiner-Coroner for the administrative functions with which this office is charged. Public information and non-medical liaison are responsibilities personally supervised by the Administrative Deputy. His other functional tasks are within three distinct areas of operational control; (1) the Administration Division, (2) the Inquest and Public Services Division, and (3) the Investigations/Mortuary Division.

ADMINISTRATION DIVISION

The Administration Division is responsible for financial planning, personnel, maintenance of the Chief Medical Examiner-Coroner's permanent records, payroll and accounting.

Also within the Administration Division, the Stenographic and Control Section provides secretarial service to the professional staff as well as maintaining files on approximately 13,000 cases annually.

INQUEST AND PUBLIC SERVICES DIVISION

This division is responsible for the preparation and conducting of all formal inquests. The inquest is a fact-finding, public hearing to determine if a death was caused by the criminal act of another person. This office averages at least one inquest daily. Inquest proceedings are available to the District Attorney, all law enforcement agencies and other interested persons.

During the 1965-67 biennium this division conducted 312 inquests.

Public Services Section

The initial reports of death are received by this section and, after tape recording, the reports are processed in a manner designed to ascertain whether cases are within the jurisdiction of the Chief Medical Examiner-Coroner's Office.

Public Services responsibilities include notifying next of kin, assuming custody of personal property and the release of remains and property of deceased persons, preparation and issuance of death certificates, and maintenance of statistical data.

INVESTIGATIONS/MORTUARY DIVISION

This division is responsible for the operation of the Chief Medical Examiner-Coroner's Office mortuary in the Hall of Justice. Its personnel work closely with other governmental agencies in the on-the-scene medical investigation of coroner's cases. This division also assumes custody of personal property found on the person of the deceased, transports coroner's cases within the metropolitan area of Los Angeles, embalms and preserves bodies. Because of the importance of medical examination without artifact, and because of the availability of scientific equipment and competent sources of consultation, deaths known or suspected to be due to homicide, abortion, narcotic, or airplane or scuba diving accidents are investigated and transported to the Hall of Justice from any location within Los Angeles County. In addition, personnel of the Mortuary Division assist Deputy Medical Examiners at the autopsy table and take and process photographs as required.

During the 1965-67 biennium, the Department of Chief Medical Examiner-Coroner harvested the benefits of the in-service training program in medical investigation which had been made available to the personnel of the division in the previous two years. The training, reclassifications, and specialized assignments resulted in an expansion of the department's metropolitan district boundaries, which resulted in the processing of an additional 1,531 cases at the Hall of Justice with no increase in the number of personnel assigned to the Mortuary Division.

Current plans for the Mortuary Division include further training in the field of coroner investigations as well as the acquisition of more modern photographic equipment.

Table No. 2

Investigations/Mortuary Division

	1965-66	1966-67	Total
Number of bodies embalmed	4,066	3,728	7,794

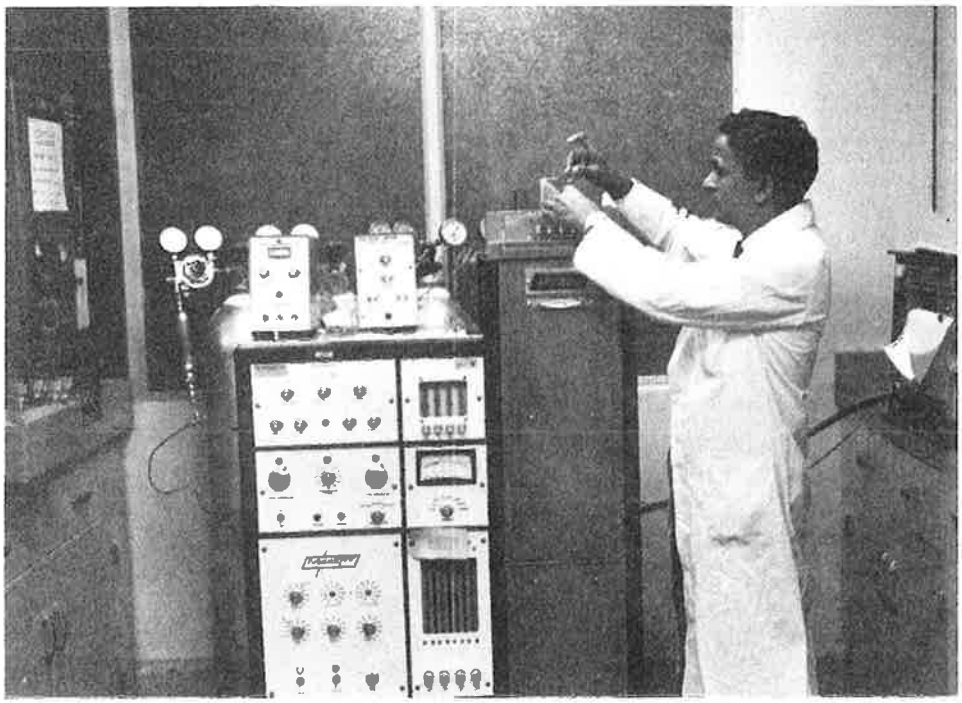
Table No. 3

Photography

	1965-66	1966-67	Total
Negatives made and processed	3,463	3,563	7,026
Black-and-white prints made and processed	6,773	7,177	13,950
Color slides	80	12	92
Black-and-white slides	31	7	38
X-rays	399	457	856
Enlargements	106	42	148
At-scene prints	2,545	2,733	5,278
	13,397	13,991	27,388

DIRECTOR OF LABORATORIES

The Director of Laboratories is responsible for the operation and control of the three laboratories; Toxicology, Histopathology and Forensic Biology.



The Toxicology Laboratory is responsible for conducting qualitative and quantitative analyses on specimens submitted by the Deputy Medical Examiners to determine the presence or absence of poisons, drugs or other chemicals. It is also responsible for related duties such as interpretation of toxicological tests and testifying in court.

The purpose of toxicological tests is to assist the Deputy Medical Examiners in determining the cause of death, and in some instances, the mode of death. Many poisons, chemicals and drugs will have indeterminate or no pathological evidence of ingestion. In these cases, the sole physical evidence of a drug death may be a toxicological report. In addition to assisting in the determination of the cause of death, there are some chemical tests, notably blood alcohol determinations, which are extremely important in contributing to the mode of death. Criminal responsibility also may be determined by toxicological tests.

Since the consequence of the toxicological testing are of such a vital nature, it is mandatory that they be conducted by a fully professional staff, equipped with the necessary scientific equipment.

The testing procedures are far from routine due to difficulties of working with biological material and to an almost unlimited number of poisons which may be encountered by the toxicologist. Any of the medicines or their metabolites on the market today may be encountered by the toxicologist in a search for poisons. Biological material also contains substances closely resembling some of these drugs and poisons. The search for these materials and interpretation of findings are what constitutes the field of forensic toxicology. Because of the unique nature of this field, it is necessary that the staff maintain communication with the relatively few other toxicologists in the world, both through professional societies and published papers.

The following are a few illustrative cases in which a toxicological report was vital:

1. Case of public interest

   A well known movie star was found dead at home. In the vicinity containers of medicine were found. The star was taking medication to break his alcoholic habits. No cause of death was found at autopsy. The toxicological analysis indicated that paraldehyde was detected in the body and the amount of paraldehyde detected indicated overdosage. A tranquilizer was also detected. The amount of paraldehyde and the tranquilizer detected in the body of the star constituted the cause of death.

2. A narcotic death

   Many deaths are caused by overdosages of morphine. Some are suicides, and a number of these are accidental. Accidental poisonings are cause by a combination of alcohol and narcotics.

   A young man was found dead, and no cause of death could be determined at autopsy. Blood alcohol level was found to be .21 percent. Morphine could not be detected in the liver, bile and urine. Traces of morphine were detected in the blood. This indicated that death occurred shortly after injection of morphine. This amount of morphine may not have been fatal under ordinary circumstances, but in combination with the amount of alcohol in the blood, it constituted the cause of death.

   It took three and one-half weeks of thorough analysis on a number of specimens before this case could be completed sucessfully.

3. Criminal liability

   A person was charged with committing murder by injecting insulin in his victim. The victim had taken a barbiturate earlier and a slight amount of barbiturate was shown in the blood. It was contended in court that the barbiturate could have been the cause of death. The Toxicologist from this department testified that the amount of barbiturate detected in the blood could not be considered toxic enough to cause death.

These cases were selected to illustrate a few of the ways a toxicological report can be of value, not only to the citizens of the community, but to the survivors of the deceased from an economic, social or legal standpoint. The relatively modest investment of the taxpayer's money for these services continues to be one of the best bargains available in government today.

IMMEDIATE CAUSES OF DEATH DETERMINED BY LABORATORY TEST

Table No. 4

1965-66

Type of Test	Total Tests	Total Number of Cases Certified	Percent of Total Cases Tested
Alcohol	4,753	38	.07%
Barbiturates	898	419	46.9%
Carbon monoxide	291	85	29.2%
Narcotics	108	41	37.9%
Poisons	513	80	17.5%
	6,563	663	10.1%

Table No. 5

1966-67

Type of Test	Total Tests	Total Number of Cases Certified	Percent of Total Cases Tested
Alcohol	4,630	33	.07%
Barbiturates	892	335	37.6%
Carbon monoxide	302	115	38.1%
Narcotics	235	117	49.8%
Poisons	821	85	10.4%
	6,880	685	10.1%

Histopathology Laboratory

This laboratory has the responsibility of processing and preparing microscopic slides, as requested by the Deputy Medical Examiners.

Table No. 6

HISTOPATHOLOGY LABORATORY SERVICES

	1965-66	1966-67	Total
Microscopic examinations	20,890	17,933	38,823
Special tissue stains	325	225	550
Cytology examinations	82	9	91
Routine tissues filed (hold jars)	6,224	5,748	11,972
	27,521	23,915	51,436

Our laboratory is concerned primarily with the histology of tissue from victims of trauma or disease. Microscopic studies are invaluable to our Deputy Medical Examiners in the determination of causes of death.

Forensic Biology Laboratory

This laboratory is responsible for conducting bacteriological studies. Studies may or may not indicate the presence of communicable disease in specimen samples from deceased persons. The discovery of the presence of these diseases may contribute effectively to the early control of possible epidemics.

All laboratories contribute to the Deputy Medical Examiner's investigation into the cause of death. As the science of pathology continues to develop, the laboratory function becomes increasingly more important.

S T A T I S T I C S

Table No. 7

MANNER OF DEATH - MEDICAL EXAMINER CASES

	1965-66		1966-67	
Manner of Death	Total Cases	Percent of Total	Total Cases	Percent of Total
Natural causes*	7,921	60.5	7,192	57.4
Home accidents	1,174	8.6	1,061	8.6
Vehicular accidents	1,153	8.8	1,218	9.8
Suicides	1,258	9.5	1,197	9.6
Homicides	484	3.7	503	4.2
Other fatal accidents	714	5.5	687	5.6
Industrial accidents	105	.7	134	1.1
Undetermined-natural	43	.3	87	.9
Aircraft	21	.2	23	.2
Criminal abortions	5	.1	3	.1
Railway accidents	10	.1	8	.1
Stillbirths	71	.5	63	.6
Misc. accidents; (accident-suicide; accident-homicide; unspecified)	169	1.5	211	1.9
TOTAL	13,128	100.0	12,387	100.0

*Excluding symptoms of senility and ill-defined conditions shown in the table.

Table No. 8

AUTOPSIES PERFORMED AND MANNER OF DEATH

Manner of Death	1965-66			1966-67		
	Total Cases	Autopsies Performed	Percent of Cases Autopsied	Total Cases	Autopsies Performed	Percent of Cases Autopsied
Natural causes	7,921	2,336	29.6	7,192	2,046	28.4
Home accidents	1,174	422	36.8	1,061	364	34.3
Vehicular accidents	1,153	1,040	90.2	1,218	1,088	89.2
Suicides	1,258	677	54.0	1,197	552	46.2
Homicides	484	472	97.5*	503	460	91.2*
Other accidents	714	314	44.0	687	214	21.2
Industrial accidents	105	102	97.1	134	118	88.1
Undetermined	43	18	44.4	87	16	18.1
Aircraft accidents	21	14	66.6**	23	23	100.0**
Abortions	5	5	100.0	3	2	66.6
Railway accidents	10	5	50.0	8	4	50.0
Stillbirths	71	29	40.8	63	22	34.8
Misc. accidents; accident-suicide; accident-homicide; unspecif.	169	21	12.4	211	16	7.6
TOTAL	13,128	5,455	41.5	12,387	4,925	39.8

* Homicides not autopsied were homicide-suicide cases.
** Pilots autopsied in each accident.

Table No. 9

DEATHS FROM NATURAL CAUSES - IN MAJOR GROUPS
(INTERNATIONAL LIST)

	1965-66		1966-67	
	Total Cases	Percent of Total	Total Cases	Percent of Total
Infective and parasitic diseases	40	.5	55	.8
Neoplasms	171	2.1	147	2.0
Allergic, endocrine, metabolic and nutritional diseases	49	.5	26	.3
Diseases of the blood and blood-forming organs	2	.1	6	.1
Mental, psychoneurotic and personality disorders	54	.7	47	.5
Diseases of the nervous system and sense organs	276	3.5	235	3.4
Diseases of the circulatory system	5,817	72.4	5,422	74.0
Diseases of the respiratory system	754	9.4	600	8.2
Diseases of the digestive system	636	7.9	557	7.5
Diseases of the genito-urinary system	15	.2	21	.3
Diseases of pregnancy, childbirth and the puerperium	10	.1	2	.1
Diseases of the bones and other organs of movement	2	.1	2	.1
Congenital malformations	41	.5	20	.2
Diseases of early infancy, prematurity	54	.7	52	.7
Symptoms, senility and ill-defined conditions	43	.4	87	1.0
Stillbirths	71	.9	63	.8
TOTAL	8,035	100.0	7,342	100.0

Table No. 10

OCCUPATIONAL ACCIDENTS - TYPE OF ACCIDENT

Type of Accident	1965-66	1966-67	Total
Drowning	1	3	4
Crushing	5	7	12
Vehicles	4	1	5
Falls	31	38	69
Caught in machinery	15	15	30
Electrocution	5	6	11
Burns	11	29	40
Other	33	35	68
TOTAL	105	134	239

Table No. 11

HOME ACCIDENTS - TYPE OF ACCIDENT

Type of Accident	1965-66	1966-67	Total
Crushing	9	7	16
Falls	753	656	1,409
Drownings	88	78	166
Burns	151	172	323
Firearms	24	16	40
Poisonings	42	41	83
Suffocation	26	23	49
Plastic bags	3	5	8
Gas heater	26	23	49
Electrocutions	6	8	14
Other	46	32	78
TOTAL	1,174	1,061	2,235

Table No. 12

VEHICULAR ACCIDENTS - TYPE OF ACCIDENT

	1965-66		1966-67	
	Total Cases	Percent of Total	Total Cases	Percent of Total
Pedestrian struck by truck	21	1.8	36	3.0
Pedestrian struck by auto	326	28.3	357	29.0
Pedestrian struck by bus	3	.3	11	1.0
Auto and auto collision	275	24.0	309	25.4
Auto and bus collision	1	--	1	--
Auto and truck collision	51	4.5	50	4.1
Auto and train collision	24	2.1	15	1.2
Auto and motorcycle collision	52	4.5	44	3.6
Auto and bicycle collision	8	.7	19	1.6
Auto and scooter collision	1	--	1	--
Truck and train collision	1	--	0	--
Auto into fixed object	185	16.0	193	16.0
Auto overturned	29	2.5	15	1.3
Auto off roadway	72	6.2	79	6.5
Fall from moving vehicle	8	.6	4	.3
Motorcycle into fixed object	26	2.2	24	2.0
Truck and motorcycle collision	2	--	9	.8
Miscellaneous	68	6.3	51	4.2
TOTAL	1,153	100.0	1,218	100.0

Table No. 13

OTHER FATAL ACCIDENTS

Manner	1965-66	1966-67	Total
Suffocation	3	2	5
Electrocution	2	4	6
Burns	14	25	39
Falls	556	514	1,070
Drownings	34	37	71
Poisonings	17	7	24
Crushing	3	2	5
Carbon monoxide	2	2	4
Firearms	7	8	15
Therapeutic accidents	55	68	123
Other	21	18	39
TOTAL	714	687	1,401

Table No. 14

SUICIDES

Manner	1965-66	1966-67	Total
Vehicles	2	1	3
Firearms	411	426	837
Hanging	116	96	212
Carbon monoxide	84	95	179
Jumping	36	42	78
Barbiturates	418	315	733
Poisons	123	144	267
Sharp instrument	24	29	53
Drowning	1	1	2
Suffocation (plastic bag)	20	23	43
Burns	19	22	41
Miscellaneous	4	3	7
TOTAL	1,258	1,197	2,455

Table No. 15

HOMICIDES

Manner	1965-66	1966-67	Total
Firearms	303	291	594
Sharp instrument	75	87	162
Blunt instrument	30	12	42
Strangulation	15	27	42
Assault	43	73	116
Criminal abortions	5	3	8
Miscellaneous	18	13	31
TOTAL	489	506	995

Table No. 16

DEATHS CAUSED OR CONTRIBUTED TO BY ALCOHOLISM

Classification	1965-66	1966-67	Total
Acute alcoholism	35	31	66
Chronic alcoholism	39	9	48
Cirrhosis and fatty liver	431	321	752
Highway accidents	252	287	539
Home accidents	402	343	745
Other fatal accidents	29	34	63
Industrial accidents	4	3	7
Railroad accidents	3	3	6
Homicides	155	157	312
Suicides	234	254	488
Natural cases	126	150	276
TOTAL	1,710	1,592	3,302

Table No. 17

INCIDENCES OF ALCOHOLISM IN
HOMICIDES, SUICIDES AND ACCIDENTS
1965-66

Manner	Total Cases	Negative or No Test	0.01-0.04	0.05-0.09	0.10-0.14	0.15-and up	Percent of Incidence of Alcoholism
Homicides	485	269	26	35	35	120	44.5
Suicides	1,258	908	40	76	56	178	27.8
Home accidents	1,174	645	53	74	73	329	45.1
Other fatal accidents	714	675	5	5	5	24	5.5
Vehicular accidents	1,153	826	25	50	52	200	28.4
Pedestrians	359	285	5	13	12	44	20.6
Passengers	276	218	8	8	14	28	20.7
Drivers	517	323	12	29	26	127	37.5

Table No. 18

INCIDENCES OF ALCOHOLISM IN
HOMICIDES, SUICIDES AND ACCIDENTS
1966-67

Manner	Total Cases	Negative or No Test	0.01-0.04	0.05-0.09	0.10-0.14	0.15-and up	Percent of Incidence of Alcoholism
Homicides	503	296	17	33	34	123	41.2
Suicides	1,197	838	50	55	67	187	29.9
Home accidents	1,061	621	30	67	61	282	41.5
Other fatal accidents	687	641	6	6	4	30	6.7
Vehicular accidents	1,218	863	23	45	52	235	20.9
Pedestrians	467	378	2	6	10	71	19.0
Passengers	243	166	16	19	13	29	27.6
Drivers	501	302	15	20	29	135	39.7

A P P E N D I X

Table No. 19

DEATHS BY AGE GROUPS -- 1965-66

Age Groups	Natural	Accident	Suicide	Homicide	Total
Stillbirths	71				71
Under 1 month	60	7			67
1 month to 1 year	362	39		11	412
1 to 14 years	123	310	7	19	459
15 to 29 years	121	499	190	167	977
30 to 39 years	296	262	200	108	866
40 to 49 years	924	302	294	80	1,600
50 to 59 years	1,527	346	269	57	2,199
60 to 69 years	1,942	250	161	30	2,483
70 to 99 years	2,602	1,228	137	16	3,983
100 years & over	5	3		1	9
Age unknown	2				2
TOTAL	8,035	3,346	1,258	489	13,128

Table No. 20

DEATHS BY AGE GROUPS -- 1966-67

Age Groups	Natural	Accident	Suicide	Homicide	Total
Stillbirths	63				63
Under 1 month	66	6		3	75
1 month to 1 year	348	35		11	394
1 to 14 years	91	325	4	27	447
15 to 29 years	145	555	216	181	1,097
30 to 39 years	266	295	186	122	869
40 to 49 years	841	333	273	73	1,520
50 to 59 years	1,528	325	253	52	2,158
60 to 69 years	1,704	310	141	15	2,170
70 to 99 years	2,283	1,152	124	20	3,579
100 years & over	2	5			7
Age unknown	5	1		2	8
TOTAL	7,342	3,342	1,197	506	12,387

DUTIES, FUNCTIONS, AND RESPONSIBILITIES OF THE CHIEF MEDICAL EXAMINER-CORONER

The duties of the Coroner are set up in the Government Code as follows:

Section 27491, Government Code:

"It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden or unusual deaths; unattended deaths; deaths wherein the deceased has not been attended by a physician in the ten days before death; deaths related to or following known or suspected self-induced or criminal abortion; known or suspected homicide, suicide, or accidental poisoning; deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent; deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, alcoholism, drug addiction, strangulation, or aspiration; death in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape or crime against nature; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public hazard; deaths from occupational diseases or occupational hazards; deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another, or any deaths reported by physicians or other persons having knowledge of death for inquiry by the coroner. Inquiry in this section does not include those investigative functions usually performed by other law enforcement agencies."

EXAMINATION, IDENTIFICATION, REMOVAL, AND NON-DISTURBANCE OF THE BODY.

Section 27491.2, Government Code:

"The coroner or his appointed deputy, on being informed of a death and finding it to fall into the classification of deaths requiring his inquiry, may immediately proceed to where the body lies, examine the body, make identification, make inquiry into the circumstances, manner, and means of death, and, as circumstances warrant, either order its removal for further investigation or disposition, or release the body to the next of kin. For purposes of inquiry, the body of one who is known to be dead under any of the circumstances enumerated in Section 27491 shall not be disturbed or moved from the position or place of death without permission of the coroner or his appointed deputy."

TAKING CHARGE OF PERSONAL EFFECTS AND PROPERTY.

Section 27491.3, Government Code:

"In any death into which the coroner is to inquire, he may take charge of any and all personal effects, valuables, and property of the deceased at the scene of death and hold or safeguard them until lawful disposition thereof can be made. He may, in his discretion, lock the premises and apply a seal to the door or doors prohibiting entrance to the premises, pending arrival of a legally authorized representative of the deceased; provided that this shall not be done in such a manner as to interfere with the investigation being conducted by other law enforcement agencies. Any costs arising from the premises being locked or sealed while occupied by property of the deceased may be a proper and legal charge against the estate of the deceased. Any such property or evidence related to the investigation or prosecution of any known or suspected criminal death may, with knowledge of the coroner, be delivered to a law enforcement agency or district attorney, receipt for which shall be acknowledged."

Section 27491.3, Government Code:

"...It shall be unlawful for any person to search for or remove any papers, moneys, valuable property or weapons constituting the estate of the deceased from the person of the deceased or from the premises, prior to the arrival of the coroner or without his permission. At the scene of any death, when it is immediately apparent or when it has not been previously recognized and the coroner's examination reveals that police investigation or criminal prosecution may ensue, the coroner shall not further willfully disturb the body or any related evidence until the law enforcement agency has had reasonable opportunity to respond to the scene, if their purposes so require and they so request."

MEDICAL DUTIES.

Section 27491.4, Government Code:

"For purposes of inquiry, the coroner may, in his discretion, take possession of the body which shall include the authority to exhume such body, order it removed to a convenient place, and make or cause to be made a post mortem examination or autopsy thereon, and make or cause to be made an analysis of the stomach, stomach contents, blood, organs, fluids, or tissues of the body... He shall have the right to retain only such tissues of the body removed at the time of the autopsy as may, in his opinion, be necessary or advisable to the inquiry into the case, or for the verification of his findings. No person may be present during the performance of a coroner's autopsy without the express consent of the coroner."

RECORDING DUTIES.

Section 27491.4, Government Code:

"...The detailed medical findings resulting from an inspection of the body or autopsy by an examining physician shall be either reduced to writing or permanently preserved on recording discs or other similar recording media, shall include all positive and negative findings pertinent to establishing the cause of death in accordance with medico-legal practice and this, along with the written opinions and conclusions of the examining physician, shall be included in the coroner's record of death."

ISSUANCE OF CERTIFICATE OF DEATH.

Section 27491.5, Government Code:

"The cause of death appearing on a certificate of death signed by the coroner shall be in conformity with facts ascertained from inquiry, autopsy and other scientific findings. In case of death without medical attendance and without violence, casualty, criminal or undue means, the coroner may, without holding an inquest or autopsy, make the certificate of death from statements of relatives, persons last in attendance, or persons present at the time of death, after due medical consultation and opinion has been given by one qualified and licensed to practice medicine and so recorded in the records of death, providing such information affords clear grounds to establish the correct medical cause of death within accepted medical practice and within the requirements for accuracy prescribed by the Division of Vital Statistics of the State Department of Public Health. The coroner shall not finally exclude crime, suicide, or accident as a cause of death because of lack of evidence."

AMENDMENTS TO THE GOVERNMENT CODE.

Section 27491.45

"The coroner shall have the right to retain tissues of the body removed at the time of autopsy as may, in his opinion, be necessary or advisable for scientific investigation."

Section 27520 (Article 2.5)

"The coroner shall perform or cause to be performed an autopsy on a decedent if the surviving spouse requests him to do so in writing. If there is no surviving spouse, the coroner shall perform the autopsy if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased. The cost of the autopsy shall be borne by the person requesting that it be performed."