

**San Francisco Office of the Chief Medical Examiner's Records**

**1902-1956**

**(bulk 1906-1956)**

Collection number: SFH 30

The Daniel E. Koshland  
San Francisco History Center, 6th floor  
San Francisco Public Library  
100 Larkin Street  
San Francisco, CA 94102  
415-557-4567

2009

## **INTRODUCTION**

### **Provenance**

The San Francisco Office of the Chief Medical Examiner's Records were transferred to The San Francisco Public Library in 2005.

### **Access**

The collection is available for research during San Francisco History Center's open hours. A minimum of 2 working days' advance notice is required.

### **Collection Number**

SFH 30

### **Size**

970 vols. (ca.171.5 cubic feet)

### **Processed by**

Tim Wilson

### **Date Completed**

December 2006.

### **Revised by**

Wendy Kramer

### **Date Revised**

July 2009.

### **Languages Represented**

Collection materials are in English.

### **Physical Location**

The collection is housed in remote storage and requires a minimum of 2 working day's advance notice for use.

### **Preferred Citation**

[*Identification of item*], San Francisco Office of the Chief Medical Examiner's Records (SFH 30), The Daniel E. Koshland San Francisco History Center, San Francisco Public Library, San Francisco, CA.

**Related Materials:**

Researchers are encouraged to see also City Records vol. 188. Record of Sale of Unclaimed Articles by Chief of Police and Coroner, 1860-1898; and Allen, Terence Beckington, MD. *San Francisco Coroner's Office: A History, 1850-1980*, 3<sup>rd</sup> ed. San Francisco: Redactors' Press, 2002.

## **INSTITUTIONAL HISTORY**

The Office of the Chief Medical Examiner, originally known as the Coroner's Office, is a county department whose legal mandate is to investigate, document, and certify sudden or unexpected individual deaths due to unnatural or unknown causes, including homicide, suicide, or accident; deaths unattended by a physician or of unidentified persons; or deaths in which there is some other potential public health interest at stake, such as suspected contagious disease.

The history and function of a medical examiner is distinct from but related to that of a coroner. While traditionally a lay office that is distinct from law enforcement and the medical profession, the Coroner has, in practice and over the course of its professionalization, overlapped with both. For example, although the Coroner is not required to be a medical doctor, San Francisco coroners have all been trained physicians since 1857. In many counties in California, the Coroner is or has been also the Sheriff.

A medical examiner is *required* to be a physician, certified by the American Board of Pathology in forensic pathology and experienced in the forensic sciences. While both medical examiners and coroners have the authority to conduct inquests—juried investigations to determine cause and manner of death—the coroner's system made more frequent use of them than does today's medical examiner system. Over the last several decades, due to budgetary and legal concerns, the number of inquests conducted in San Francisco has severely decreased, so that today, although one of the functions of the San Francisco Medical Examiner's Office is to present evidence in court, it rarely conducts separate inquests. Both medical examiners and coroners have the power and, in some cases, the legal obligation, to conduct autopsies.

In San Francisco in 1916, a long-running public controversy began about whether to replace the coroner system with a medical-examiner system. By July 1973, the name of the office reflected this dual-role when it began appearing in Annual Reports as the Chief Medical Examiner-Coroner's Office. Today, the office is known simply as the Office of the Chief Medical Examiner, and its website describes it as “a modern replacement for the Coroner's Office.”

Until 1951, San Francisco coroners were elected; thereafter, they were appointed as part of the Civil Service and approved by the Board of Supervisors.

## **SCOPE AND CONTENT**

The San Francisco Office of the Chief Medical Examiner's Records contain the death reports (1906-1956) of individuals who died in San Francisco and whose deaths legally required investigation. The records also include Necropsy Reports (1928-1956), six volumes of Personal Descriptions of Unknown / Unidentified Dead (1902-1927, 1931-1940), a two-volume Register of Deaths (Dec. 1906-May 1915), and one volume of Coroner's Office Statistics (1913-1931).

As noted above in the Administrative History, not all deaths that occur within the City and County of San Francisco are reported to or recorded by the Office of the Chief Medical Examiner. Since deaths due to natural causes are not usually reported and therefore are not recorded in these records, these records do not contain a comprehensive record of deaths in San Francisco.

Most of the Office's records prior to January 1906 were destroyed in the earthquake and fire of April 1906. Copies of records from January 1, 1957 through the present time may be obtained from the Office of the Chief Medical Examiner, Hall of Justice, 850 Bryant Street - North Terrace, San Francisco, California 94103, telephone number (415) 553-1694; Fax: (415) 553-1650; email: [Medical.Examiner@sfgov.org](mailto:Medical.Examiner@sfgov.org); website: [www.sfgov.org/med\\_examiner](http://www.sfgov.org/med_examiner). When requesting records, please provide the full name of the deceased person and, if known, the date of death and the Medical Examiner's Case Number. It can take up to a week for the Office to recover the records from storage.

Inquest testimony, by which jurors and the coroner determined cause and manner of death, is not part of this collection. Inquests are no longer conducted in most California counties. Inquest testimony is not currently available from the Office of the Chief Medical Examiner.

Death certificates for all deaths within the City and County of San Francisco may be obtained from the Department of Public Health, Records and Statistics, 101 Grove Street, San Francisco, California 94102, telephone number (415) 554-2710. The Division of Vital Statistics, Birth and Death Registration is located on the first floor of 101 Grove Street.

## ARRANGEMENT NOTE

The Office of the Chief Medical Examiner's Records are arranged in five series:

- I. Death Reports and Coroner's Registers (1906-1956)
- II. Personal Descriptions of Unknown / Unidentified Dead (1902-1927, 1931-1940)
- III. Necropsy Reports (1928-1956)
- IV. Register of Deaths (December 1906-May 1915)
- V. Coroner's Office Statistics (1913-1922)

## SERIES DESCRIPTIONS

### **SERIES I: Death Reports and Coroner's Registers (1906-1956)**

616 vols. (ca. 100 cu. ft.)

Volumes bound chronologically by date of death, mostly one volume per month. 1906 and July 1929 consist of 3 volumes each.

This series contains the cumulated records of individual deaths, called *Death Reports* (Jan. 1906-June 1927), then *Coroner's Registers* (July 1927-1956). In addition to the name change, the report format also changes in June 1927; additional information is requested in the Coroner's Register form. The format change is also reflected in that there is a blank volume from July 1927.

Death Report volumes contain two-page (11" x 17") forms documenting individual deaths. Each death report is divided into five sections. Depending on the case, some or all of the requested information may be filled in. The first section records general information: date and time body is received; name of person reporting the case; name, address, telephone number, sex, color, age, nativity, marital status, occupation, and residence of deceased; time of death or time discovered dead; place of death; presumable cause of death; time body received at morgue; deputy's name; messenger's name; undertaker's name and address; signature of person who signed for the burial, and his or her relation to the deceased.

The second section, labeled "In case of accident, suicide, etc.: information prior to time of death," records time, place, and nature of accident or suicide; time/date received in hospital; predisposing cause (if suicide); and date and verdict of inquest.

The third section, labeled "Autopsy Certificate," records date, name of deceased, date and time of autopsy, cause of death, and signature of physician.

The fourth section records names and addresses of witnesses, along with any information provided by them, and the signature of the person receiving the report.

The fifth section, labeled "History of the Case," contains narrative notes related to the death. By 1923, this section also includes a brief "Property Receipt" area.

As mentioned above, the Coroner's Register form has a re-designed and expanded format, titled "Record of Death." As with the Death Reports, depending on the case, some or all of the requested information may be filled in. Besides the information included in the Death Reports, Coroner's Registers include additional information on the decedent, disposition of the body, and notification or involvement of officials, as well as new categories of data on insurance, emergency hospital records, evidence, autopsy surgeon's report, result of inquest, property, disposition of property, receipt for clothing, and newspaper clippings. Some volumes contain cumulated statistics and indexes by last name in the prefatory pages

**SERIES II: Personal Descriptions of Unknown / Unidentified Dead (1902-1927, 1931-1940)**

6 oversize vols. (ca. 2 cu. ft.)

Arranged chronologically.

This series consists of six volumes of death reports of unknown or unidentified individuals. The form lists when and where the deceased was found; name and address of person finding the body; and physical characteristics and features of the deceased, as well as clothing and property found on their person at time of death. Each report includes a photograph of the person's face and head.

Some entries include names entered once the body is identified, in which case the person is cross-listed in Series I: Death Reports/Coroner's Registers.

**SERIES III: Necropsy Reports (1928-1956)**

345 vols. (ca. 68.5 cu. ft.)

Bound by year, with reports arranged chronologically by case number as body was received.

A necropsy, more commonly known as an autopsy, is the medical examination of a dead body by a specially-trained physician. The examination may be legally required (such as in the case of suspicious death including suicide, homicide, accident, etc.), but autopsies also may be ordered by the medical examiner or requested by next of kin. The scope of the examination can include the entire body, or it may be limited to a particular part of the body.

Necropsy Report forms request the following information: case number, name of deceased, date and hour of necropsy, age, height, weight, description of body exterior and internal organs, diagnosis, cause of death, notes on specimens taken for further study and the department to which the specimens were sent, and signature of Necropsy Surgeon to the Coroner. Depending on the case, some or all of the requested information may be filled in.

When specimens were sent to the Pathology or Toxicology Departments for further examination, those reports are amended to the Necropsy Report. Pathology Report forms request the following information: name of deceased, necropsy report case number, date specimen(s) received, identification of specimen, description of gross examination and of microscopic examination of specimen, diagnosis, cause of death, and signature of Pathologist to the Coroner. Toxicology Report forms request the following information: necropsy report case number, date of report,

identification of specimen(s) and evidence received, name of deceased, date specimen(s) received, findings based on analysis of specimen, alcohol, barbiturate, heavy metal levels in blood, toxicological examination of evidence, and signature of Toxicologist to the Coroner.

Individuals entered in this series are cross-listed in Series I: Death Reports/Coroner's Registers.

**SERIES IV: Register of Deaths (December 1906-May 1915)**

2 oversize vols. (ca. 0.5 cu. ft.)

Arranged chronologically.

Volumes contain single-line entries for individual deaths, listed chronologically by date of death. The two-page format is headed "Register of Deaths Reported to the Coroner." Each entry includes date, name, color or race, age, sex, marital status, nativity, occupation, cause of death, crime if any, last place of residence or where found, autopsy if any & by whom, and remarks.

Entries are cross-referenced with corresponding Death Reports/Coroner's Registers in Series I.

**SERIES V: Coroner's Office Statistics (1913-1931)**

1 oversize volume (ca. 0.5 cu. ft.)

This volume is divided into ten sections that broadly categorize individual deaths by industry, type of accident, or institution. Most sections include sub-categories; however, section 10 is solely for Automobiles. Within each section, entries record location of death, together with summary findings, recommendations, and verdict of the inquest jury. Entries are cross-referenced to page number, month, and year of corresponding Death Reports/Coroner's Registers in Series I.