

COUNTY OF MONTEREY

ANNUAL REPORT OF THE CORONER



2005

MIKE KANALAKIS
SHERIFF-CORONER

MONTEREY COUNTY SHERIFF'S OFFICE
1414 NATIVIDAD ROAD
SALINAS, CA 93906

TABLE OF CONTENTS

| | |
|--|-------|
| Introduction..... | 1-4 |
| Deaths Reportable to the Coroner..... | 5-6 |
| Investigation, Coroner Cases, Physician Certified..... | 7 |
| Statistics For Calendar Year 2005..... | 8 |
| General Classification of Death..... | 9 |
| Investigations 1999 – 2005..... | 10 |
| Natural Deaths..... | 11 |
| Sudden Infant Death Syndrome..... | 12-13 |
| Motor Vehicle Fatalities..... | 14-16 |
| Accident Deaths..... | 17-18 |
| Homicide Deaths..... | 19-20 |
| Suicide Deaths..... | 21-22 |
| Undetermined Deaths..... | 23 |
| Indigent Cremation..... | 24 |

COUNTY OF MONTEREY

2005

ANNUAL REPORT OF THE CORONER

SHERIFF-CORONER-PUBLIC ADMINISTRATOR

MIKE KANALAKIS

DIVISION COMMANDER

GREGORY CLARK

INVESTIGATIVE SERGEANT

STACIE MCGRADY

CORONER INVESTIGATORS

THOMAS JENKINS ANDREW KOPICKI
ALFRED MARTINEZ J.D. DAVIDSON

CORONER SECRETARIES

DIANE JOHNSON
GINGER COSNOWSKI

FORENSIC PATHOLOGIST

JOHN R. HAIN, M.D.

FORENSIC TECHNICIAN

ANGELA FRAHER

TOXICOLOGY

CENTRAL VALLEY TOXICOLOGY

FORENSIC ODONTOLOGIST

DR. KEVIN G. LANDON, D.D.S.

FORENSIC ANTHROPOLOGIST

ALISON GALLOWAY

DEPUTY PUBLIC ADMINISTRATOR

MARTHA HERNANDEZ

2005 ANNUAL REPORT OF THE CORONER

In Monterey County, the Sheriff-Coroner and Public Administrator are one and the same. This multi-position was initiated in January 1982. The Coroner's Division is comprised of one (1) Division Commander, one (1) Investigative Sergeant, four (4) Deputy Coroner Investigators, one (1) Forensic Autopsy Technician and one and one-half (1 ½) Coroner's Clerks. Personnel from this office are available twenty-four hours a day, seven days a week, for Coroner investigations, family contact and assistance, as well as disaster situations.

The County of Monterey covers an area of 3,325 square miles. The State mandates that only the Coroner or his duly appointed Deputy has jurisdiction over a deceased person at any death scene, as well as the deceased's property, pending lawful disposition. In the year 2005, the Division's investigating Deputy Coroner's drove a total of approximately 35,000 miles in the course of their duties.

During the 2005 calendar year, 2239 deaths were recorded in Monterey County. Of these recorded deaths, 1043 were reported to the Coroner's Office pursuant to California Government Code Section 27491 and California Health and Safety Code Section 102850, which directs the Coroner to inquire into and determine the circumstances, manner and cause of those reportable deaths.

After investigation, 319 of the cases reported to the Coroner were kept as full Coroner cases with the final cause of death signed by the Coroner or his designated authority. In 251 of these cases, it was necessary to perform a postmortem examination in order to determine the cause of death. The remaining 724 cases initially reported to the Coroner, with follow-up investigation, revealed the person expired of obvious "Natural" causes and were referred to their attending physician of record for certification of the death.

Occasionally the Coroner's Division employs the services of a Forensic Odontologist and/or a Forensic Anthropologist. These services are necessary to determine positive identification through dental comparison as well as ascertaining causes of death through the study of skeletal remains. All unidentified persons are listed with the Coroner's Records as either a John Doe or Jane Doe, depending on the sex. The dental records and x-rays are forwarded to the California State Department of Justice in Sacramento for possible future match with the dental records of reported missing persons. In 2005, the Coroner's Office investigated the deaths of 4 John Does with no John Doe's remaining unidentified. There were no Jane Does reported in 2005.

This Annual Report of the Coroner provides a summary of the cases reported and investigated by the Coroner's Division. Included is a statistical breakdown of the types of deaths that occurred within Monterey County.

DEATHS REPORTABLE TO THE CORONER

Government Code, State of California, Section 27491 and Health and Safety Code, State of California, Section 102850, directs the Coroner to investigate into and determine the Circumstances, Manner and Cause of the following deaths that are immediately reportable.

1. No physician in attendance.
2. Medical attendance less than 24 hours (hospital or residence).
3. Wherein the deceased has not been attended by a physician in the 20 days prior to death.
4. Wherein the physician is unable to state the cause of death.
5. Known or suspected homicide.
6. Known or suspected suicide.
7. Involving any criminal action or suspicion of a criminal act.
8. Related to or following a known or suspected self-induced or criminal abortion.
9. Associated with a known or alleged rape of crime against nature.
10. Following an accident or injury, old or recent, (primary or contributory, occurring immediately or at some remote time.)
11. All deaths due to Drowning, Fire, Hanging, Gunshot, Stabbing, Cutting, Starvation, Exposure, Acute Alcoholism, Drug Addiction, Strangulation or Aspiration.
12. Accidental poisoning, (Food, Chemical Agent, Drug or Therapeutic Agent).
13. Occupational disease or occupational hazards.
14. Known or suspected contagious disease constituting a public health hazard, **INCLUDING AIDS.**
15. All deaths in operating rooms.
16. All deaths where the patient has not fully recovered from an anesthetic whether in surgery, recovery room or elsewhere.

DEATHS REPORTABLE TO THE CORONER (CONTINUED)

17. All deaths wherein the patient expired within 24 hours of an operation or surgical procedure.
18. All deaths in which the patient was comatose throughout the period of the physician's attendance, whether at home or hospital.
19. All solitary deaths.
20. All deaths of unidentified persons.
21. All deaths where the suspected cause of death is Sudden Infant Death Syndrome (Crib Death).
22. All deaths in prison, jails or of persons under the control of a law enforcement agency.
23. All deaths of patients in state mental hospitals.
24. Wherein there is no known next of kin.

SUMMARY OF INVESTIGATIONS

2005

| INVESTIGATIONS <u>CORONER</u> | INVESTIGATIONS <u>*PHYSICIAN CERTIFIED</u> | AUTOPSIES <u>PERFORMED</u> | INVESTIGATIONS <u>TOTAL</u> |
|----------------------------------|---|-------------------------------|--------------------------------|
| JAN 28 | 68 | 19 | 96 |
| FEB 36 | 55 | 35 | 92 |
| MAR 24 | 62 | 17 | 86 |
| APR 26 | 56 | 20 | 82 |
| MAY 34 | 65 | 29 | 99 |
| JUN 24 | 45 | 19 | 69 |
| JUL 28 | 53 | 22 | 81 |
| AUG 22 | 57 | 17 | 79 |
| SEP 25 | 60 | 16 | 85 |
| OCT 18 | 65 | 13 | 83 |
| NOV 32 | 70 | 25 | 102 |
| DEC 22 | 68 | 19 | 90 |
| <u>TOTAL: 319</u> | 724 | 251 | 1043 |

* After thorough investigation by the Coroner's Office, it was determined that these deaths were due to natural causes. The Attending Physician signed out the death certificates without them being completed as full Coroner's cases. Our office required no autopsies be conducted.

STATISTICS FOR CALENDAR YEAR 2005

| | <u>Natural</u> | <u>Accident</u> | <u>Suicide</u> | <u>Pending</u> | <u>Homicide</u> | <u>Undetermined</u> | <u>Accident (Vehicle)</u> | <u>Natural (Cancer)</u> | <u>Month Total</u> |
|------------------|----------------|-----------------|----------------|----------------|-----------------|---------------------|---------------------------|-------------------------|--------------------|
| January | 66 | 8 | 3 | 0 | 4 | 0 | 4 | 11 | 96 |
| February | 55 | 8 | 5 | 0 | 1 | 1 | 10 | 11 | 91 |
| March | 56 | 8 | 1 | 0 | 1 | 0 | 4 | 16 | 86 |
| April | 60 | 11 | 3 | 0 | 1 | 0 | 3 | 4 | 82 |
| May | 71 | 8 | 2 | 0 | 4 | 1 | 4 | 9 | 99 |
| June | 45 | 5 | 7 | 0 | 1 | 2 | 4 | 5 | 69 |
| July | 58 | 7 | 3 | 0 | 0 | 2 | 3 | 8 | 81 |
| August | 59 | 6 | 3 | 0 | 0 | 2 | 2 | 7 | 79 |
| September | 57 | 5 | 4 | 0 | 1 | 1 | 7 | 11 | 86 |
| October | 54 | 4 | 0 | 0 | 1 | 2 | 8 | 14 | 83 |
| November | 78 | 8 | 1 | 1 | 2 | 1 | 4 | 6 | 101 |
| December | 66 | 9 | 1 | 1 | 0 | 0 | 5 | 8 | 90 |
| Totals | 725 | 87 | 33 | 2 | 18 | 10 | 58 | 110 | 1043 |

GENERAL CLASSIFICATIONS OF DEATHS HANDLED BY THE CORONER

2005

| | |
|--|------------|
| NATURAL..... | 108 |
| SUDDEN INFANT DEATH SYNDROME (SIDS)..... | 3 |
| MOTOR VEHICLE DEATHS..... | 58 |
| ACCIDENT..... | 87 |
| SUICIDE..... | 33 |
| HOMICIDE..... | 18 |
| UNDETERMINED..... | 10 |
| PENDING..... | 2 |
| <u>TOTAL:</u> | 319 |

CORONER INVESTIGATIONS 1999 – 2005

CLASSIFICATIONS

| | <u>2005</u> | <u>2004</u> | <u>2003</u> | <u>2002</u> | <u>2001</u> | <u>2000</u> | <u>1999</u> |
|---------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| NATURAL | 108 | 118 | 105 | 102 | 121 | 118 | 115 |
| SIDS | 3 | 7 | 7 | 5 | 1 | 5 | 2 |
| MOTOR VEHICLE | 58 | 93 | 62 | 61 | 61 | 56 | 46 |
| ACCIDENT | 87 | 72 | 74 | 77 | 67 | 49 | 80 |
| HOMICIDE | 18 | 40 | 27 | 26 | 32 | 29 | 32 |
| SUICIDE | 33 | 38 | 61 | 28 | 34 | 21 | 27 |
| UNDETERMINED | 10 | 12 | 10 | 9 | 4 | 6 | 4 |
| PENDING | 2 | 0 | 0 | 0 | 0 | 0 | 0 |

INVESTIGATIONS

| | CORONER CERTIFIED | PHYS. CERT. | TOTAL INVEST. | TOTAL AUTOPSIES | TOTAL EXTERNALS | TOTAL PC AUT. |
|-------------|----------------------|----------------|------------------|--------------------|--------------------|------------------|
| 2004 | 380 | 759 | 1139 | 306 | 69 | 2 |
| 2003 | 346 | 789 | 1135 | 286 | 58 | 3 |
| 2002 | 308 | 864 | 1172 | 245 | 48 | 1 |
| 2001 | 328 | 827 | 1155 | 246 | 49 | 2 |
| 2000 | 284 | 798 | 1082 | 232 | 29 | 1 |
| 1999 | 309 | 820 | 1129 | 273 | 12 | 8 |

NATURAL DEATHS – 2005

NATURAL DEATHS BY AGE AND SEX

| <u>AGE</u> | <u>MALE</u> | <u>FEMALE</u> | <u>TOTAL</u> |
|-------------|-------------|---------------|--------------|
| 00-11 (MOS) | 2 | 0 | 2 |
| 01-10 (YRS) | 0 | 0 | 0 |
| 11-20 | 1 | 0 | 1 |
| 21-30 | 5 | 1 | 6 |
| 31-40 | 5 | 1 | 6 |
| 41-50 | 20 | 5 | 25 |
| 51-60 | 22 | 5 | 27 |
| 61-70 | 10 | 7 | 17 |
| 71-80 | 8 | 4 | 11 |
| 81-90 | 3 | 9 | 12 |
| 91-100 | 0 | 0 | 0 |

TOTAL: 108

NATURAL DEATHS BY MONTH

| | | | |
|-----|----|-----|----|
| JAN | 7 | JUL | 12 |
| FEB | 13 | AUG | 9 |
| MAR | 9 | SEP | 7 |
| APR | 8 | OCT | 3 |
| MAY | 15 | NOV | 13 |
| JUN | 7 | DEC | 5 |

SUDDEN INFANT DEATH SYNDROME (SIDS) – 2005

| <u>MONTH</u> | <u>MALE</u> | <u>FEMALE</u> | <u>AGE</u> |
|--------------|-------------|---------------|------------|
| JANUARY | 0 | 1 | 1 MONTH |
| MARCH | 1 | 0 | 8 MONTHS |
| JULY | 0 | 1 | 2 DAYS |

TOTAL: 3

SIDS DEATHS IN RECENT YEARS

| | |
|------|---|
| 2004 | 7 |
| 2003 | 7 |
| 2002 | 5 |
| 2001 | 1 |
| 2000 | 5 |
| 1999 | 2 |

SIDS (BASIC FACTS)

SIDS (Sudden Infant Death Syndrome), commonly known as “crib death”, is the number one cause of death in infants after the first week of life. SIDS is not a rare disease. SIDS causes approximately 6,000 to 7,000 babies to die each year in the United States. SIDS happens about two out of every 1,000 live births.

SIDS most commonly occurs in infants between the ages of four weeks and seven months, but occasionally an older or younger baby may die of SIDS, some even as old as 14 months.

A minor illness such as a common cold may precede the death, but many victims display no observable symptoms. A typical case is when an infant is put to bed without any suspicion that things are out of the ordinary. Upon checking the infant later, he or she is discovered unresponsive.

An autopsy may reveal, at most, a minor degree of inflammation of the upper respiratory tract, but no lesion sufficient to account for the death. Often the autopsy reveals absolutely no evidence of illness.

SIDS occurs among families of all social and economic strata. For the typical SIDS victim, there are currently no sure preventive measures to be taken.

2005 – MOTOR VEHICLE FATALITIES

| | |
|-----------------------------------|-----------|
| OPERATORS OF MOTOR VEHICLES..... | 31 |
| PASSENGERS OF MOTOR VEHICLES..... | 16 |
| PEDESTRIANS..... | 5 |
| BICYCLIST..... | 1 |
| MOTORCYCLIST..... | 4 |
| WHEELCHAIR..... | 1 |
| TOTAL..... | 58 |

The Coroner’s Office, as well as the law enforcement agency having jurisdiction where the fatality occurred, conduct a thorough investigation in cases of motor vehicle related fatalities. A suspected traffic fatality can sometimes be the result of natural causes which can be disclosed, in most cases, at time of autopsy as opposed to death by traumatic injuries. Also, a traffic fatality may be ruled a suicide, accident or homicide.

MOTOR VEHICLE FATALITIES – 2005

BY AGE AND SEX

| <u>AGE</u> | <u>MALE</u> | <u>FEMALE</u> | <u>TOTAL</u> |
|-------------|-------------|---------------|--------------|
| 0-11 (MOS) | 0 | 0 | 0 |
| 01-10 (YRS) | 0 | 0 | 0 |
| 11-20 | 9 | 7 | 16 |
| 21-30 | 13 | 2 | 15 |
| 31-40 | 3 | 2 | 5 |
| 41-50 | 4 | 2 | 6 |
| 51-60 | 5 | 4 | 9 |
| 61-70 | 1 | 2 | 3 |
| 71-80 | 3 | 1 | 4 |
| 81-90 | 0 | 0 | 0 |
| 91-100 | 0 | 0 | 0 |

TOTAL: 58

BY MONTH

| | | | |
|-----|----|-----|---|
| JAN | 4 | JUL | 3 |
| FEB | 10 | AUG | 2 |
| MAR | 4 | SEP | 7 |
| APR | 3 | OCT | 8 |
| MAY | 4 | NOV | 4 |
| JUN | 4 | DEC | 5 |

2005 – TRAFFIC FATALITY – ALCOHOL/DRUG TOXICOLOGY

The Coroner investigates suspected traffic fatalities. Pursuant to California Government Code Section 27491.25, the Coroner’s Pathologist takes available blood and urine samples from the deceased to make appropriate related chemical tests to determine the alcoholic and/or drug related derivative contents, if any, in the body. In some cases, the traffic victims are hospitalized for a lengthy period of time prior to expiration and therefore blood and urine samples are not available for testing.

ALCOHOL

Not tested: 1
Negative: 35
Alcohol present: 22

| <u>ALCOHOL PRESENT</u> | <u>TOTAL</u> |
|------------------------|--------------|
| .00 TO .05 | 2 |
| .06 TO .09 | 2 |
| .10 TO .15 | 7 |
| .16 TO .20 | 5 |
| .21 TO .30 | 4 |
| .31 TO .40 | 2 |
| .41 TO .50 | 0 |

VEHICLE RELATED DEATH - DRUG SCREENS

| | |
|-------------------------|---|
| <u>Not tested:</u> 1 | <u>Drugs Found:</u> |
| <u>Negative:</u> 40 | delta-9-THC, Methamphetamine, Methadone |
| <u>Drug Positive</u> 17 | Methadone, Cocaine, Diazepam, Citalopram, Diphenhydramine, Fluoxetine, Acetaminophen |

2005 – TYPES OF FATAL ACCIDENTS

TOTAL ACCIDENTAL DEATHS: 87

BY ACCIDENT TYPE

| | |
|-------------------------------|----|
| ASPHYXIATION..... | 5 |
| ELECTROCUTION..... | 3 |
| THERAPEUTIC MISADVENTURE..... | 1 |
| DROWNINGS..... | 10 |
| BOATING (RIVER)..... | 2 |
| POND..... | 1 |
| RIVER..... | 2 |
| SCUBA..... | 3 |
| BATHTUB..... | 2 |
| FALLS:..... | 24 |
| RESIDENCE..... | 10 |
| HORSE..... | 1 |
| CLIFF..... | 1 |
| SKILLED NURSING FACILITY..... | 4 |
| SIDEWALK..... | 2 |
| PARK..... | 1 |
| PARKING LOT..... | 2 |
| MOTEL..... | 1 |
| WHEELCHAIR..... | 1 |
| INDUSTRIAL (PALLETS)..... | 1 |
| OVERDOSE:..... | 43 |
| ALCOHOL..... | 2 |
| ALCOHOL/DRUG..... | 9 |
| DRUGS MULTIPLE..... | 17 |
| PRESCRIPTION DRUGS..... | 15 |
| UNDETERMINED..... | 1 |

2005 – ACCIDENTS

ACCIDENTS BY AGE AND SEX

| <u>AGE</u> | <u>MALE</u> | <u>FEMALE</u> | <u>TOTAL</u> |
|------------|-------------|---------------|--------------|
| 0-11 (MOS) | 1 | 1 | 2 |
| 0-10 (YRS) | 1 | 0 | 1 |
| 11-20 | 2 | 0 | 2 |
| 21-30 | 6 | 2 | 8 |
| 31- 40 | 13 | 1 | 14 |
| 41-50 | 15 | 4 | 19 |
| 51- 60 | 14 | 4 | 18 |
| 61-70 | 5 | 2 | 7 |
| 71- 80 | 2 | 1 | 3 |
| 81- 90 | 3 | 4 | 7 |
| 91-100 | 1 | 5 | 6 |

TOTAL: 87

ACCIDENTS BY MONTH

| | | | |
|-----|----|-----|---|
| JAN | 8 | JUL | 7 |
| FEB | 8 | AUG | 6 |
| MAR | 8 | SEP | 5 |
| APR | 11 | OCT | 4 |
| MAY | 7 | NOV | 9 |
| JUN | 5 | DEC | 9 |

TYPES OF HOMICIDES - 2005

| | |
|-------------------------|-----------|
| ASPHYXIA..... | 2 |
| STABBED..... | 3 |
| GUNSHOT..... | 9 |
| STABBED/BEAT..... | 1 |
| TRAUMA-BLUNT FORCE..... | 3 |
| TOTAL..... | 18 |

8 OF THE 18 HOMICIDE CASES WERE GANG RELATED

| <u>TYPES OF HOMICIDES:</u> | <u>1999</u> | <u>2000</u> | <u>2001</u> | <u>2002</u> | <u>2003</u> | <u>2004</u> |
|-----------------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|
| DRUG INTOXICATION | 0 | 0 | 0 | 0 | 0 | 1 |
| ASPHYXIATION | 1 | 0 | 0 | 0 | 0 | 2 |
| ASSAULT | 0 | 0 | 1 | 0 | 0 | 1 |
| STABBED | 3 | 4 | 4 | 2 | 2 | 2 |
| GUNSHOT | 23 | 24 | 23 | 24 | 19 | 27 |
| GSW/STABBED | 0 | 0 | 1 | 0 | 0 | 4 |
| MALNUTRITION | 0 | 0 | 0 | 0 | 1 | 0 |
| UNDETERMINED | 1 | 0 | 0 | 0 | 0 | 0 |
| STRANGULATON | 1 | 1 | 1 | 0 | 4 | 0 |
| TRAUMA/BLUNT FORCE | 1 | 3 | 3 | 0 | 0 | 3 |
| THERMAL BURN | 0 | 0 | 0 | 0 | 1 | 0 |
| <u>TOTAL HOMICIDES:</u> | 29 | 32 | 33 | 26 | 27 | 40 |

2005 - HOMICIDES

HOMICIDES BY AGE AND SEX

| <u>AGE</u> | <u>MALE</u> | <u>FEMALE</u> | <u>TOTAL</u> |
|------------|-------------|---------------|--------------|
| 0-11 (MOS) | 0 | 0 | 0 |
| 1-10 (YRS) | 0 | 0 | 0 |
| 11-20 | 2 | 0 | 2 |
| 21-30 | 8 | 0 | 8 |
| 31- 40 | 5 | 0 | 5 |
| 41-50 | 1 | 0 | 1 |
| 51- 60 | 2 | 0 | 2 |
| 61-70 | 0 | 0 | 0 |
| 71- 80 | 0 | 0 | 0 |
| 81- 90 | 0 | 0 | 0 |

TOTAL: 18

HOMICIDES BY MONTH

| | | | |
|-----|---|-----|---|
| JAN | 4 | JUL | 0 |
| FEB | 1 | AUG | 2 |
| MAR | 1 | SEP | 1 |
| APR | 1 | OCT | 1 |
| MAY | 4 | NOV | 2 |
| JUN | 1 | DEC | 0 |

2005 SUICIDES

SUICIDES BY TYPE

DROWNING..... 2

DRUG OVERDOSE (ILLICIT) 3

PRESCRIPTION MEDICATIONS 1

GUNSHOT..... 11

HANGING..... 10

INCISED WOUNDS..... 1

POISONING..... 1

SMOTHERING..... 1

TRACTOR..... 1

VEHICLE..... 2

TOTAL: 33

2005 SUICIDES

BY AGE AND SEX

| <u>AGE</u> | <u>MALE</u> | <u>FEMALE</u> | <u>TOTAL</u> |
|------------|-------------|---------------|--------------|
| 1-10 (YRS) | 0 | 0 | 0 |
| 11-20 | 4 | 0 | 4 |
| 21-30 | 2 | 0 | 2 |
| 31-40 | 4 | 1 | 5 |
| 41-50 | 6 | 1 | 7 |
| 51-60 | 4 | 3 | 7 |
| 61-70 | 0 | 0 | 0 |
| 71-80 | 4 | 1 | 5 |
| 81-90 | 0 | 1 | 1 |
| 91-100 | 1 | 1 | 2 |

TOTAL: 33

SUICIDES BY MONTH

| | | | |
|-----|---|-----|---|
| JAN | 3 | JUL | 3 |
| FEB | 5 | AUG | 3 |
| MAR | 1 | SEP | 4 |
| APR | 3 | OCT | 0 |
| MAY | 2 | NOV | 1 |
| JUN | 7 | DEC | 1 |

UNDETERMINED MODES OF DEATH – 2005

| <u>MONTH REPORTED</u> | <u>SEX</u> | <u>AGE</u> |
|-----------------------|------------|------------|
| FEBRUARY | F | 89 |
| MAY | F | 58 |
| JUNE | M | 30 |
| | M | 30 |
| JULY | F | 15 |
| | F | 2 MONTHS |
| SEPTEMBER | M | 34 |
| OCTOBER | M | 47 |
| | M | 38 |
| NOVEMBER | M | 2 |

TOTAL: 10

2005 INDIGENT CREMATIONS

BY MONTH

| | | | | | |
|-----|---|-----|---|-----|---|
| JAN | 0 | MAY | 0 | SEP | 0 |
| FEB | 1 | JUN | 1 | OCT | 0 |
| MAR | 0 | JUL | 0 | NOV | 3 |
| APR | 1 | AUG | 2 | DEC | 1 |

TOTAL: 9

***By Monterey County resolution, cremation is the method of final disposition for indigent remains.**

INDIGENT CREMATIONS IN PREVIOUS YEARS

| <u>YEAR</u> | <u>TOTAL</u> |
|-------------|--------------|
| 1998 | 26 |
| 1999 | 11 |
| 2000 | 20 |
| 2001 | 17 |
| 2002 | 13 |
| 2003 | 4 |
| 2004 | 13 |