

**BOARD OF MEDICOLEGAL INVESTIGATIONS
OFFICE OF THE CHIEF MEDICAL EXAMINER**

Central Office
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OFFICE USE ONLY

Re _____ Co _____

I hereby certify that this is a true and correct copy of the original document. Valid only when copy bears imprint of the office seal.

By _____

Date _____

SUMMARY REPORT

DECEDENT First-Middle-Last Names (Please avoid use of initials) VERONICA CLAIRE BUTLER	Age 27	Birth Date 2/28/1997	Race WHITE	Sex F
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HOME ADDRESS - No. - Street, City, State
1109 SOUTH JEFFERSON STREET, HUGOTON, KS

EXAMINER NOTIFIED BY - NAME - TITLE (AGENCY, INSTITUTION, OR ADDRESS) OKLAHOMA STATE BUREAU OF INVESTIGATION, AGENT JOSH DEAN	DATE 4/10/2024	TIME 21:48
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INJURED OR BECAME ILL AT (ADDRESS)	CITY	COUNTY	TYPE OF PREMISES	DATE	TIME
UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN	Unknown	Unknown
LOCATION OF DEATH 36.740016, -102.003840	TEXHOMA	TEXAS	FIELD	4/14/2024 FOUND	13:57 FOUND
BODY VIEWED BY MEDICAL EXAMINER 921 NORTHEAST 23RD STREET	OKLAHOMA CITY	OKLAHOMA	AUTOPSY SUITE	4/16/2024	8:30

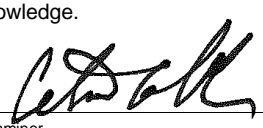
TRANSPORTATION INJURY DRIVER PASSENGER PEDESTRIAN

TYPE OF VEHICLE: AUTOMOBILE LIGHT TRUCK HEAVY TRUCK BICYCLE MOTORCYCLE OTHER: _____

DESCRIPTION OF BODY	RIGOR	LIVOR	EXTERNAL OBSERVATION		NOSE	MOUTH	EARS
					BLOOD	OTHER	DIRT
EXTERNAL PHYSICAL EXAMINATION	Jaw <input type="checkbox"/> Complete <input type="checkbox"/> Neck <input type="checkbox"/> Absent <input type="checkbox"/> Arms <input type="checkbox"/> Passing <input type="checkbox"/> Legs <input type="checkbox"/> Passed <input type="checkbox"/> Decomposed <input checked="" type="checkbox"/>	Color GREEN Lateral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input checked="" type="checkbox"/> Regional _____	Beard _____ Hair RED Eyes: Color UNKNOWN Mustache _____ Opacities _____ Pupils: R _____ L _____ Body Length 65" Body Weight 253 LBS.		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Significant observations and injury documentations - (Please use space below)
SEE AUTOPSY REPORT

<i>Probable Cause of Death:</i> MULTIPLE SHARP FORCE TRAUMA	<i>Manner of Death:</i> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Unknown <input type="checkbox"/> Pending <input type="checkbox"/> Not Assigned <input type="checkbox"/>	<i>Case disposition:</i> Autopsy YES Authorized by CELIA COBB M.D. Pathologist CELIA COBB M.D. Not a medical examiner case <input type="checkbox"/>
	<i>Other significant conditions contributing to death (but not resulting in the underlying cause given)</i>	

MEDICAL EXAMINER: Name, and Address: CELIA COBB M.D. 921 NE 23rd St. Oklahoma City, OK 73105	I hereby state that, after receiving notice of the death described herein, I conducted an investigation as to the cause and manner of death, as required by law, and that the facts contained herein regarding such death are true and correct to the best of my knowledge.  _____ Signature of Medical Examiner Computer generated report	_____ CELIA COBB M.D.	4/14/2024 Date Case Initiated 10/28/2024 Date Case Finalize
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