

AUTHORIZATION FOR RELEASE OF REMAINS

Date: _____

To: _____
Name of Facility

- ☐ Please Release the Remains and Personal Effects of:
- ☐ Please Release the Personal Effects/Valuables of:

Name of Deceased

Date of Birth

Date of Death

To **Cochrane & Wagemann Funeral Directors**

Signature: _____ Relationship: _____

Address: _____

City, State, Zip: _____ Telephone: _____

CW Representative Present: _____