

## 2005 ANNUAL REPORT

# Office of the Chief Medical Examiner Commonwealth of Virginia

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Commonwealth of Virginia  
Virginia Department of Health  
Office of the Chief Medical Examiner  
December 2005

# 2005 ANNUAL REPORT

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**Annual Report 2005**  
**Office of the Chief Medical Examiner**  
**Department of Health**  
**Commonwealth of Virginia**

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*\* 17 years of age and younger*

## **Letter from the Chief Medical Examiner**

The staff of the OCME offers this report as a source of information on the state of Virginia's health as reflected by the investigation of the sudden, unexpected and violent deaths occurring in calendar 2004. The OCME offers this report for agents of change with the hope that the individual classes of death may inspire more intense study directed to prevention.

The identification of the classes of sudden unexpected natural death offers an opportunity for health care providers to focus their attention on the diseases that strike our citizens in their prime years. The number of deaths of infants has remained relatively constant the last several years since the reduction in deaths associated with the "Back to Sleep" campaign indicating a continuing need to study the etiology of this heartbreaking phenomenon. Accidents, for the most part are preventable. Many could be avoided by utilizing current safety measures at home, in school, on the highway and in the workplace. Continuous education in health and safety targeted at our younger citizens might greatly reduce the years of life lost. Suicide is a measure of despair. The individual stories underlying accomplished suicides at all ages are profoundly sad. Many show profound social and emotional isolation suggesting a variety of strategies need to be directed to reach out to Virginia's emotionally wounded citizens. Homicides in Virginia are unsettling to all citizens, disturbing the public peace in addition to terminating lives and shattering families and friends. Efforts directed at altering high risk life styles and intervening in the high risk cases of intimate and family violence need to be continued by health, mental health, criminal justice, legislative and other professionals who often labor under discouraging circumstances. Workers in these areas need our encouragement and thanks.

The good news is that the annual report also shows when interventions are successful as the number of fatalities in certain classes drops.

The report is the cooperative effort of many – from the local medical examiners and medical investigators who collected the initial circumstantial and medical information, law enforcement investigators who tracked down the fine details and circumstances surrounding the death event,

the pathologists who examined the dead and established the cause and manner of death, to the OCME staff who faithfully and accurately entered the data generated by the former into the OCME data base. Forensic epidemiologists Timothy Powell and Dr. Anna Noller analyzed the mountains of data and translated it into meaningful useful formats for the OCME and for all others who have an interest in the sudden unexpected and violent deaths of Virginians. Thank you all.

Readers are encouraged to take this report and use the information it highlights to improve the public health, reduce crime and prevent premature and preventable deaths.

Marcella F. Fierro, MD  
Chief Medical Examiner

## **Introduction**

This report presents the deaths investigated by the Virginia Department of Health, Office of the Chief Medical Examiner in 2004 and follows a similar format as the 2004 Annual Report.

## **Preparation for the Annual Report**

The OCME data from which this report was compiled are maintained on a Solaris SunFire 280R enterprise server, running Solaris 8 and Oracle 8i, and is located at the Central district office of the OCME in Richmond. Timothy A. Powell, MPH used SPSS v11.0 and Microsoft Office 2000 Professional to co-prepare this report. Anna C. Noller, PhD co-prepared the report also using Office 2000 Professional. Mary Neathawk designed the original layout of this report.



## **SECTION 1: OVERVIEW- OFFICE OF THE CHIEF MEDICAL EXAMINER**

In 1946, Virginia became one of the first states to institute a statewide medical examiner system. In that same year, the General Assembly of Virginia abolished the Office of Coroner's Physician and appointed a Chief Medical Examiner. Four years later, in 1950, the OCME became an office within the Virginia Department of Health.

Pursuant to § 32.1-283 of the Code of Virginia, all of the following deaths are investigated by the OCME:

- Any death from trauma, injury, violence, or poisoning attributable to accident, suicide or homicide;
- Sudden deaths to persons in apparent good health or deaths unattended by a physician;
- Deaths of persons in jail, prison, or another correctional institution, or in police custody (this includes deaths from legal intervention);
- Deaths of patients/residents of state mental health or mental retardation facilities;
- The sudden death of any infant less than eighteen months of age whose death might be attributable to Sudden Infant Death Syndrome; and
- Any other suspicious, unusual, or unnatural death.

In Virginia, medical examiners conduct a medicolegal death investigation, serving as the principal case investigator in their locality for deaths falling within their jurisdiction and statutory authority. The OCME currently supports more than 253 local medical examiners, who receive the initial notification of death and determine if the death should come under the jurisdiction of the medical examiner. Local medical examiners may examine the body, collect a toxicology sample, and sign the certificate of death on medical examiner cases or, using professionally established guidelines, refer certain classes of cases for more intensive death investigation and medicolegal autopsy.

When an autopsy is required, it is conducted in one of four district offices: Northern, Tidewater, Central or Western. Each district is staffed by board certified forensic pathologists, death investigators, clerical and morgue personnel. The Chief Medical Examiner, Dr. Marcella F. Fierro, resides in the Richmond office and is responsible for the overall operations of the state's medical examiner system.

The overall vision of the OCME is to be the best medical examiner system in the world. The following missions form the core of OCME staff members' efforts in accomplishing this goal:

- Conduct medicolegal death investigations.
- Perform autopsies to certify cause and manner of death.
- Provide public service to citizens and professional colleagues throughout the Commonwealth.
- Educate peers and professionals on subjects related to death investigation.
- Reduce violent death by conducting surveillance and fatality review.
- Provide support and technical assistance to local fatality review teams.
- Administer the State Anatomical Program.

Virginia's medical examiners and forensic pathologists are committed to public safety and to public health. To promote public safety, they testify to their findings in civil and criminal courts throughout the Commonwealth. They advance public health through their investigations of deaths that present a hazard to Virginia's citizens, such as emerging infections and bioterrorism. This report describes medical examiner activities for the 2004 calendar year.

In addition to its central mission – conducting medico-legal death investigation to identify the cause and manner of death – the OCME has another mission related to injury and violence prevention. The OCME houses four fatality review and surveillance projects, which are designed to:

- Understand the circumstances of death.
- Provide information to legislators, policy makers, and other advocates for injury prevention.
- Make direct recommendations for prevention and intervention.
- Measure the impact of prevention programs and practices.
- Make something good come from the violence and destruction of human life.

**The Child Fatality Review Team** was established by the Virginia General Assembly and the Governor of Virginia. Working in the spirit of public health, this Team reviews violent and unexpected child deaths and develops consensus recommendations to prevent similar deaths in

the future. It is a multidisciplinary Team with representatives from pediatrics, child psychiatry, law enforcement, social services, forensic pathology, commonwealth's attorneys, local fire and emergency medical services providers, the Virginia SIDS alliance, and state agencies. Published reports are available at <http://www.vdh.state.va.us/medexam/Fatality.asp>.

The OCME's **Family and Intimate Partner Violence Surveillance Project** uses OCME records and news reports to identify the circumstances and the dynamics of fatal family violence. Staff members publish annual information on every homicide in the Commonwealth with a focus on family and intimate partner violence. Published reports are available at [www.vdh.state.va.us/medexam/violence.asp](http://www.vdh.state.va.us/medexam/violence.asp).

In partnership with the Office of Family Health Services, the OCME coordinates the work of the **Maternal Mortality Review Team**. This effort involves review of the circumstances surrounding all maternal deaths in the Commonwealth by an interdisciplinary team of professionals, including representatives from local health departments, obstetrician-gynecologists, medical social workers, nurse-midwives, nurse practitioners, and state planning agencies. Maternal deaths include all deaths to women during or within one year of the termination of pregnancy, regardless of outcome of the pregnancy or cause and manner of death. This Team's preliminary report will be published in 2006, and will be available at the following website: <http://vdhweb/medexam/Fatalreview.asp>.

The OCME was the first statewide medical examiner system to be selected as a demonstration site for the Center for Disease Control and Prevention's **National Violent Death Reporting System**. Known more commonly as NVDRS, the National Violent Death Reporting System is a relatively new venture for the OCME. NVDRS collects information from a variety of sources – forensic pathology, forensic science, law enforcement, vital records, health statistics, and child fatality review – in order to comprehend the circumstances of violent death. Information will be used to frame violence and injury prevention programs at the national, state and local levels. Published reports are available at <http://vdhweb/medexam/reports.asp>.

## **Training and Education**

### ***Forensic Pathology Fellowship Programs***

Website — <http://www.vdh.state.va.us/medexam/Forensic.asp>

The Virginia Commonwealth University, School of Medicine (VCU) and the Eastern Virginia Medical School (EVMS) in conjunction with the OCME offer residency/fellowship training in the subspecialty of forensic pathology. The four board-certified forensic pathologists of the Central District office are the core faculty of the Department of Legal Medicine at VCU, and faculty in the Division of Forensic Pathology of the Department of Pathology at VCU. Medical Examiner's office staff has full access to facilities at VCU and its medical, dental, pharmacy, hospital administration, nursing, and other health science schools. The three board-certified forensic pathologists including a pediatric pathologist of the Tidewater District office are faculty in the Department of Pathology at EVMS and the Department of Legal Medicine at VCU. The Tidewater District office staff has full access to EVMS. The forensic pathology training program is designed to provide flexibility in training and experience depending upon the individual physician's career objectives.

- A 1 or 2-month experience for the trainee who desires a brief exposure to forensic pathology as part of a general anatomic pathology program.
- A 3 to 6-month experience for trainees desiring more intensive exposure as part of a general anatomic pathology program.
- A 12-month experience for a trainee desiring eligibility to take the American Board of Pathology examination in forensic pathology.

The Central District office provides forensic pathology and medical examiner administrative services to the county and city medical examiners in the central region of Virginia including the Richmond Metropolitan area. The Tidewater District office provides forensic pathology and medical examiner administrative services to the county and city medical examiners in the eastern region of Virginia including the Norfolk, Virginia Beach, Hampton, Portsmouth, and Newport News metropolitan areas.

It is the aim of the forensic pathology training program that, by the end of the fellowship year, the trainee can adequately manage the great majority of medicolegal deaths with self-assurance

and technical competence. The trainee should be equipped to step into a position as an able assistant in an established Medical Examiner's or Coroner's Office of a county, city, or state.

### ***Virginia Institute of Forensic Science and Medicine***

Website — <http://www.vifsm.org/>

The Virginia Institute for Forensic Science and Medicine, a 501(c) (3) organization founded in 1999, is a premier provider of hands on training in a working forensic environment for aspiring forensic scientists and pathologists. To the nation, VIFSM promotes a Virginia brand of justice forged from the cooperative efficiencies and innovations of its medical examiner system and forensic science laboratories. Over 200 world-renowned faculty members, many of whom are staff members of the Division of Forensic Science and Office of the Chief Medical Examiner, lend their expertise as foremost practitioners of all disciplines of forensic science and medicine. VIFSM offers state-of-the-art postgraduate fellowships as preparation for careers in these forensic disciplines. Through its training seminars, VIFSM enhances the knowledge and performance of those engaged in violent crime and death investigation.

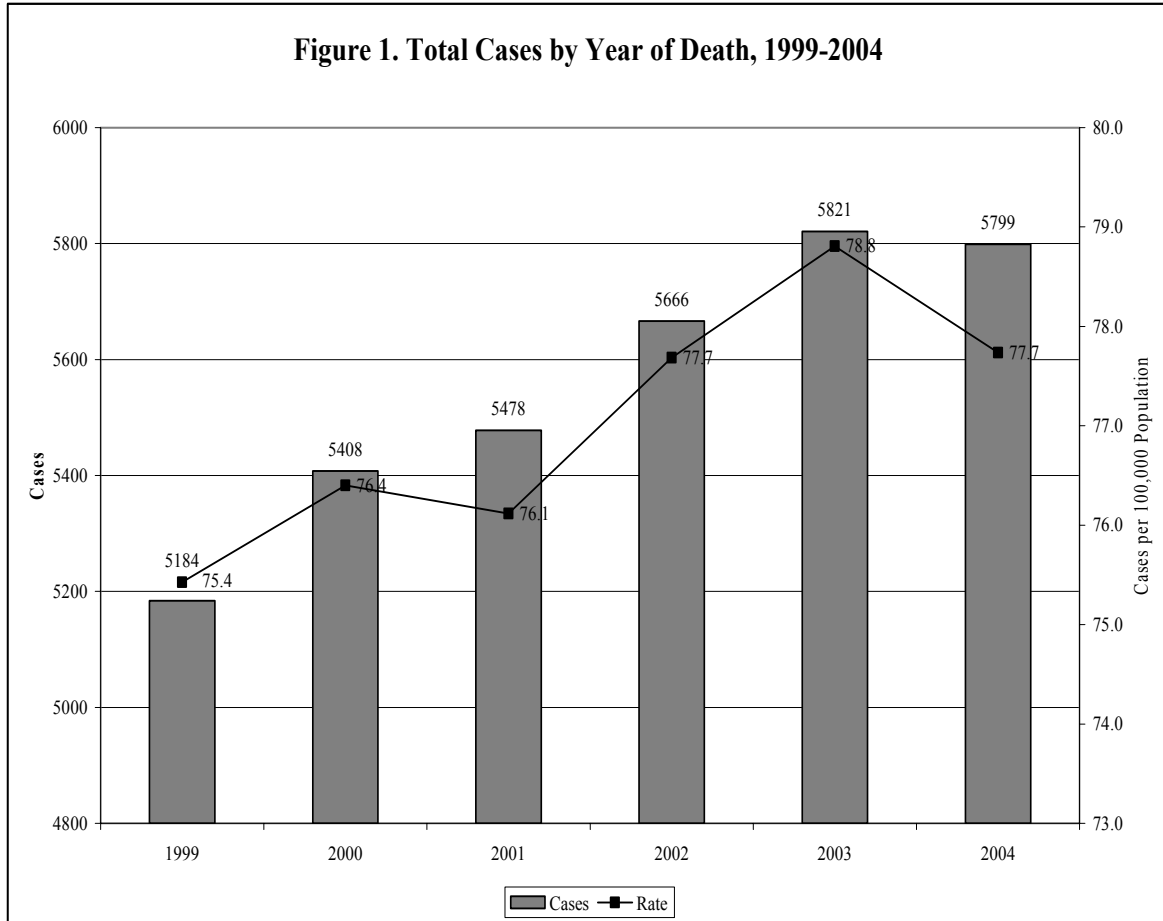
### ***Virginia 2004***

In 2004, the estimated population of the Commonwealth was 7,459,827, ranking 12<sup>th</sup> among the states. Virginia has a land area of 39,594 square mile and a population density of 188.4 persons per square mile; although an estimated 81.2 percent of the population lives in urban areas. Racially, whites constituted 73.76 percent of the population, blacks 19.88 percent, Native Americans 0.33 percent, Asians 4.42 percent, Native Hawaiian and other Pacific Islanders 0.07 percent, and those of mixed heritage 1.54 percent. Hispanics, who may be of any race, were 5.71 percent of Virginia's people. The median household income in 2004 was \$53,847.

## **SECTION 2: TOTAL CASES**

Since 1999 the number of deaths investigated annually by the OCME has increased by a total of 11.9 percent, while during the same time frame the population of Virginia has increased by 8.5 percent. In 2004, the OCME investigated 5,799 deaths, representing 10.3 percent of the estimated total deaths in Virginia. Of the deaths investigated by the OCME in 2004:

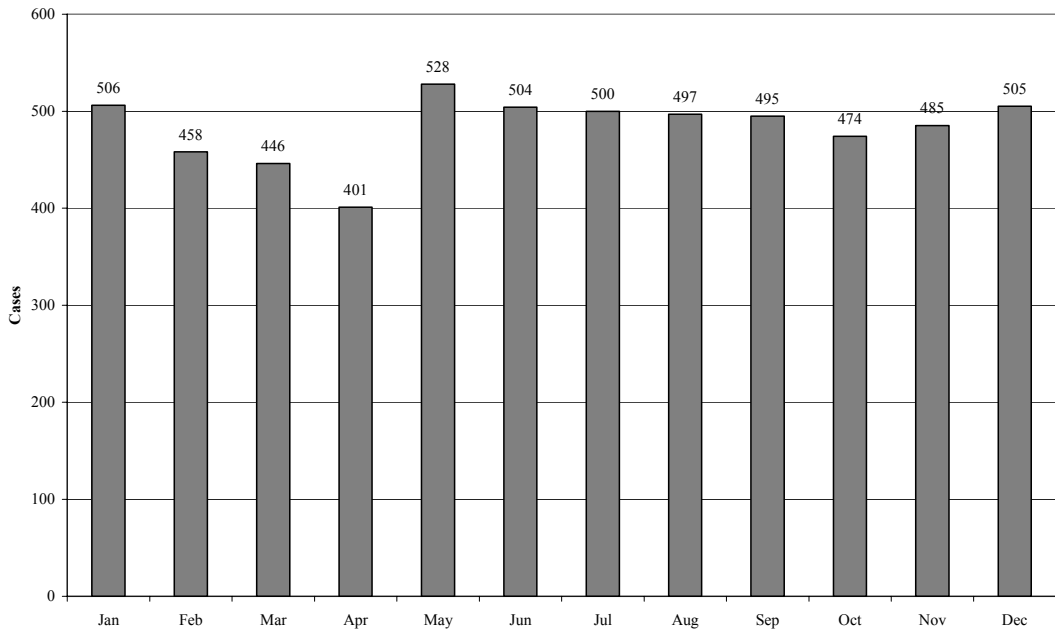
- The total number of deaths investigated represents a 0.4 percent decrease from the 2003 total, but has increased 11.9 percent overall since 1999.
- The highest total number of deaths occurred in May, and the fewest in April. More deaths occurred on Saturdays than any other day of the week, and the least on Thursdays.
- The ratio of male to female deaths was 2.3:1. Decedents classified as white represented 70.1 percent of the total.
- The City of Richmond continued to have greater than twice as many homicide deaths of its residents than Norfolk, which was the locality with the second greatest number of homicides in 2004. Fairfax County experienced the greatest number of accidental, natural, and suicide deaths in its residents.
- Autopsies were conducted in 38.1 percent of cases due to accidental deaths, 98.1 percent of homicides, 35.9 percent of natural causes, 82.1 percent of suicides, 95.2 percent of undetermined deaths, and 48.9 percent of all cases in 2004.
- Gunshot wounds were the cause of death in 824 deaths in 2004, 14.2 percent of total cases.
- Whites represented the greatest proportion of cases by all manners of death except homicide where blacks represented 61.7 percent of cases.
- The number of accidental deaths increased annually from 1999 to 2003, but remained stable from 2003 into 2004. The number of deaths by all other manners has remained stable.
- The number of suicides was almost twice the number of homicides in 2004.



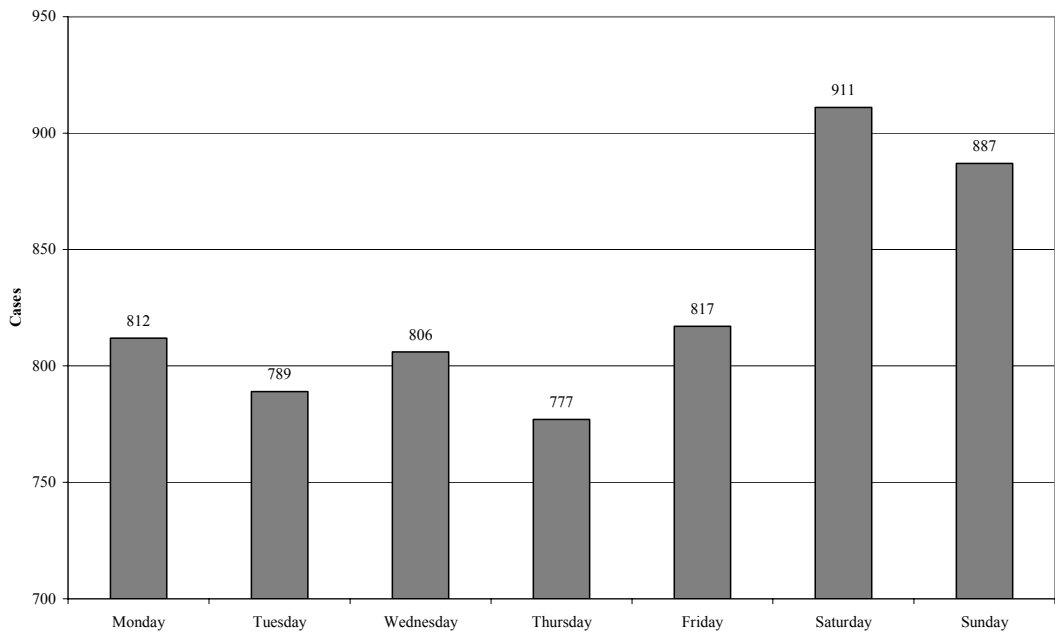
**Table 1. Total Cases by Manner of Death by OCME District, 2004**

Manner	OCME District				Total
	Central	Northern	Tidewater	Western	
Accident	735	462	430	685	2312
Homicide	192	37	130	70	429
Natural	664	435	627	409	2135
Suicide	236	196	164	244	840
Undetermined	25	13	18	27	83
<b>Total</b>	<b>1852</b>	<b>1143</b>	<b>1369</b>	<b>1435</b>	<b>5799</b>

**Figure 2. Total Cases by Month of Death, 2004**



**Figure 3. Total Cases by Day of Death, 2004**





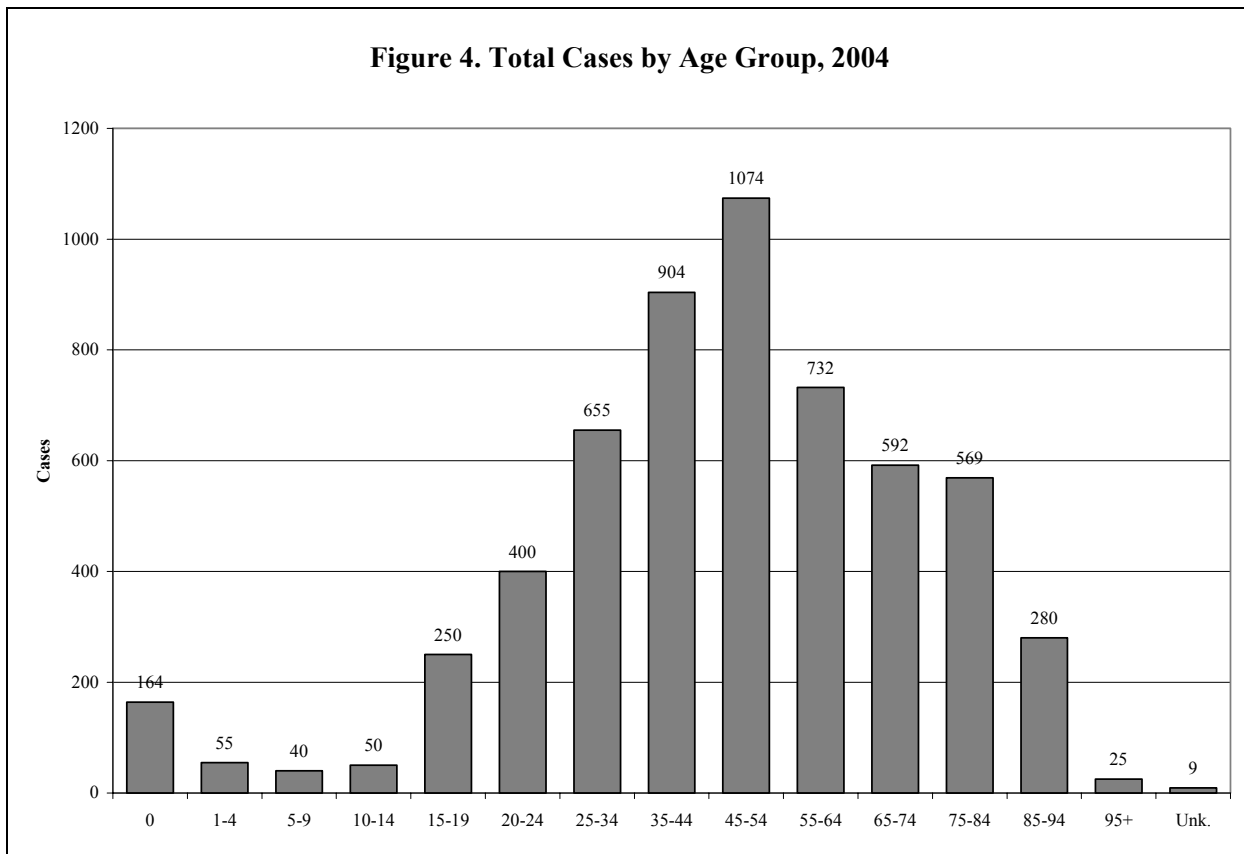
**Table 2. Total Cases by Gender, 2004**

Male	Female	Unknown	Total
4044	1753	2	5799

**Table 3. Total Cases by Race/Ethnicity, 2004**

White	Black	Asian	Native American	Hawaiian/Pacific Islander	Other	Unknown	Total
4063	1472	77	5	4	144	34	5799

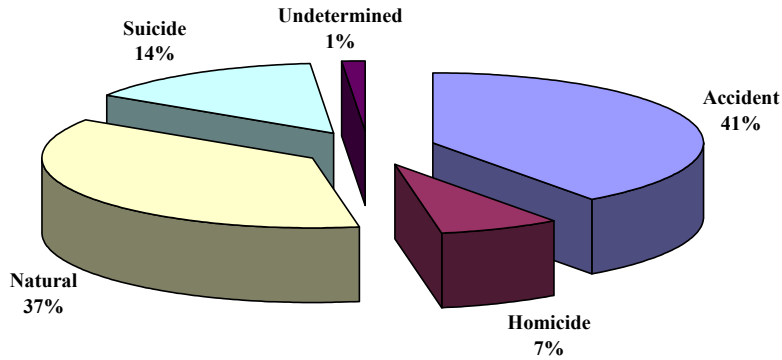
**Figure 4. Total Cases by Age Group, 2004**



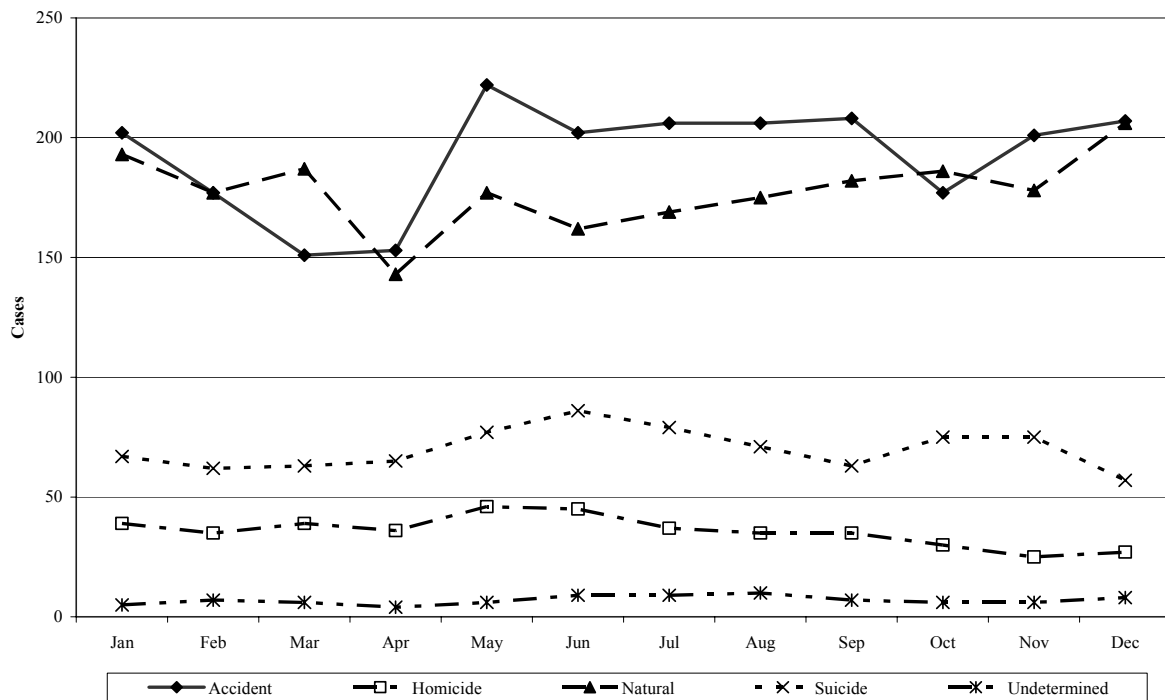
**Table 4. Total Cases by Autopsy Status, 2004**

Manner of Death						
Autopsy	Accident	Homicide	Natural	Suicide	Undetermined	Total
Yes	881	421	766	690	79	2837
No	1431	8	1369	150	4	2962
%	38.1	98.1	35.9	82.1	95.2	48.9
<b>Total</b>	<b>2312</b>	<b>429</b>	<b>2135</b>	<b>840</b>	<b>83</b>	<b>5799</b>

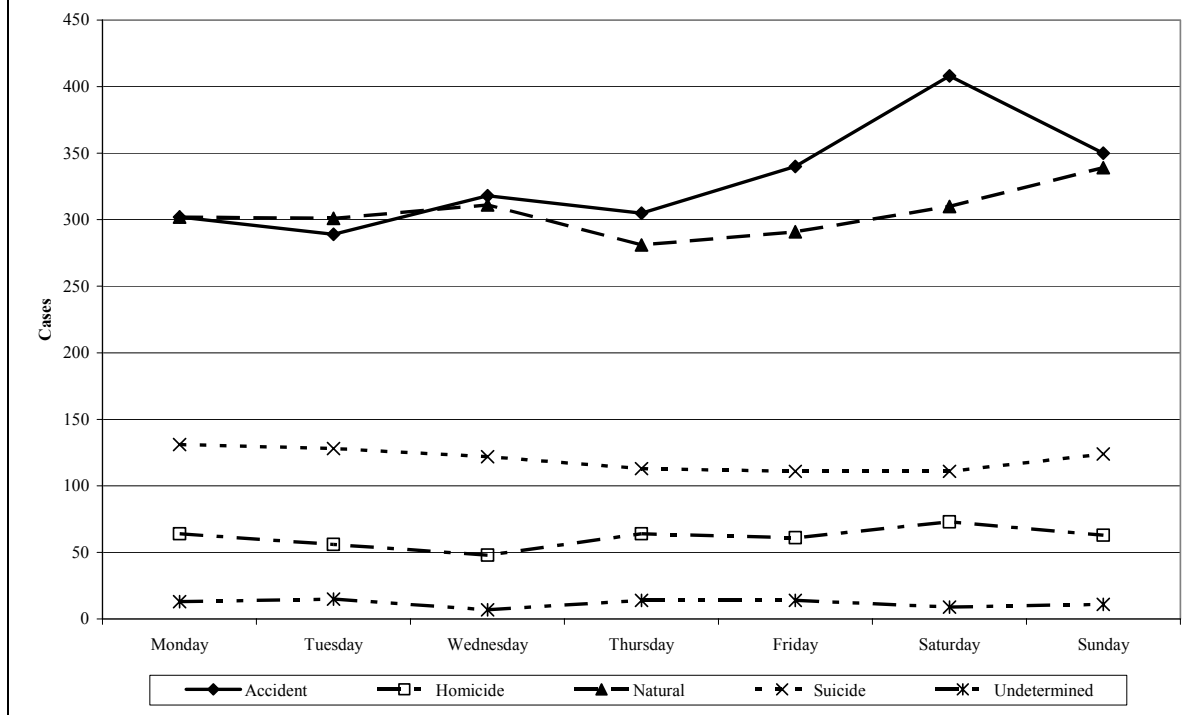
**Figure 5. Proportion of Cases by Manner of Death, 2004**



**Figure 6. Total Cases by Manner of Death by Month of Death, 2004**



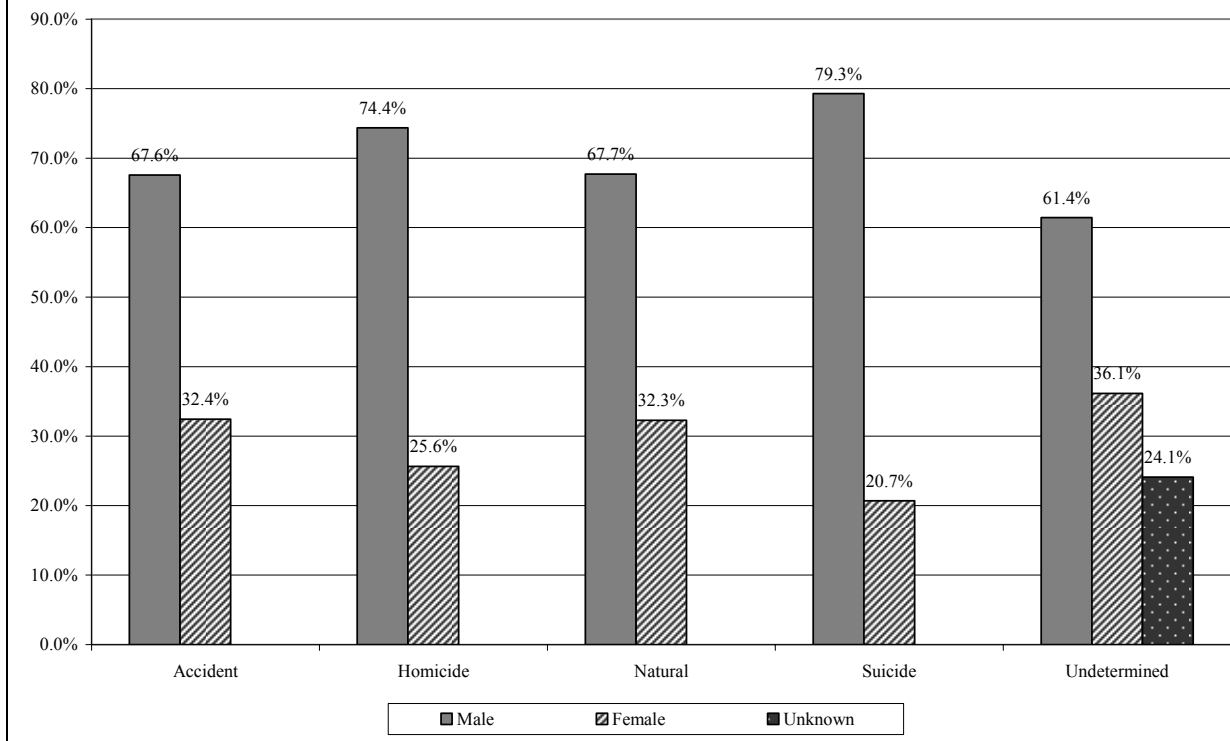
**Figure 7. Total Cases by Manner of Death by Day of Death, 2004**



**Table 5. Total Cases by Manner of Death by Gender, 2004**

Manner of Death						
Gender	Accident	Homicide	Natural	Suicide	Undetermined	Total
Male	1562	319	1446	666	51	4044
Female	750	110	689	174	30	1753
Unknown	0	0	0	0	2	2
<b>Total</b>	<b>2312</b>	<b>429</b>	<b>2135</b>	<b>840</b>	<b>83</b>	<b>5799</b>

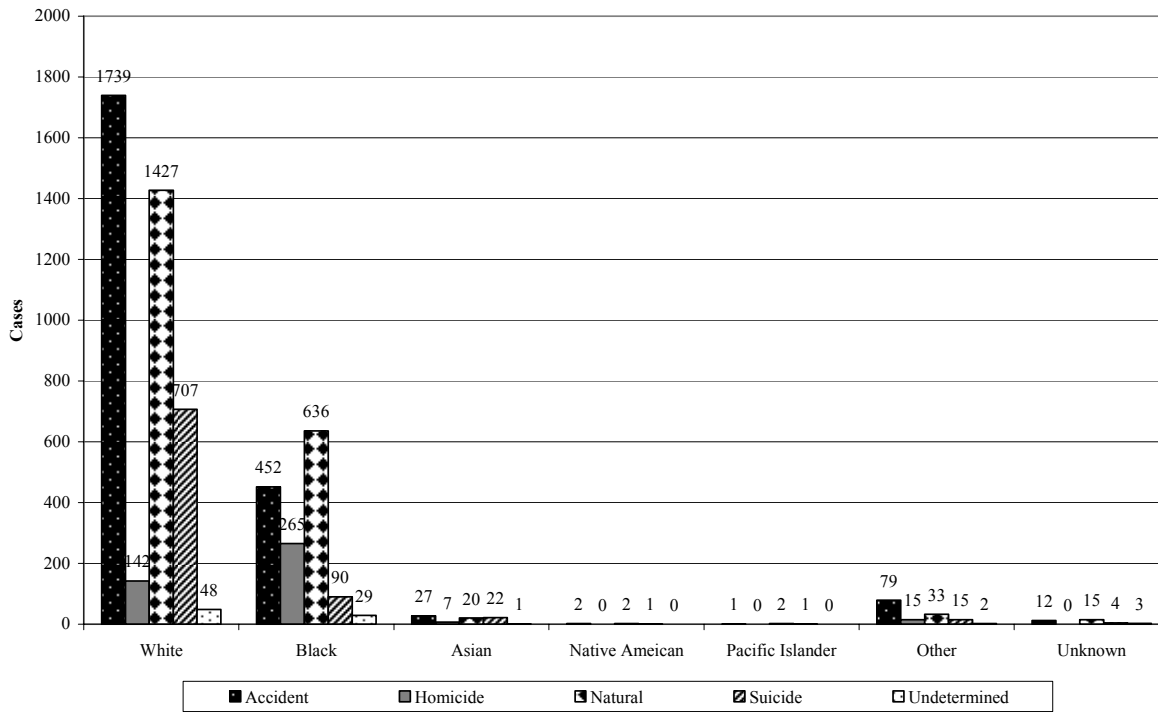
**Figure 8. Total Cases by Manner of Death by Gender, 2004**



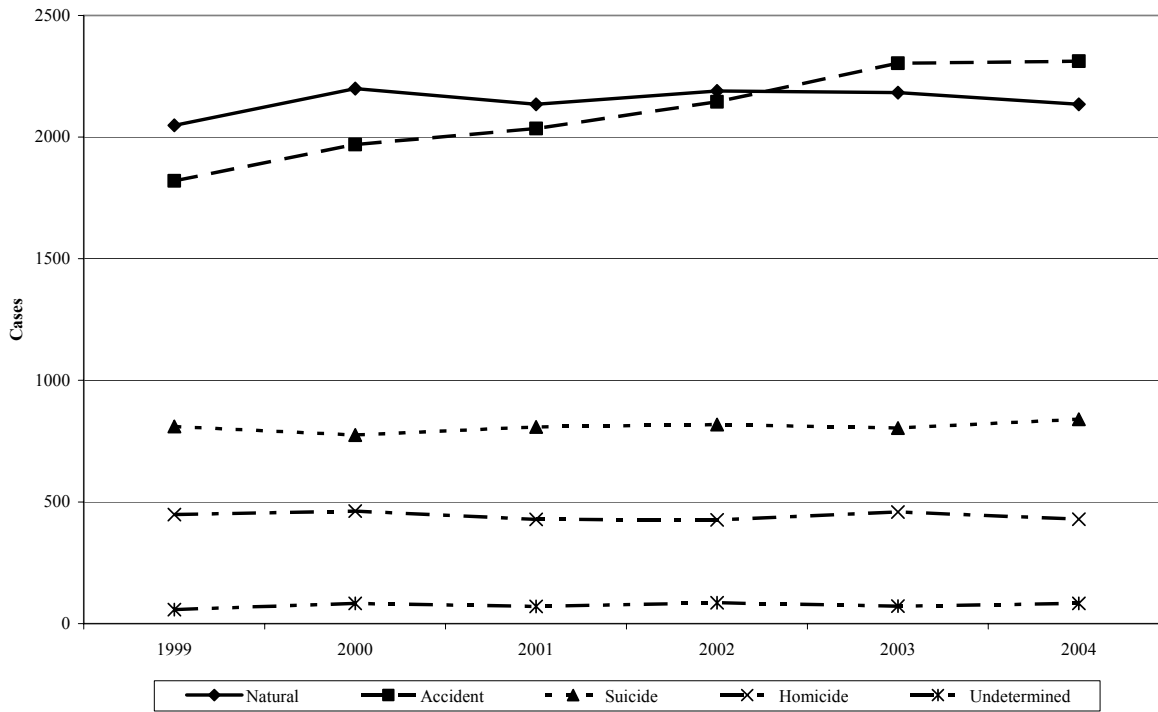
**Table 6. Total Cases by Manner of Death by Age Group by Gender, 2004**

Gender	Age	Manner of Death					Total
		Accident	Homicide	Natural	Suicide	Undetermined	
<b>Male</b>	<1	20	2	61	0	18	101
	1-4	21	4	7	0	0	32
	5-9	19	1	5	0	0	25
	10-14	15	8	9	4	0	36
	15-19	111	33	6	34	3	187
	20-24	165	80	17	51	0	313
	25-34	245	85	60	92	6	488
	35-44	248	44	191	136	9	628
	45-54	263	33	346	131	6	779
	55-64	144	16	313	87	4	564
	65-74	113	6	240	56	2	417
	75-84	126	4	152	53	1	336
	85-94	69	3	35	21	0	128
	95+	2	0	2	0	0	4
	Unknown	1	0	2	1	2	6
	<b>Subtotal</b>	<b>1562</b>	<b>319</b>	<b>1446</b>	<b>666</b>	<b>51</b>	<b>4044</b>
<b>Female</b>	<1	10	2	41	0	10	63
	1-4	9	8	6	0	0	23
	5-9	12	2	1	0	0	15
	10-14	9	0	4	1	0	14
	15-19	43	9	4	7	0	63
	20-24	53	11	12	10	1	87
	25-34	83	24	31	27	2	167
	35-44	107	28	89	49	3	276
	45-54	106	9	129	46	5	295
	55-64	45	7	94	20	2	168
	65-74	61	2	106	5	1	175
	75-84	114	6	102	7	4	233
	85-94	85	1	63	2	1	152
	95+	13	1	7	0	0	21
	Unknown	0	0	0	0	1	1
	<b>Subtotal</b>	<b>750</b>	<b>110</b>	<b>689</b>	<b>174</b>	<b>30</b>	<b>1753</b>
<b>Unknown</b>	Unknown	0	0	0	0	2	2
<b>Total</b>		<b>2312</b>	<b>429</b>	<b>2135</b>	<b>840</b>	<b>83</b>	<b>5799</b>

**Figure 9. Total Cases by Manner of Death by Race/Ethnicity, 2004**



**Figure 10. Total Cases by Manner of Death by Year of Death, 1999-2004**



**Table 7. Total Cases by Locality of Death, 2004**

Locality of Death	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
ACCOMACK	17	1	7	2	1	28
ALBEMARLE COUNTY	37	2	17	16	2	74
ALEXANDRIA CITY	18	2	43	14	0	77
ALLEGHANY COUNTY	5	2	6	1	0	14
AMELIA COUNTY	4	0	2	3	0	9
AMHERST COUNTY	3	1	21	4	1	30
APPOMATTOX COUNTY	2	0	3	1	0	6
ARLINGTON	21	2	44	14	0	81
AUGUSTA COUNTY	28	7	16	13	2	66
BATH COUNTY	2	0	5	2	0	9
BEDFORD CITY	0	0	4	0	0	4
BEDFORD COUNTY	18	0	12	5	0	35
BLAND COUNTY	2	0	0	2	0	4
BOTETOURT COUNTY	10	0	3	2	0	15
BRISTOL	4	0	6	3	0	13
BRUNSWICK COUNTY	12	2	3	1	0	18
BUCHANAN COUNTY	21	2	10	8	0	41
BUCKINGHAM COUNTY	6	0	2	1	0	9
BUENA VISTA	1	0	0	2	0	3
CAMPBELL COUNTY	10	2	10	6	0	28
CAROLINE COUNTY	12	1	8	1	0	22
CARROLL COUNTY	9	0	3	8	0	20
CHARLES CITY COUNTY	2	0	2	1	0	5
CHARLOTTE COUNTY	4	0	3	1	0	8
CHARLOTTESVILLE CITY	58	7	20	13	1	99
CHESAPEAKE	37	8	66	19	1	131
CHESTERFIELD COUNTY	48	8	48	27	2	133
CLARKE COUNTY	3	1	1	1	1	7
CLIFTON FORGE	0	0	1	0	0	1
COLONIAL HEIGHTS CITY	1	4	4	1	0	10
COVINGTON	0	0	1	1	0	2
CRAIG COUNTY	0	0	3	0	0	3
CULPEPER COUNTY	15	0	20	7	0	42
CUMBERLAND COUNTY	1	0	4	1	1	7
DANVILLE	25	5	27	6	0	63
DICKENSON COUNTY	10	3	4	3	0	20
DINWIDDIE COUNTY	12	3	8	3	0	26
EMPORIA CITY	4	1	10	1	0	16
ESSEX COUNTY	11	1	8	2	0	22
FAIRFAX CITY	1	0	2	1	0	4
FAIRFAX COUNTY	217	16	141	72	5	451
FALLS CHURCH CITY	0	0	1	1	0	2
FAUQUIER COUNTY	22	0	11	13	2	48
FLOYD COUNTY	4	0	3	3	0	10
FLUVANNA COUNTY	3	0	4	1	0	8
FRANKLIN COUNTY	18	2	9	9	0	38
FREDERICK COUNTY	17	2	13	10	0	42
FREDERICKSBURG CITY	29	2	24	5	0	60
GALAX	2	0	4	1	0	7
GILES COUNTY	6	1	2	3	0	12
GLOUCESTER COUNTY	7	1	10	8	0	26
GOOCHLAND COUNTY	2	1	6	1	0	10
GRAYSON COUNTY	8	1	4	5	0	18

**Table 7. Total Cases by Locality of Death, 2004 ~continued**

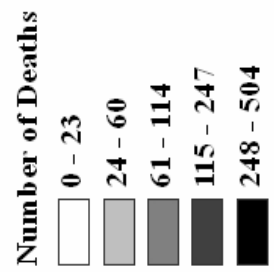
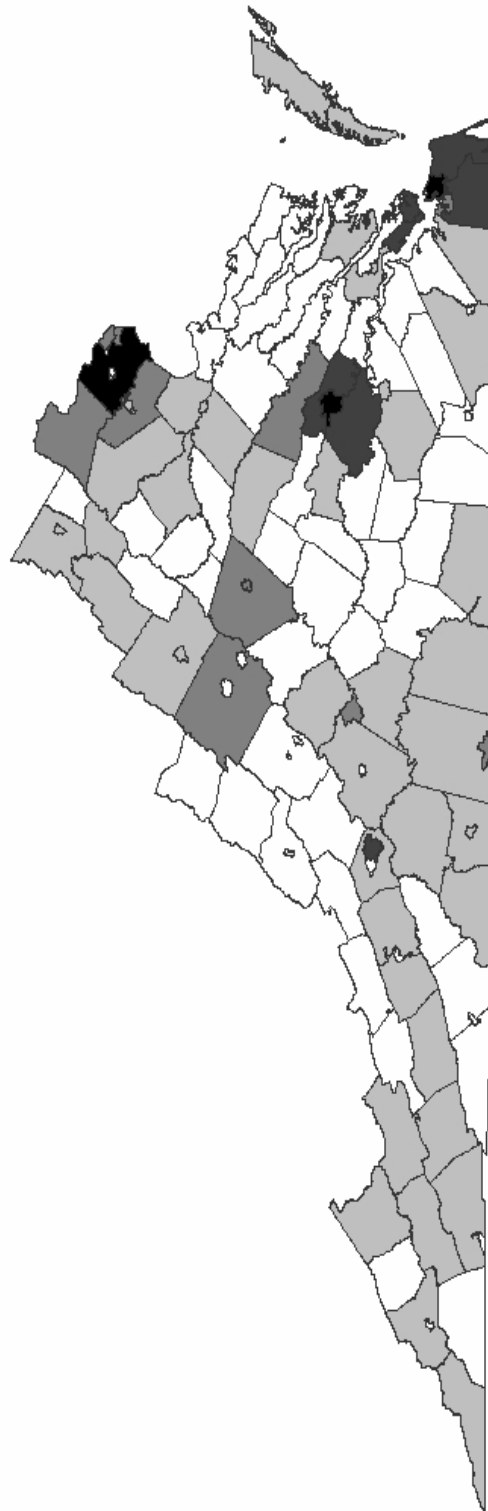
Locality of Death	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
GREENE COUNTY	8	1	6	3	0	18
GREENSVILLE COUNTY	5	4	9	0	0	18
HALIFAX COUNTY	26	2	10	5	1	44
HAMPTON	24	10	100	13	3	150
HANOVER COUNTY	35	3	28	8	0	74
HARRISONBURG	12	1	15	1	2	31
HENRICO COUNTY	64	20	61	21	2	168
HENRY COUNTY	13	3	5	8	1	30
HIGHLAND COUNTY	0	1	1	2	0	4
HOPEWELL CITY	5	1	9	1	1	17
ISLE OF WIGHT	7	2	5	5	0	19
JAMES CITY COUNTY	10	0	10	6	0	26
KING & QUEEN COUNTY	3	0	0	1	0	4
KING GEORGE COUNTY	4	1	4	2	0	11
KING WILLIAM COUNTY	2	0	0	3	0	5
LANCASTER COUNTY	3	0	6	0	0	9
LEE COUNTY	17	2	11	9	0	39
LEXINGTON	4	0	2	0	0	6
LOUDOUN COUNTY	35	2	40	17	0	94
LOUISA COUNTY	14	0	15	6	0	35
LUNENBURG COUNTY	5	0	0	3	0	8
LYNCHBURG	50	5	33	6	5	99
MADISON COUNTY	5	0	3	1	0	9
MANASSAS CITY	5	3	16	1	0	25
MARTINSVILLE	20	1	10	6	2	39
MECKLENBURG COUNTY	12	1	12	9	1	35
MIDDLESEX COUNTY	5	0	2	2	0	9
MONTGOMERY COUNTY	24	1	14	10	0	49
NELSON COUNTY	4	1	2	2	0	9
NEW KENT COUNTY	2	0	4	4	0	10
NEWPORT NEWS	54	21	80	18	3	176
NORFOLK	129	52	145	32	5	363
NORTHAMPTON COUNTY	11	3	16	4	0	34
NORTHUMBERLAND COUNTY	1	0	5	1	0	7
NORTON	11	0	4	3	0	18
NOTTOWAY COUNTY	5	0	13	4	1	23
ORANGE COUNTY	9	1	6	0	1	17
PAGE COUNTY	5	0	2	0	0	7
PATRICK COUNTY	20	2	2	6	0	30
PETERSBURG CITY	7	5	35	5	0	52
PITTSYLVANIA COUNTY	14	2	13	5	2	36
POQUOSON	2	0	0	0	0	2
PORTSMOUTH	34	7	61	10	2	114
POWHATAN COUNTY	2	0	22	4	0	28
PRINCE EDWARD COUNTY	7	1	8	2	0	18
PRINCE GEORGE COUNTY	10	1	6	6	0	23
PRINCE WILLIAM COUNTY	34	6	50	17	2	109
PULASKI COUNTY	13	0	15	7	0	35
RADFORD	2	0	0	2	0	4
RAPPAHANNOCK COUNTY	3	0	2	1	0	6
RICHMOND CITY	203	108	154	27	12	504
RICHMOND COUNTY	1	0	1	1	0	3
ROANOKE CITY	99	13	40	17	3	172



**Table 7. Total Cases by Locality of Death, 2004 ~continued**

Locality of Death	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
ROANOKE COUNTY	10	1	11	9	2	33
ROCKBRIDGE COUNTY	13	0	4	5	0	22
ROCKINGHAM COUNTY	20	1	10	6	0	37
RUSSELL COUNTY	25	0	4	9	1	39
SALEM	6	0	5	6	0	17
SCOTT COUNTY	12	0	0	3	0	15
SHENANDOAH COUNTY	11	1	10	6	1	29
SMYTH COUNTY	12	0	6	5	1	24
SOUTH BOSTON CITY	1	0	3	0	0	4
SOUTHAMPTON COUNTY	12	2	12	2	2	30
SPOTSYLVANIA COUNTY	12	2	12	8	0	34
STAFFORD COUNTY	8	4	14	9	0	35
STAUNTON CITY	2	0	3	3	0	8
SUFFOLK	22	5	22	8	1	58
SURRY COUNTY	1	1	2	0	0	4
SUSSEX COUNTY	3	2	3	1	0	9
TAZEWELL COUNTY	26	1	11	6	1	45
VIRGINIA BEACH	76	18	105	48	0	247
WARREN COUNTY	19	1	10	14	0	44
WASHINGTON COUNTY	26	3	18	8	2	57
WAYNESBORO	3	0	1	4	1	9
WESTMORELAND COUNTY	3	3	0	1	1	8
WILLIAMSBURG CITY	9	0	25	4	0	38
WINCHESTER CITY	23	0	20	6	1	50
WISE COUNTY	27	1	8	2	0	38
WYTHE COUNTY	15	1	6	5	1	28
YORK COUNTY	5	1	7	3	0	16
OUT OF STATE	2	3	1	3	0	9
<b>Total</b>	<b>2312</b>	<b>429</b>	<b>2135</b>	<b>840</b>	<b>83</b>	<b>5799</b>

**Figure 11. Total Cases by Locality of Death, 2004**



**Table 8. Total Cases by Locality of Residence, 2004**

Locality of Residence	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
ACCOMACK	21	4	15	2	0	42
ALBEMARLE COUNTY	23	1	17	12	2	55
ALEXANDRIA CITY	18	3	20	15	0	56
ALLEGHANY COUNTY	1	2	5	3	0	11
AMELIA COUNTY	3	0	5	3	1	12
AMHERST COUNTY	10	0	28	3	1	42
APPOMATTOX COUNTY	8	0	6	2	0	16
ARLINGTON	20	2	35	15	0	72
AUGUSTA COUNTY	23	5	12	14	2	56
BATH COUNTY	5	0	4	0	0	9
BEDFORD COUNTY	28	0	15	6	1	50
BLAND COUNTY	4	0	0	2	0	6
BOTETOURT COUNTY	13	0	5	3	0	21
BRISTOL	5	1	7	3	0	16
BRUNSWICK COUNTY	7	0	8	3	0	18
BUCHANAN COUNTY	20	4	8	7	0	39
BUCKINGHAM COUNTY	11	0	3	1	0	15
BUENA VISTA	2	0	0	2	0	4
CAMPBELL COUNTY	16	1	21	6	1	45
CAROLINE COUNTY	8	1	7	2	0	18
CARROLL COUNTY	8	1	3	8	0	20
CHARLES CITY COUNTY	0	0	3	1	0	4
CHARLOTTE COUNTY	5	0	5	1	0	11
CHARLOTTESVILLE CITY	12	4	13	3	0	32
CHESAPEAKE	43	15	76	21	1	156
CHESTERFIELD COUNTY	62	17	56	30	2	167
CLARKE COUNTY	2	1	2	1	1	7
COLONIAL HEIGHTS CITY	5	6	5	1	0	17
COVINGTON	3	0	2	1	0	6
CRAIG COUNTY	0	2	2	0	0	4
CULPEPER COUNTY	16	0	17	7	0	40
CUMBERLAND COUNTY	0	0	4	0	1	5
DANVILLE	19	6	15	6	0	46
DICKENSON COUNTY	10	2	2	3	0	17
DINWIDDIE COUNTY	9	3	9	3	0	24
EMPORIA CITY	2	1	2	1	1	7
ESSEX COUNTY	13	2	6	3	0	24
FAIRFAX CITY	4	0	4	1	0	9
FAIRFAX COUNTY	138	12	111	63	4	328
FALLS CHURCH CITY	2	0	1	1	0	4
FAUQUIER COUNTY	22	0	9	10	2	43
FLOYD COUNTY	7	0	4	4	0	15
FLUVANNA COUNTY	8	0	4	2	0	14
FRANKLIN COUNTY	19	2	14	7	0	42
FREDERICK COUNTY	21	1	18	12	0	52
FREDERICKSBURG CITY	13	0	9	2	0	24
GALAX	0	0	1	0	0	1
GILES COUNTY	5	1	1	3	0	10
GLOUCESTER COUNTY	13	1	9	8	0	31
GOOCHLAND COUNTY	13	1	8	2	1	25
GRAYSON COUNTY	8	1	3	5	0	17
GREENE COUNTY	8	2	6	2	0	18

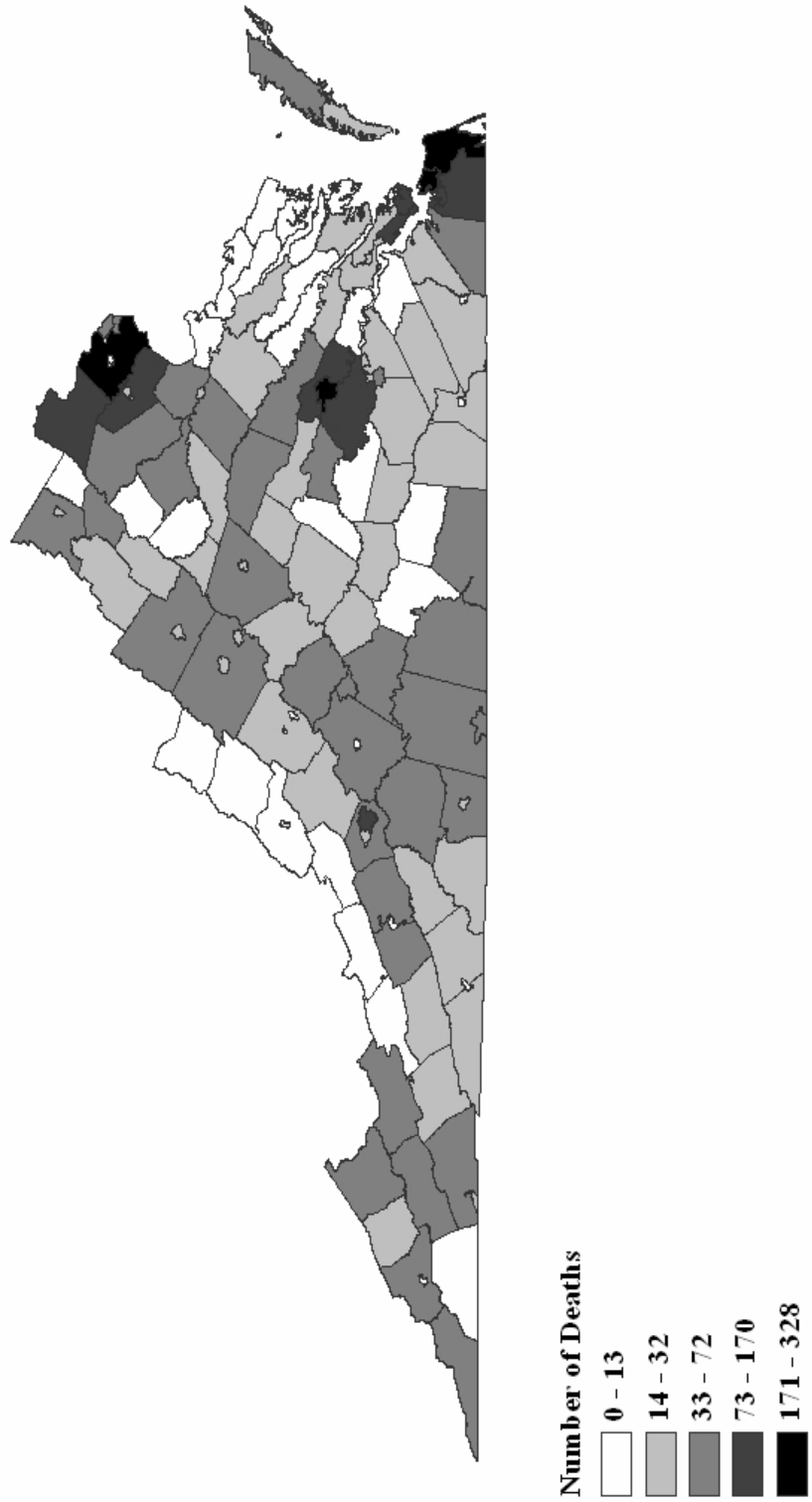
**Table 8. Total Cases by Locality of Residence, 2004 ~continued**

Locality of Residence	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
GREENSVILLE COUNTY	3	3	12	0	0	18
HALIFAX COUNTY	20	2	7	5	1	35
HAMPTON	34	10	92	12	3	151
HANOVER COUNTY	33	5	22	8	0	68
HARRISONBURG	5	2	11	1	1	20
HENRICO COUNTY	63	27	56	23	1	170
HENRY COUNTY	26	4	10	10	2	52
HIGHLAND COUNTY	1	1	1	2	0	5
HOPEWELL CITY	5	1	7	3	1	17
ISLE OF WIGHT	10	2	9	5	2	28
JAMES CITY COUNTY	9	0	9	6	0	24
KING & QUEEN COUNTY	4	0	3	1	0	8
KING GEORGE COUNTY	2	1	4	2	0	9
KING WILLIAM COUNTY	5	0	1	4	0	10
LANCASTER COUNTY	0	0	6	0	0	6
LEE COUNTY	19	2	10	9	0	40
LEXINGTON	2	0	1	0	0	3
LOUDOUN COUNTY	45	2	34	17	0	98
LOUISA COUNTY	16	0	13	5	0	34
LUNENBURG COUNTY	7	0	2	2	0	11
LYNCHBURG	21	3	15	7	4	50
MADISON COUNTY	7	0	3	1	0	11
MANASSAS CITY	5	2	8	0	0	15
MARTINSVILLE	8	1	7	3	1	20
MATHEWS COUNTY	4	0	1	0	0	5
MECKLENBURG COUNTY	9	2	15	9	1	36
MIDDLESEX COUNTY	7	1	3	2	0	13
MONTGOMERY COUNTY	26	4	8	8	0	46
NELSON COUNTY	9	1	3	1	0	14
NEW KENT COUNTY	6	0	4	4	0	14
NEWPORT NEWS	40	20	70	19	3	152
NORFOLK	62	32	108	22	4	228
NORTHAMPTON COUNTY	9	2	6	4	0	21
NORTHUMBERLAND COUNTY	2	1	2	1	0	6
NORTON	1	0	2	2	0	5
NOTTOWAY COUNTY	5	0	12	4	0	21
ORANGE COUNTY	10	1	7	2	1	21
PAGE COUNTY	12	0	2	2	0	16
PATRICK COUNTY	12	2	1	6	0	21
PETERSBURG CITY	11	3	24	3	1	42
PITTSYLVANIA COUNTY	23	1	22	5	2	53
POQUOSON	2	0	4	0	0	6
PORTSMOUTH	41	11	50	12	1	115
POWHATAN COUNTY	6	0	26	4	0	36
PRINCE EDWARD COUNTY	10	1	2	3	0	16
PRINCE GEORGE COUNTY	9	3	5	9	0	26
PRINCE WILLIAM COUNTY	50	8	54	18	2	132
PULASKI COUNTY	21	0	15	8	0	44
RADFORD	2	1	0	2	0	5
RAPPAHANNOCK COUNTY	2	0	3	2	0	7
RICHMOND CITY	110	81	107	18	7	323
RICHMOND COUNTY	4	0	2	0	0	6
ROANOKE CITY	36	7	39	13	2	97

**Table 8. Total Cases by Locality of Residence, 2004 ~continued**

Locality of Residence	Manner of Death					Total
	Accident	Homicide	Natural	Suicide	Undetermined	
ROANOKE COUNTY	22	1	7	9	1	40
ROCKBRIDGE COUNTY	8	0	4	6	0	18
ROCKINGHAM COUNTY	30	1	12	6	1	50
RUSSELL COUNTY	28	0	5	9	1	43
SALEM	13	0	5	3	0	21
SCOTT COUNTY	8	0	0	3	0	11
SHENANDOAH COUNTY	11	1	13	7	0	32
SMYTH COUNTY	13	0	9	5	1	28
SOUTH BOSTON CITY	1	1	2	0	0	4
SOUTHAMPTON COUNTY	10	2	8	2	0	22
SPOTSYLVANIA COUNTY	27	3	18	9	0	57
STAFFORD COUNTY	23	3	18	10	0	54
STAUNTON CITY	9	0	4	4	0	17
SUFFOLK	24	3	19	7	1	54
SURRY COUNTY	2	0	4	0	0	6
SUSSEX COUNTY	3	3	6	2	0	14
TAZEWELL COUNTY	29	1	11	7	1	49
VIRGINIA BEACH	89	19	112	49	1	270
WARREN COUNTY	20	1	10	13	0	44
WASHINGTON COUNTY	17	2	17	11	2	49
WAYNESBORO	8	1	2	4	1	16
WESTMORELAND COUNTY	4	0	2	2	1	9
WILLIAMSBURG CITY	12	0	11	4	1	28
WINCHESTER CITY	7	0	11	1	1	20
WISE COUNTY	31	0	14	5	0	50
WYTHE COUNTY	12	1	4	4	1	22
YORK COUNTY	9	1	9	2	0	21
OUT OF COUNTRY	3	1	2	0	0	6
OUT OF STATE	207	25	203	31	2	468
UNKNOWN	5	4	8	0	6	23
<b>Total</b>	<b>2312</b>	<b>429</b>	<b>2135</b>	<b>840</b>	<b>83</b>	<b>5799</b>

**Figure 12. Total Cases by Locality of Residence, 2004**



**Table 9. Total Cases by Cause of Death, 2004**

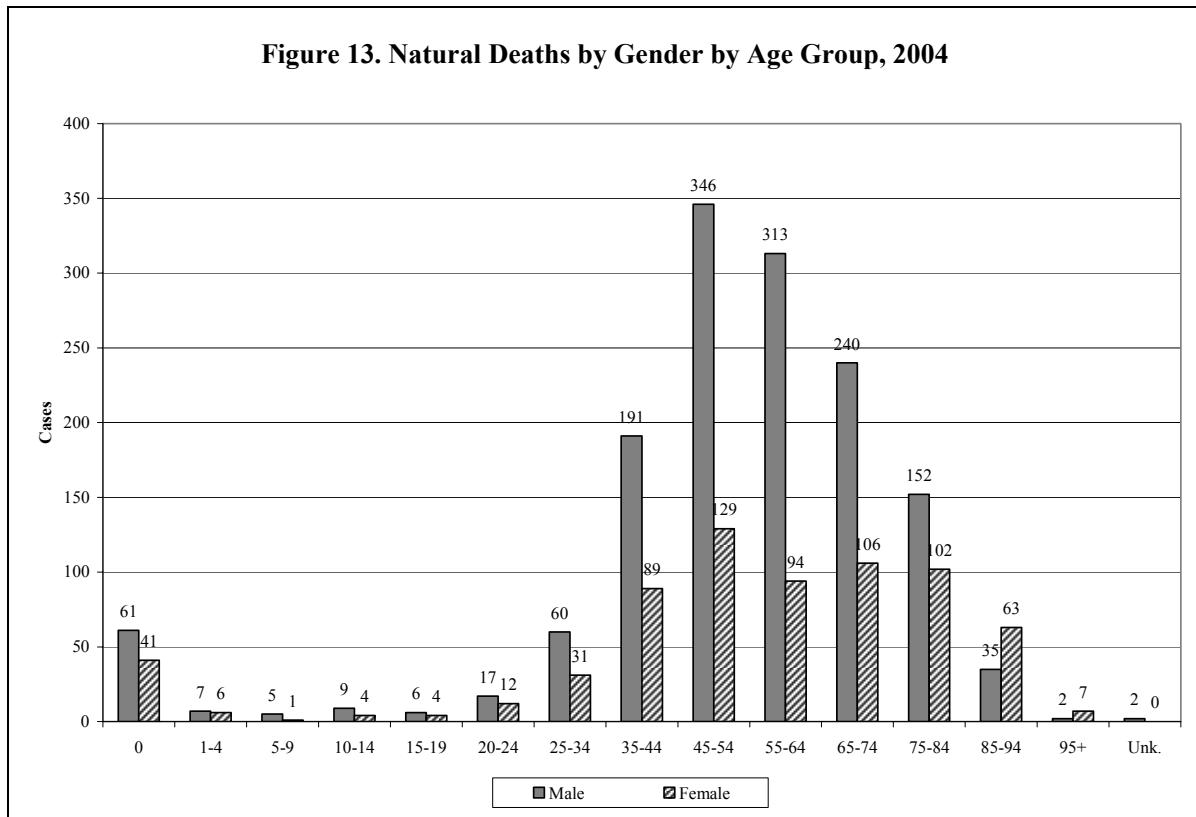
<b>Natural Deaths</b>	<b>Total Cases</b>	<b>Autopsied</b>
AIDS	6	3
Alzheimers Disease	7	1
Aneurysm	14	10
Aspiration	5	1
Asthma	13	7
Blood Disorders	2	1
Carcinoma	83	31
Cerebrovascular	66	29
COPD	16	4
Congenital Defect	4	3
Dehydration	3	2
Diabetes	36	13
Emboli	56	32
Emphysema	6	1
Epilepsy	19	10
Ethanolism	53	11
Gastrointestinal Hemorrhage	41	8
Heart Disease	1422	409
Hepatic Failure	6	2
History of Illness or Injury	1	0
Hypertension	5	0
Intrauterine Fetal Death	4	3
Leukemia	1	0
Medical Treatment	1	0
Meningitis	5	5
Obesity	1	0
Obstruction (blockage)	3	2
Pancreas	3	2
Parkinson's Disease	1	0
Pathologic Injuries	14	10
Pneumonia	99	48
Prematurity	5	3
Pulmonary Edema	3	0
Renal Failure	15	1
Respiratory Distress Syndrome	5	0
Sepsis	33	7
Spontaneous Hemorrhage	2	2
Sudden Infant Death Syndrome	84	83
Natural - Other	79	44
<b>Subtotal</b>	<b>2222</b>	<b>788</b>
<b>Unnatural Deaths</b>		
Asphyxia	104	65
Carbon Monoxide Poisoning	121	88
Child Abuse	7	7
Drowning	118	63
Electrocution	11	8
Ethanol Poisoning	30	21
Exposure (Cold)	18	11
Exposure (Heat)	4	1
Exsanguination	18	14
Gunshot Wound	824	813
Hanging	154	64
Head and Neck Injuries	649	120
Judicial Execution	5	2
Multiple Injuries	685	150
Narcotic Abuse	216	182
Stab Wound	45	44
Subdural Hematoma	97	4
Substance Poisoning	359	316
Thermal Injuries (burns)	46	28
Unnatural - Other	30	12
<b>Subtotal</b>	<b>3541</b>	<b>2013</b>
<b>Undetermined Deaths</b>		
Skeletal/Mummified Remains	2	2
Undetermined after Autopsy and/or Investigation	34	34
<b>Subtotal</b>	<b>36</b>	<b>36</b>
<b>Total</b>	<b>5799</b>	<b>2837</b>

## SECTION 3: MANNER OF DEATH

### NATURAL DEATH

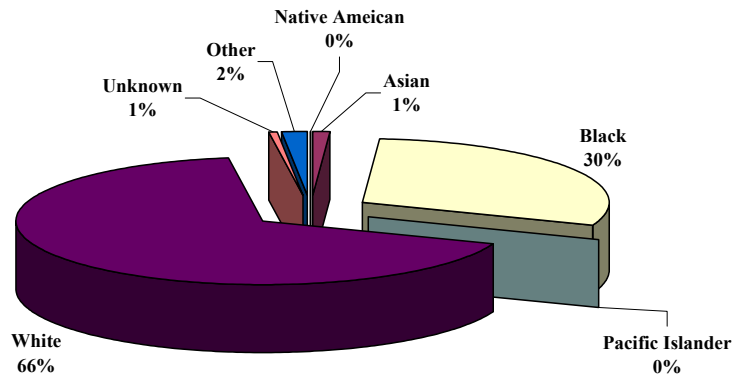
Natural deaths enter the medical examiner system as deaths that are sudden, unexpected and suspicious; that upon examination and investigation are established as natural or as unattended by a physician for a disease process that could reasonable be expected to account for death.

Natural deaths accounted for 37.0 percent of the deaths investigated by the OCME in 2004; the number investigated has increased 4.2 percent since 1999. For children 17 years and younger, the highest number of deaths occurred for those aged under 1 years old.

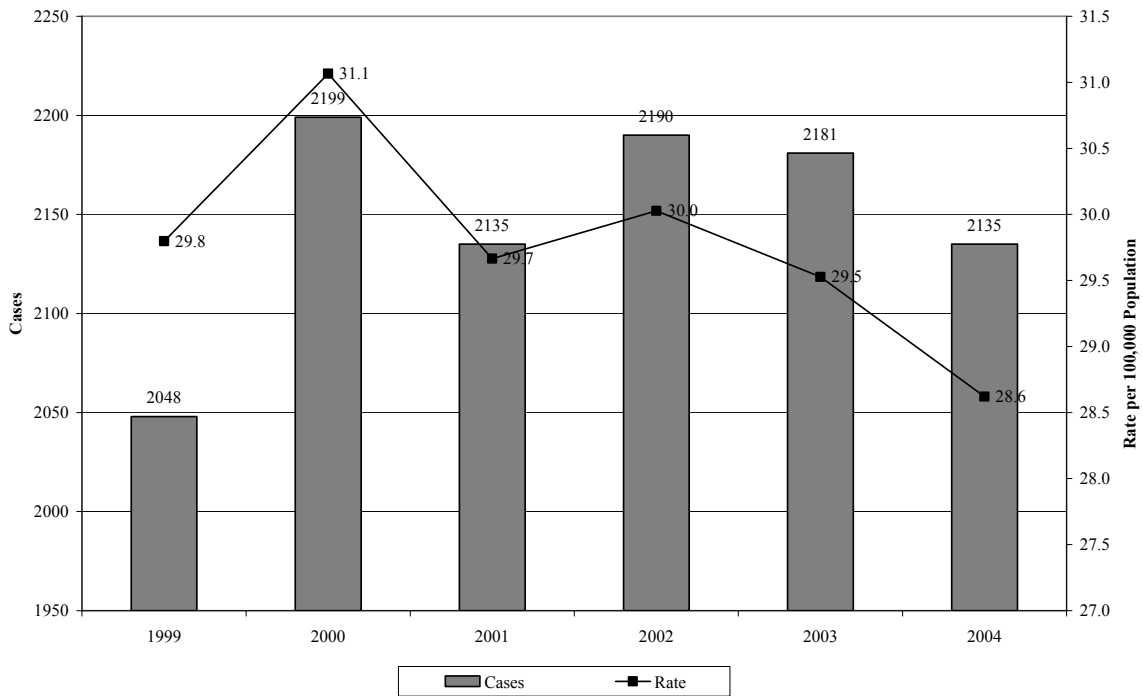




**Figure 14. Natural Deaths by Race/Ethnicity, 2004**

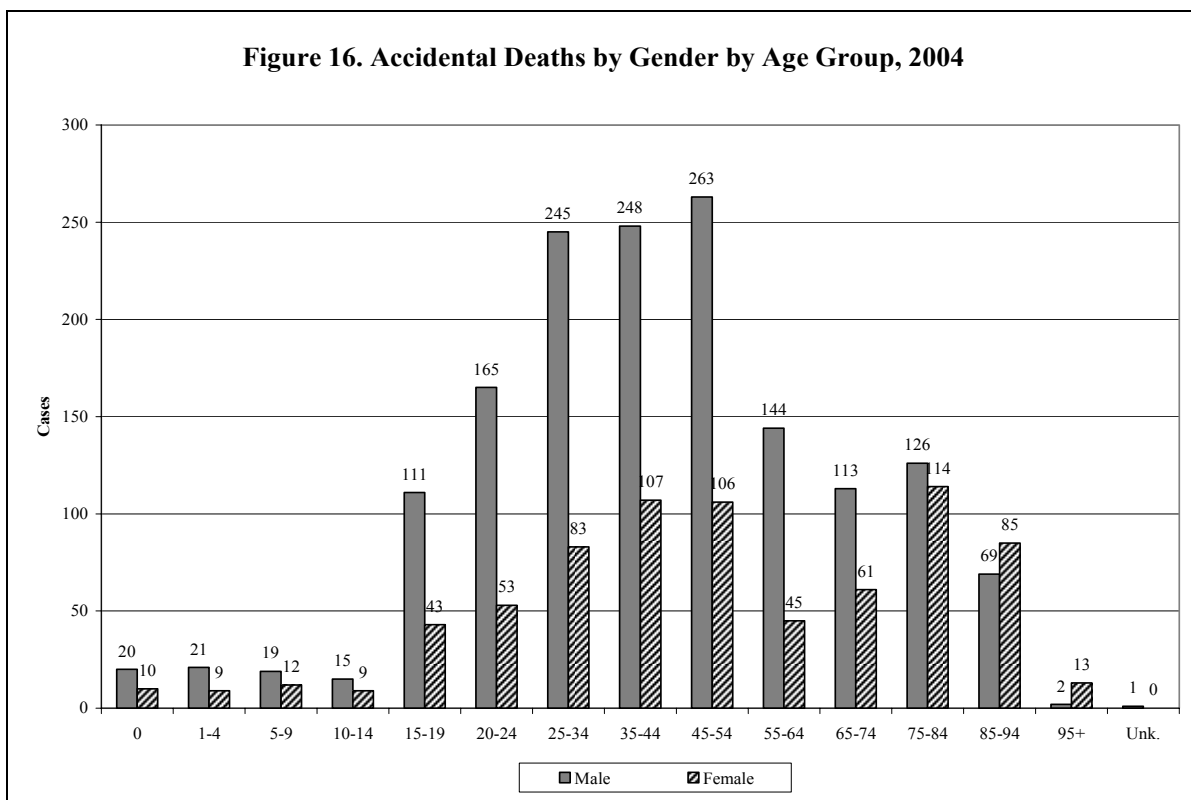


**Figure 15. Natural Deaths by Year of Death, 1999-2004**

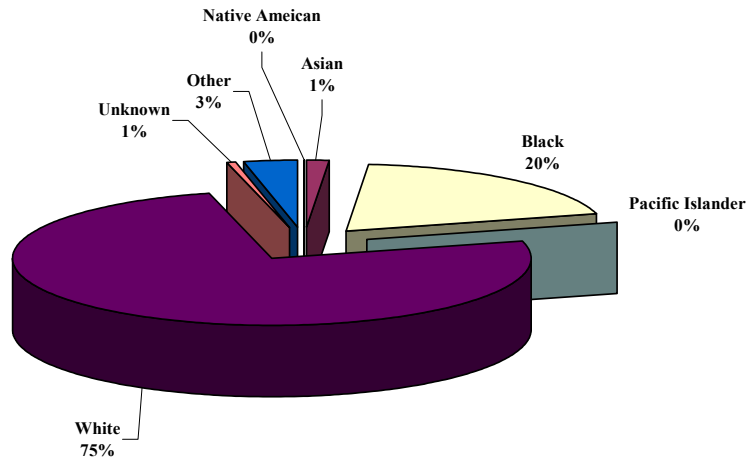


## ACCIDENTAL DEATHS

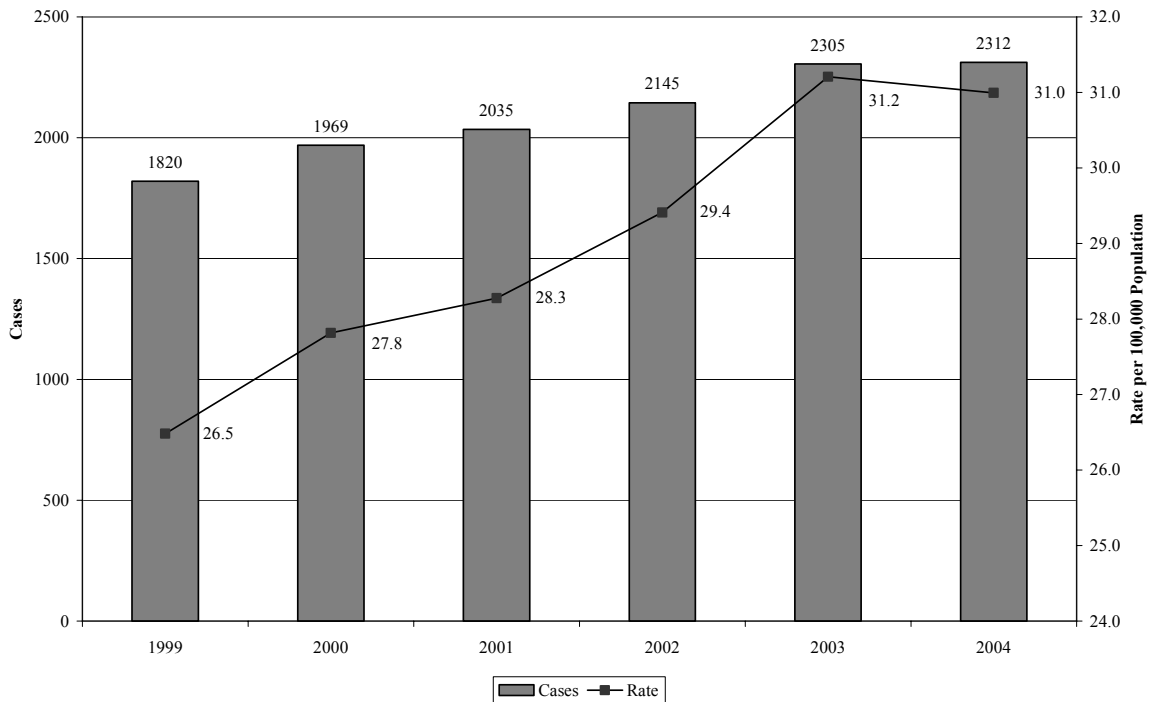
Accidental deaths accounted for 40.0 percent of the deaths investigated by OCME in 2004; this represents the greatest proportion of deaths by manner. The number of accidental deaths investigated annually by the OCME has increased 27.0 percent since 1999. Accidents involving a motor vehicle were the most common cause of accidental deaths with 43.8 percent; this was more than double the next leading cause, drug use, with 21.0 percent of all accidental deaths. Localities such as Buchanan and Tazewell have seen 2.0 and 2.4 fold increases, respectively, in accidental deaths since 1999.



**Figure 17. Proportion of Accidental Deaths by Race/Ethnicity, 2004**



**Figure 18. Accidental Deaths by Year of Death, 1999-2004**



**Table 10. Accidental Deaths by Method of Death, 2004**

<b>Method of Death</b>	<b>Total Cases</b>	<b>Autopsied</b>
<b><i>Aircraft</i></b>		
Passenger/Pilot in aircraft crash	13	12
<b><i>Animal Related</i></b>		
Animal related (bitten, kicked, trampled)	4	0
<b><i>Asphyxia</i></b>		
Accidental ligature strangulation	2	1
Choked on foreign object	20	9
Crushed/suffocated	42	30
Drowned	103	51
<b><i>Drug Use</i></b>		
Ingested alcohol (ethanol)	29	20
Ingested and/or injected illicit drug and/or prescription medications	458	404
<b><i>Electrical</i></b>		
Contacted electrical current	12	9
Struck by lightning	1	0
<b><i>Exposure</i></b>		
Exposed to cold	18	11
Exposed to heat	4	1
<b><i>Fall</i></b>		
Fall from all heights	391	52
<b><i>Fire</i></b>		
Scalded by hot water, hot oil, other agent	1	0
Smoke Inhalation (Carbon Monoxide)	85	65
Victim of explosion	3	3
Victim of Fire	43	26
<b><i>Machinery</i></b>		
Farm or industrial machinery accident	13	7
<b><i>Motor Vehicle</i></b>		
Vehicular: ATV	12	2
Vehicular: auto/truck (driver)	559	59
Vehicular: auto/truck (passenger)	199	31
Vehicular: auto/truck (pedestrian)	99	30
Vehicular: auto/truck (unknown)	58	10
Vehicular: bicycle	4	0
Vehicular: mo-ped	2	0
Vehicular: motorcycle	47	4
Vehicular: tractor/heavy construction equipment	17	3
Vehicular: train	4	3
Vehicular: other	12	3
<b><i>Poisoned</i></b>		
Inhaled toxic agent (Carbon Monoxide - Other)	6	4
<b><i>Traumatic Injury</i></b>		
Accidental discharge of firearm	14	12
Accidental cut injury	3	3
Received blow/collided with object	11	5
Sports related	3	0
<b><i>Unknown</i></b>		
Accident - Unknown	19	11
<b>Total</b>	<b>2312</b>	<b>881</b>

**Table 11. Accidental Deaths by Locality of Death by Year of Death, 1999-2004**

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Accomack	13	17	17	14	16	17	94
Albemarle	15	6	7	22	26	37	113
Alexandria	19	16	17	20	14	18	104
Alleghany	4	3	3	4	3	5	22
Amelia	4	5	3	5	2	4	23
Amherst	9	4	5	3	5	3	29
Appomattox	2	1	3	6	2	2	16
Arlington	28	35	34	44	31	21	193
Augusta	16	18	24	24	26	28	136
Bath	3	1	2	3	6	2	17
Bedford City	1	1	5	2	2	0	11
Bedford	15	9	16	16	14	18	88
Bland	2	1	8	4	2	2	19
Botetourt	9	7	9	8	6	10	49
Bristol	1	1	0	2	6	4	14
Brunswick	8	8	7	9	5	12	49
Buchanan	11	10	16	19	20	21	97
Buckingham	8	7	8	5	8	6	42
Buena Vista	0	0	0	1	0	1	2
Campbell	11	12	7	12	15	10	67
Caroline	9	12	8	16	6	12	63
Carroll	7	9	5	5	8	9	43
Charles City	2	2	2	6	4	2	18
Charlotte	10	4	5	3	4	4	30
Charlottesville	74	60	70	71	83	58	416
Chesapeake	26	24	30	44	38	37	199
Chesterfield	43	43	28	46	50	48	258
Clarke	1	2	3	2	6	3	17
Colonial Heights	0	3	1	0	1	1	6
Covington	3	0	0	0	2	0	5
Craig	0	0	0	3	1	0	4
Culpepper	5	8	12	8	12	15	60
Cumberland	6	4	1	0	2	1	14
Danville	17	23	22	16	21	25	124
Dickenson	4	2	7	9	7	10	39
Dinwiddie	7	10	5	6	8	12	48
Emporia	8	4	4	7	8	12	43
Essex	6	5	10	6	8	11	46
Fairfax City	3	0	2	2	3	1	11
Fairfax	171	201	196	235	232	217	1252
Falls Church	0	1	1	0	0	0	2
Fauquier	24	11	17	11	21	22	106
Floyd	5	8	7	6	11	4	41
Fluvanna	2	4	2	2	11	3	24
Franklin City	0	0	1	0	1	0	2
Franklin	17	9	19	14	16	18	93
Frederick	0	2	2	6	15	17	42
Fredericksburg	20	27	18	26	39	29	159
Galax	5	5	8	6	3	2	29
Giles	6	5	6	4	12	6	39
Gloucester	8	7	12	4	11	7	49

**Table 11. Accidental Deaths by Locality of Death by Year of Death, 1999-2004***~continued*

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Goochland	3	4	3	2	8	2	22
Grayson	6	7	2	3	4	8	30
Greene	6	3	2	5	3	8	27
Greensville	3	4	1	2	3	5	18
Halifax	22	16	16	18	16	26	114
Hampton	25	17	19	21	33	24	139
Hanover	20	27	13	16	25	35	136
Harrisonburg	14	19	6	11	10	12	72
Henrico	40	51	50	59	65	64	329
Henry	7	6	8	8	17	13	59
Highland	3	2	2	0	0	0	7
Hopewell	7	6	14	5	3	5	40
Isle of Wight	8	7	10	4	13	7	49
James City	4	7	4	7	11	10	43
King & Queen	2	2	0	3	3	3	13
King George	4	1	2	8	5	4	24
King William	2	4	5	14	3	2	30
Lancaster	11	8	5	9	4	3	40
Lee	8	14	13	6	23	17	81
Lexington	10	4	1	5	1	4	25
Loudoun	15	16	25	15	26	35	132
Louisa	7	11	8	12	7	14	59
Lunenburg	7	4	2	8	2	5	28
Lynchburg	39	42	39	40	45	50	255
Madison	2	2	2	4	5	5	20
Manassas	15	10	12	12	14	14	77
Martinsville	17	13	24	15	17	20	106
Mathews	2	1	3	2	4	0	12
Mecklenburg	13	14	12	13	13	12	77
Middlesex	5	2	4	6	4	5	26
Montgomery	29	21	29	22	22	24	147
Nelson	5	5	5	9	7	4	35
New Kent	2	6	7	2	8	2	27
Newport News	56	56	52	52	56	54	326
Norfolk	114	127	144	138	105	129	757
Northampton	9	7	13	10	10	11	60
Northumberland	0	3	2	1	3	1	10
Norton	6	5	6	5	5	11	38
Nottoway	7	3	6	2	10	5	33
Orange	7	4	6	10	6	9	42
Page	3	10	10	7	7	5	42
Patrick	4	6	8	7	6	20	51
Petersburg	19	18	10	18	13	7	85
Pittsylvania	8	12	21	21	7	14	83
Poquoson	3	0	2	0	0	2	7
Portsmouth	24	23	24	24	27	34	156
Powhatan	0	2	5	3	8	2	20
Prince Edward	2	7	11	4	8	7	39
Prince George	3	9	7	8	5	10	42
Prince William	20	38	36	36	42	34	206
Pulaski	11	8	18	20	14	13	84
Radford	2	3	1	3	0	2	11
Rappahannock	1	0	1	1	3	3	9
Richmond City	166	200	188	179	225	203	1161

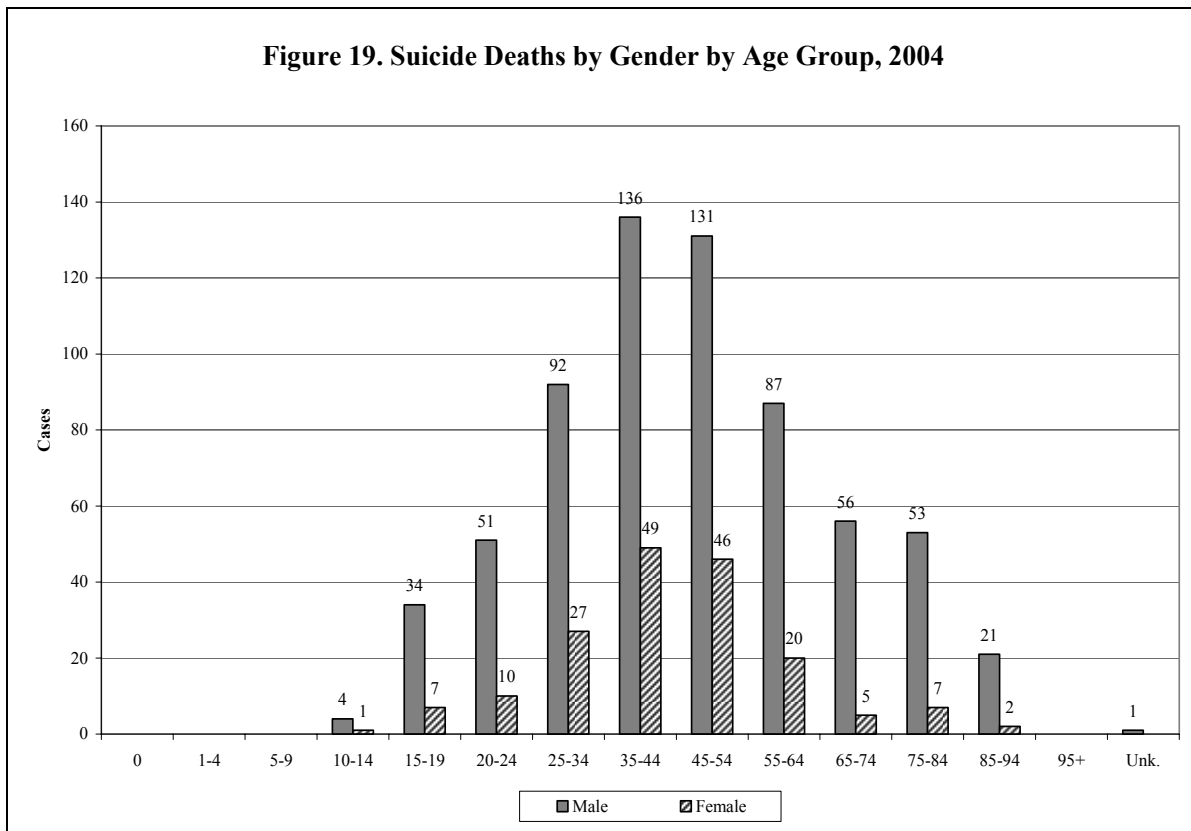
**Table 11. Accidental Deaths by Locality of Death by Year of Death, 1999-2004**

*~continued*

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Richmond	3	1	1	2	1	1	9
Roanoke City	74	76	80	98	89	99	516
Roanoke	8	10	10	8	15	10	61
Rockbridge	6	11	2	9	12	13	53
Rockingham	10	9	11	13	19	20	82
Russell	9	11	29	12	29	25	115
Salem	3	10	6	8	10	6	43
Scott	3	10	9	12	9	12	55
Shenandoah	6	8	7	12	11	11	55
Smyth	9	10	9	10	11	12	61
Southampton	9	17	12	6	7	12	63
Spotsylvania	13	21	15	8	13	12	82
Stafford	7	7	12	4	12	8	50
Staunton	1	1	3	1	6	2	14
Suffolk	20	21	17	31	14	22	125
Surry	1	5	3	4	1	1	15
Sussex	9	3	7	9	6	3	37
Tazewell	8	9	15	19	20	26	97
Virginia Beach	57	70	73	67	72	76	415
Warren	7	11	5	9	16	19	67
Washington	19	21	9	17	25	26	117
Waynesboro	2	1	3	3	0	3	12
Westmoreland	5	1	9	6	5	3	29
Williamsburg	2	10	16	13	7	9	57
Winchester	16	21	25	29	18	23	132
Wise	7	16	7	11	21	27	89
Wythe	6	15	12	20	6	15	74
York	2	8	12	2	11	5	40
Unknown	1	0	0	0	0	0	1
Out of State	1	1	2	0	2	2	8
<b>TOTAL</b>	<b>1820</b>	<b>1969</b>	<b>2035</b>	<b>2145</b>	<b>2305</b>	<b>2312</b>	<b>12586</b>

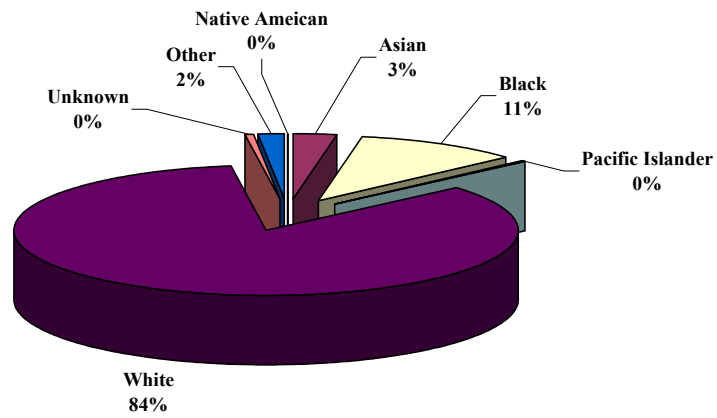
## SUICIDE DEATHS

In 2004, suicide deaths occurred most frequently in males (79.3%) and those aged 35-44 years (22.0%). Sixty percent of suicides were committed using some type of a firearm. Among blacks and white, whites committed suicide at approximately twice the rate of blacks and Asians (12.8 per 100,000 for whites compared to 6.1 per 100,000 for blacks and 6.7 per 100,000 for Asians). Additionally, black females are 8.4 times less likely to commit suicide than white males. Fairfax continued to be the locality with the highest number or 8.6 percent of suicide deaths in 2004 and 8.7 percent of all suicide deaths since 1999. Falls Church and Lexington have the lowest total numbers of suicide deaths in Virginia.

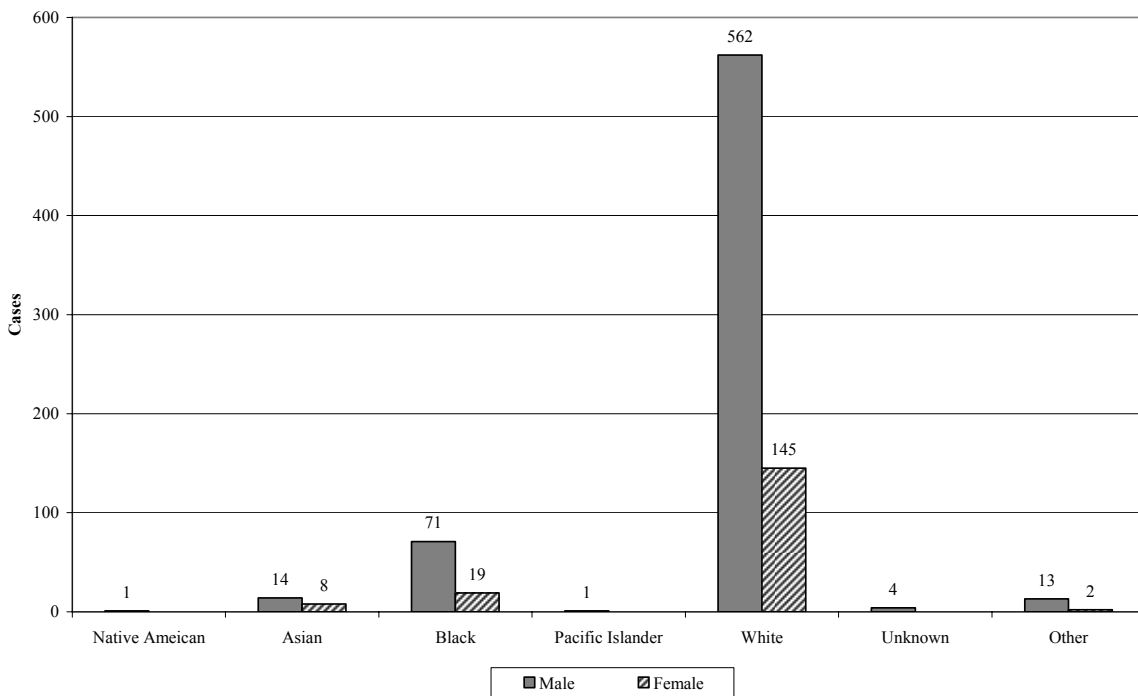




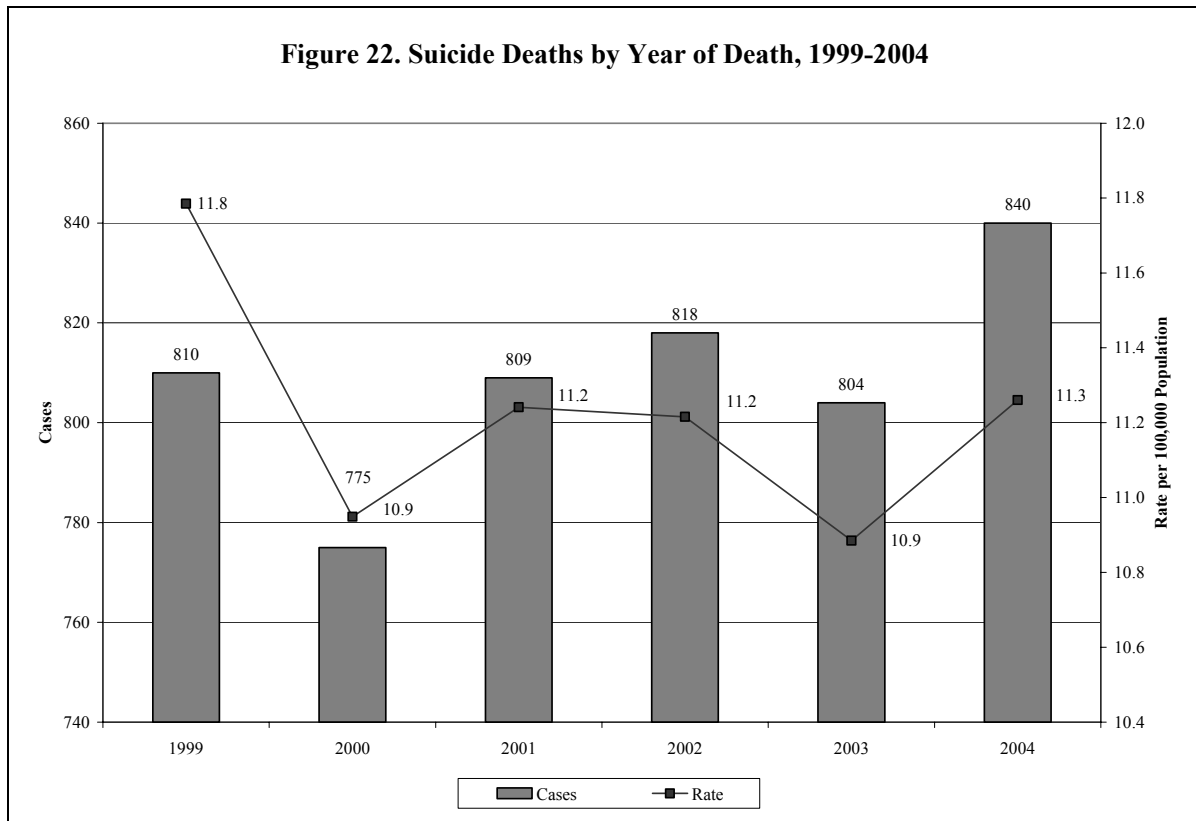
**Figure 20. Suicide Deaths by Race/Ethnicity, 2004**



**Figure 21. Suicide Deaths by Gender by Race/Ethnicity, 2004**



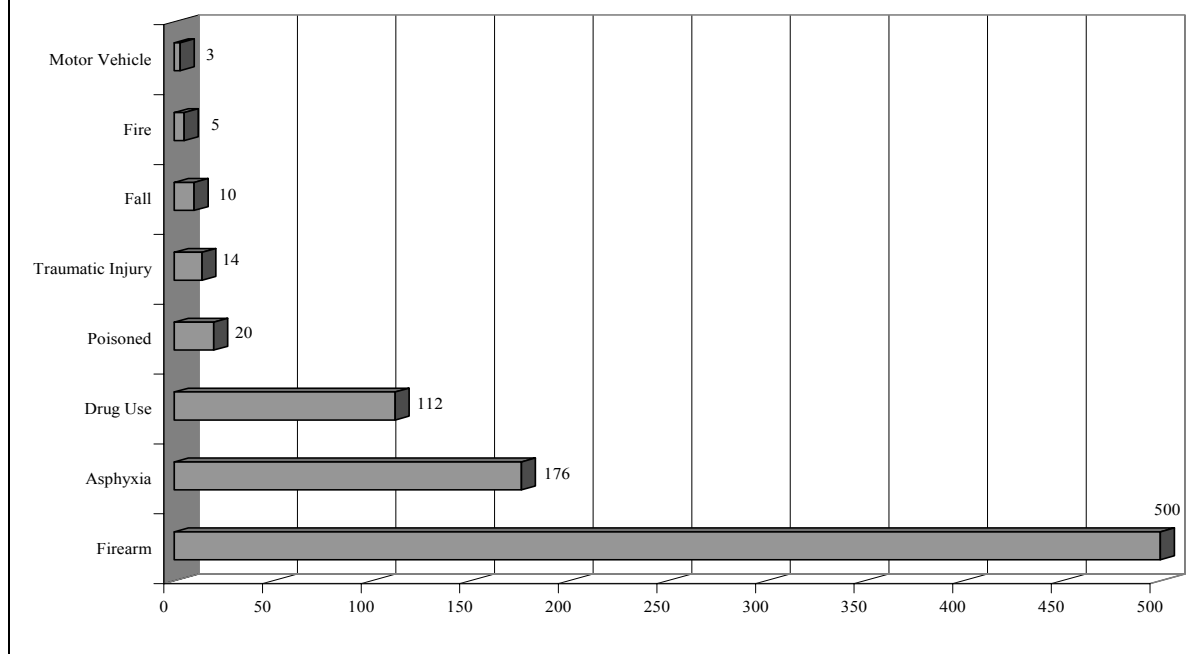
**Figure 22. Suicide Deaths by Year of Death, 1999-2004**



**Table 12. Suicide Deaths by Method of Death, 2004**

<b>Method of Death</b>	<b>Total Cases</b>	<b>Autopsied</b>
<i>Asphyxia</i>		
Drowned self	12	8
Hanged self	151	62
Suffocated self	13	7
<i>Drug Use</i>		
Ingested, injected or inhaled medication	109	90
<i>Fall</i>		
Jumped from height	10	6
<i>Fire</i>		
Burned self	4	2
Smoke Inhalation (Carbon Monoxide)	1	1
<i>Poisoned</i>		
Inhaled toxic agent (Carbon Monoxide)	20	4
Ingested alcohol	3	3
<i>Traumatic Injury</i>		
Cut/Stabbed self	12	11
Shot self with firearm	500	493
- Handgun	(321)	(316)
- Rifle	(48)	(48)
- Shotgun	(78)	(78)
- Unspecified	(53)	(51)
Traumatic - Other	2	2
<i>Vehicular</i>		
Pedestrian struck by motor vehicle	3	1
<b>Total</b>	<b>840</b>	<b>690</b>

**Figure 23. Suicide Deaths by Method of Death, 2004**



**Table 13. Suicide Deaths by Locality of Death by Year of Death, 1999 – 2004**

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Accomack	6	4	2	2	4	2	20
Albemarle	7	8	7	5	10	16	53
Alexandria	8	9	11	13	18	14	73
Alleghany	0	2	3	1	4	1	11
Amelia	0	0	1	2	2	3	8
Amherst	4	1	3	10	1	4	23
Appomattox	0	0	1	4	2	1	8
Arlington	9	14	10	22	15	14	84
Augusta	11	6	3	10	12	13	55
Bath	0	0	1	0	0	2	3
Bedford City	1	2	2	0	0	0	5
Bedford	9	11	10	4	7	5	46
Bland	3	0	1	0	3	2	9
Botetourt	5	4	4	4	2	2	21
Bristol	0	2	1	1	3	3	10
Brunswick	0	1	0	2	4	1	8
Buchanan	6	4	9	8	5	8	40
Buckingham	4	4	2	2	0	1	13
Buena Vista	0	2	0	1	0	2	5
Campbell	4	5	9	2	5	6	31
Caroline	5	3	1	2	5	1	17

**Table 13. Suicide Deaths by Locality of Death by Year of Death, 1999 – 2004**  
*~continued*

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Carroll	6	10	3	3	2	8	32
Charles City	1	1	0	1	1	1	5
Charlotte	3	0	3	1	0	1	8
Charlottesville	10	13	16	7	8	13	67
Chesapeake	18	8	17	12	16	19	90
Chesterfield	28	22	25	26	29	27	157
Clarke	3	1	0	2	2	1	9
Colonial Heights	3	1	1	3	1	1	10
Covington	0	2	0	2	0	1	5
Craig	1	0	0	2	3	0	6
Culpepper	10	2	5	5	8	7	37
Cumberland	2	1	0	1	0	1	5
Danville	11	12	11	7	10	6	57
Dickenson	3	3	4	6	4	3	23
Dinwiddie	8	5	2	6	6	3	30
Emporia	2	0	0	1	1	1	5
Essex	1	1	1	4	3	2	12
Fairfax City	2	1	0	2	0	1	6
Fairfax	62	75	64	87	64	72	424
Falls Church	0	1	0	0	0	1	2
Fauquier	5	3	7	6	8	13	42
Floyd	1	0	1	2	0	3	7
Fluvanna	1	0	3	1	3	1	9
Franklin	5	6	9	9	8	9	46
Frederick	1	2	0	6	7	10	26
Fredericksburg	5	6	5	8	11	5	40
Galax	3	1	2	3	1	1	11
Giles	0	5	2	1	3	3	14
Gloucester	3	2	3	6	6	8	28
Goochland	2	1	2	2	2	1	10
Grayson	1	0	0	0	5	5	11
Greene	2	3	1	0	2	3	11
Greensville	2	6	2	2	2	0	14
Halifax	5	6	4	8	3	5	31
Hampton	12	10	12	10	11	13	68
Hanover	4	10	13	6	7	8	48
Harrisonburg	7	2	3	2	3	1	18
Henrico	32	26	37	19	35	21	170
Henry	6	8	5	5	4	8	36
Highland	1	0	0	1	0	2	4
Hopewell	4	3	5	3	2	1	18
Isle of Wight	2	7	3	4	4	5	25
James City	1	3	3	4	3	6	20
King & Queen	3	1	1	0	1	1	7
King George	4	3	2	2	1	2	14
King William	2	1	2	0	1	3	9
Lancaster	0	2	0	1	1	0	4
Lee	5	4	3	6	5	9	32
Lexington	1	1	0	0	0	0	2
Loudoun	13	6	17	10	17	17	80
Louisa	4	3	6	3	5	6	27
Lunenburg	2	0	0	3	2	3	10
Lynchburg	8	10	5	12	10	6	51
Madison	1	4	2	1	1	1	10

**Table 13. Suicide Deaths by Locality of Death by Year of Death, 1999 – 2004**  
*~continued*

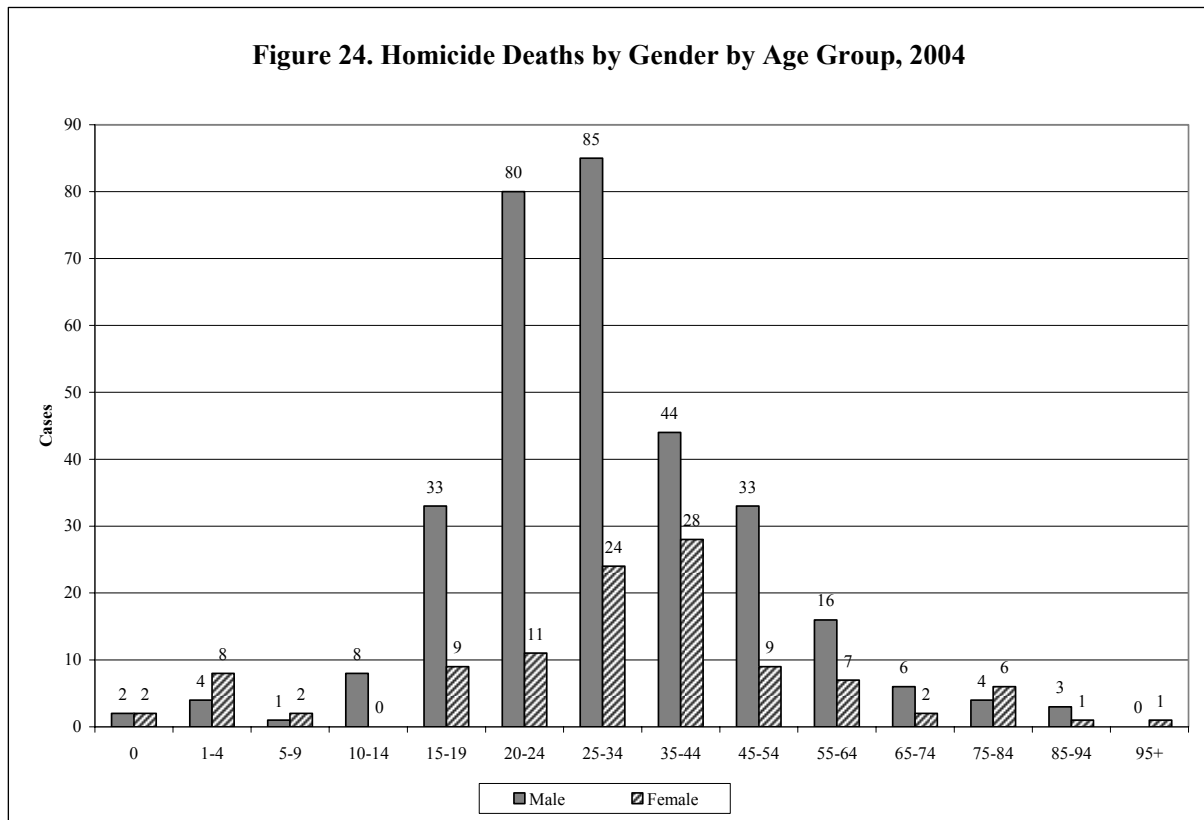
Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Manassas	7	4	3	3	3	1	21
Martinsville	4	5	9	6	9	6	39
Mathews	1	3	0	2	0	0	6
Mecklenburg	4	3	6	4	6	9	32
Middlesex	1	0	2	2	1	2	8
Montgomery	13	3	10	8	4	10	48
Nelson	7	3	2	2	5	2	21
New Kent	3	4	2	4	1	4	18
Newport News	15	24	23	16	16	18	112
Norfolk	28	28	43	32	31	32	194
Northampton	1	4	0	4	1	4	14
Northumberland	1	0	1	2	1	1	6
Norton	2	5	5	0	2	3	17
Nottoway	2	1	0	4	1	4	12
Orange	4	3	1	3	3	0	14
Page	1	2	3	3	5	0	14
Patrick	5	3	1	6	4	6	25
Petersburg	4	4	4	3	3	5	23
Pittsylvania	9	9	9	15	8	5	55
Poquoson	2	0	1	1	1	0	5
Portsmouth	13	6	14	10	10	10	63
Powhatan	1	2	5	6	1	4	19
Prince Edward	4	2	1	1	1	2	11
Prince George	4	3	0	6	3	6	22
Prince William	26	25	21	15	20	17	124
Pulaski	4	4	7	11	7	7	40
Radford	3	3	1	2	0	2	11
Rappahannock	0	1	0	2	1	1	5
Richmond City	42	21	45	44	27	27	206
Richmond	1	1	4	0	3	1	10
Roanoke City	22	28	18	21	19	17	125
Roanoke	6	12	10	15	10	9	62
Rockbridge	4	3	2	2	2	5	18
Rockingham	2	5	12	5	4	6	34
Russell	6	9	9	6	2	9	41
Salem	3	4	1	2	8	6	24
Scott	7	9	4	3	3	3	29
Shenandoah	5	8	5	5	8	6	37
Smyth	6	4	3	3	2	5	23
Southampton	3	4	3	3	2	2	17
Spotsylvania	5	5	9	11	9	8	47
Stafford	12	5	5	8	7	9	46
Staunton	2	3	3	4	3	3	18
Suffolk	0	9	7	4	8	8	36
Surry	1	1	1	1	1	0	5
Sussex	3	1	4	2	3	1	14
Tazewell	15	9	7	5	9	6	51
Virginia Beach	44	42	37	35	43	48	249
Warren	5	6	6	4	1	14	36
Washington	8	16	12	6	7	8	57
Waynesboro	3	3	2	4	1	4	17
Westmoreland	1	4	2	2	2	1	12
Williamsburg	3	2	2	2	5	4	18
Winchester	12	8	5	10	9	6	50

**Table 13. Suicide Deaths by Locality of Death by Year of Death, 1999 – 2004**  
*~continued*

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Wise	7	3	8	9	7	2	36
Wythe	4	3	8	7	5	5	32
York	5	4	3	1	7	3	23
Out of State	0	3	5	2	5	3	18
<b>TOTAL</b>	<b>810</b>	<b>775</b>	<b>809</b>	<b>818</b>	<b>804</b>	<b>840</b>	<b>4856</b>

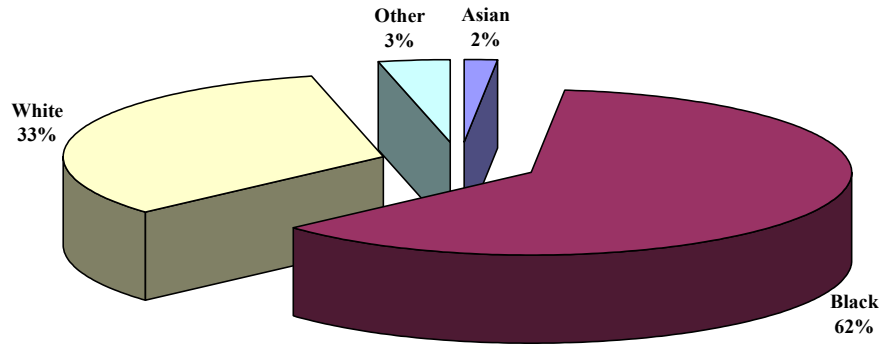
## HOMICIDE DEATHS

The number of homicides in Virginia decreased by 6.5 percent from 2003 to 2004. Homicide deaths occurred most frequently in males (74.3%), blacks (62.0%), and those aged 25-34 years (25.4%). Seventy-one percent of homicides were committed using a firearm, with handguns the most common type of firearm used in 44.2 percent of all homicide cases. Richmond City continues to be the locality with the highest number or 22.4 percent of all homicide deaths since 1999, followed by Norfolk (12.3%) and Newport News (5.7%). Forty-six of 125 Virginian localities, or 36.8 percent, experienced no homicides at all in 2004.

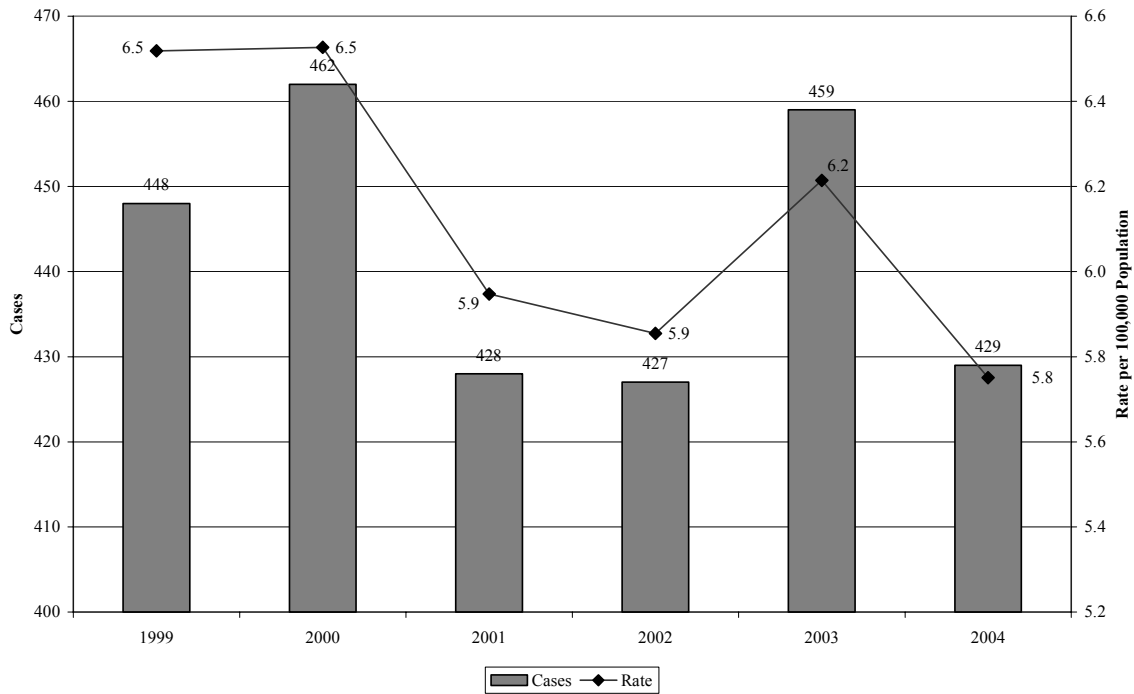




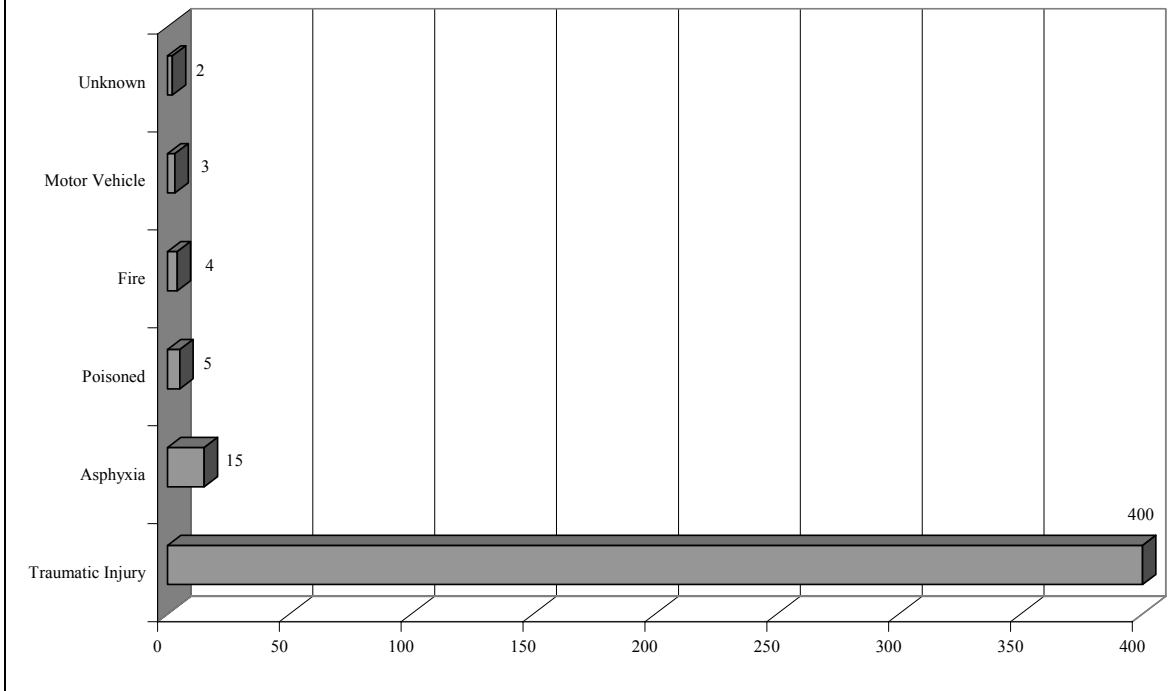
**Figure 25. Homicide Deaths by Race/Ethnicity, 2004**



**Figure 26. Homicide Deaths by Year of Death, 1999-2004**



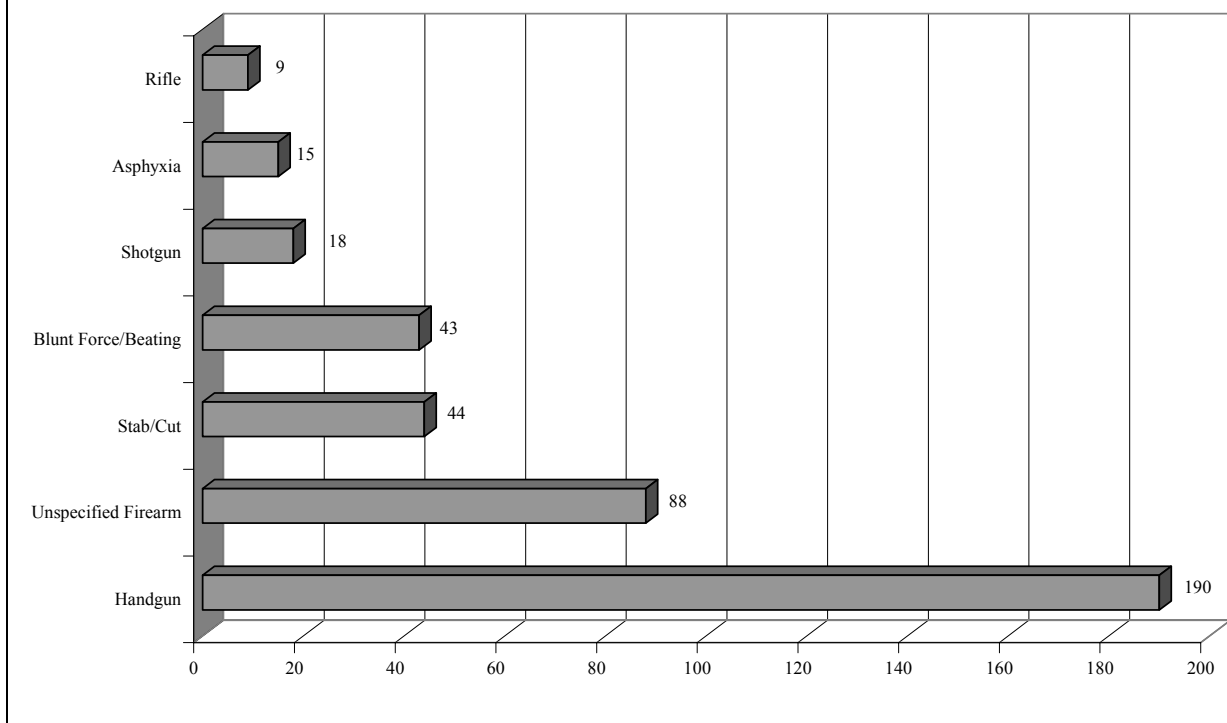
**Figure 27. Homicide Deaths by Method of Death, 2004**



**Table 14. Homicide Deaths by Method of Death, 2004**

Method of Death	Total Case	Autopsied
<b>Asphyxia</b>		
Strangled by assailant(s)	15	15
<b>Fire</b>		
Victim of intentionally set fire	4	3
<b>Poisoned</b>		
Judicial Execution	5	2
<b>Traumatic Injury</b>		
Beaten by assailant(s)	49	49
Shot by assailant(s) with firearm	305	302
- Handgun	(190)	(188)
- Rifle	(9)	(9)
- Shotgun	(18)	(18)
- Unspecified	(88)	(87)
Stabbed by assailant(s)	44	44
Traumatic - Other	2	1
<b>Vehicular</b>		
Struck with auto by assailant(s)	3	3
<b>Unknown</b>		
Homicide - Other	2	2
<b>Total</b>	<b>429</b>	<b>421</b>

**Figure 28. Homicide Deaths by Leading Methods of Death, 2004**



**Table 15. Homicide Deaths by Locality of Death by Year of Death, 1999- 2003**

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Accomack	2	1	1	0	1	1	6
Albemarle	5	1	3	2	3	2	16
Alexandria	2	2	5	0	5	2	16
Alleghany	0	0	0	2	0	2	4
Amelia	0	1	0	0	1	0	2
Amherst	1	3	0	1	1	1	7
Appomattox	1	0	0	1	0	0	2
Arlington	3	10	2	5	3	2	25
Augusta	1	3	1	3	4	7	19
Bedford	2	1	1	2	0	0	6
Bland	0	1	0	0	0	0	1
Botetourt	0	2	0	0	1	0	3
Bristol	1	1	2	0	0	0	4
Brunswick	1	1	0	2	2	2	8
Buchanan	1	2	1	4	2	2	12
Buckingham	0	0	0	0	2	0	2
Campbell	2	1	0	0	0	2	5
Caroline	0	0	1	0	0	1	2
Carroll	1	2	0	1	1	0	5
Charles City	0	1	0	0	0	0	1
Charlotte	2	0	0	2	1	0	5
Charlottesville	6	7	7	5	4	7	36

**Table 15. Homicide Deaths by Locality of Death by Year of Death, 1999- 2003**

*~continued*

Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
Chesapeake	6	9	8	5	4	8	40
Chesterfield	8	6	6	5	7	8	40
Clarke	2	0	0	1	1	1	5
Colonial Heights	1	0	0	0	0	4	5
Covington	0	0	0	1	0	0	1
Craig	0	0	0	1	0	0	1
Culpepper	0	1	3	1	2	0	7
Cumberland	0	2	0	0	0	0	2
Danville	9	10	6	8	5	5	43
Dickenson	0	1	0	2	0	3	6
Dinwiddie	1	1	2	2	2	3	11
Emporia	0	2	2	0	0	1	5
Essex	0	1	3	1	0	1	6
Fairfax City	0	0	0	1	0	0	1
Fairfax	26	21	23	19	15	16	120
Falls Church	1	0	0	0	0	0	1
Fauquier	3	0	3	1	2	0	9
Floyd	0	1	2	0	0	0	3
Fluvanna	0	1	0	0	0	0	1
Franklin	2	2	2	2	3	2	13
Frederick	0	0	0	2	1	2	5
Fredericksburg	4	4	3	1	0	2	14
Galax	4	1	2	0	0	0	7
Giles	0	0	0	1	0	1	2
Gloucester	1	2	1	3	2	1	10
Goochland	0	0	2	0	2	1	5
Grayson	0	0	2	1	0	1	4
Greene	0	0	0	0	4	1	5
Greensville	15	9	3	6	2	4	39
Halifax	2	4	3	8	4	2	23
Hampton	14	8	10	7	12	10	61
Hanover	2	3	1	4	2	3	15
Harrisonburg	1	4	1	0	0	1	7
Henrico	12	8	8	7	19	20	74
Henry	3	2	1	6	2	3	17
Highland	0	0	0	0	1	1	2
Hopewell	5	1	1	3	2	1	13
Isle of Wight	1	1	1	0	0	2	5
James City	0	1	3	0	0	0	4
King & Queen	0	0	3	0	2	0	5
King George	1	1	1	0	0	1	4
King William	1	0	0	1	1	0	3
Lancaster	0	0	3	0	0	0	3
Lee	1	2	2	1	2	2	10
Loudoun	1	1	6	3	1	2	14
Louisa	0	3	1	1	1	0	6
Lunenburg	0	0	0	1	0	0	1
Lynchburg	6	6	5	12	7	5	41
Madison	0	0	0	1	0	0	1
Manassas	2	2	0	1	5	3	13
Martinsville	6	11	8	3	1	1	30
Mecklenburg	3	2	2	3	1	1	12
Montgomery	0	1	0	1	1	1	4
Nelson	0	1	2	0	0	1	4

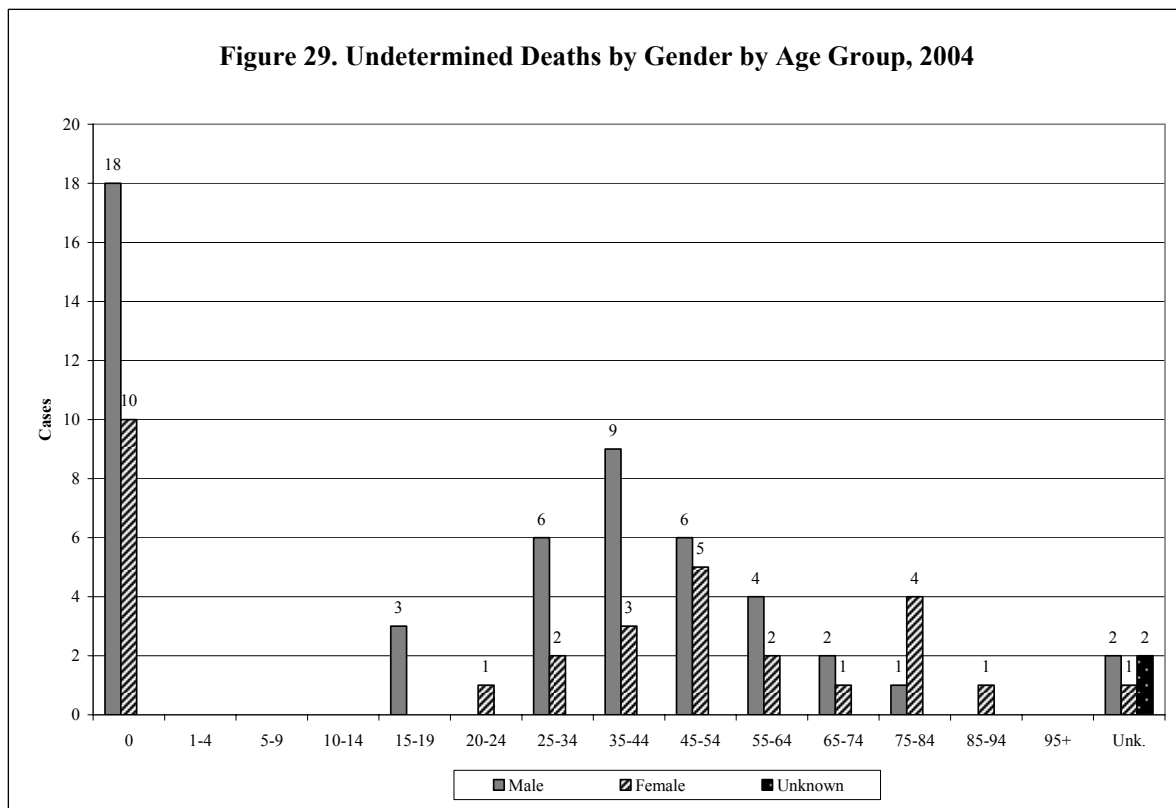
**Table 15. Homicide Deaths by Locality of Death by Year of Death, 1999- 2003**

*~continued*

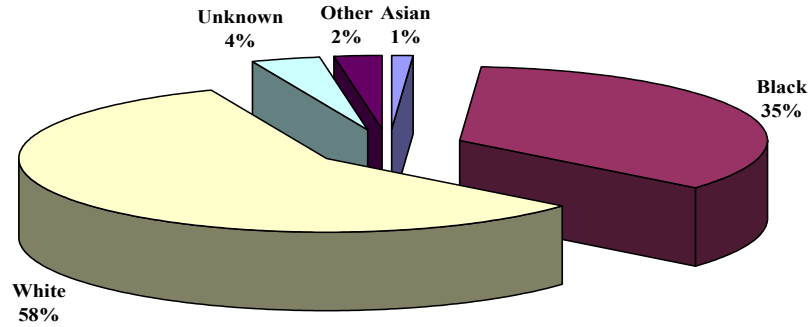
Locality of Death	Year of Death						Total
	1999	2000	2001	2002	2003	2004	
New Kent	2	1	0	2	0	0	5
Newport News	20	23	34	23	29	21	150
Norfolk	61	61	51	54	59	52	338
Northampton	1	3	1	0	1	3	9
Northumberland	0	0	1	0	0	0	1
Norton	1	1	0	0	0	0	2
Nottoway	1	1	1	1	0	0	4
Orange	0	1	1	1	0	1	4
Page	1	0	0	0	0	0	1
Patrick	0	1	1	0	0	2	4
Petersburg	8	9	5	7	7	5	41
Pittsylvania	0	3	5	7	2	2	19
Portsmouth	12	16	11	8	11	7	65
Powhatan	0	1	1	1	0	0	3
Prince Edward	0	1	3	1	0	1	6
Prince George	1	1	1	1	1	1	6
Prince William	11	5	8	4	8	6	42
Pulaski	2	2	2	1	0	0	7
Radford	0	1	0	0	0	0	1
Rappahannock	1	0	0	0	1	0	2
Richmond City	92	95	83	102	115	108	595
Richmond	1	0	0	0	0	0	1
Roanoke City	13	14	18	20	22	13	100
Roanoke	0	1	0	2	1	1	5
Rockbridge	0	0	0	0	3	0	3
Rockingham	1	0	1	1	0	1	4
Russell	0	4	0	2	1	0	7
Salem	0	0	1	0	0	0	1
Scott	0	0	0	1	1	0	2
Shenandoah	0	1	0	0	3	1	5
Smyth	0	0	0	3	0	0	3
Southampton	4	1	1	0	2	2	10
Spotsylvania	1	1	0	3	4	2	11
Stafford	0	2	1	1	4	4	12
Staunton	0	0	1	0	1	0	2
Suffolk	5	3	6	4	2	5	25
Surry	1	1	0	1	0	1	4
Sussex	2	2	3	0	0	2	9
Tazewell	0	3	1	2	2	1	9
Virginia Beach	12	7	11	5	23	18	76
Warren	0	1	0	1	0	1	3
Washington	2	3	3	2	2	3	15
Waynesboro	1	2	0	0	0	0	3
Westmoreland	3	2	0	0	0	3	8
Williamsburg	0	0	1	2	2	0	5
Winchester	6	3	2	5	2	0	18
Wise	1	1	2	2	1	1	8
Wythe	2	2	2	0	0	1	7
York	1	2	1	0	0	1	5
Out of State	3	4	5	0	2	3	17
<b>Total</b>	<b>448</b>	<b>462</b>	<b>428</b>	<b>427</b>	<b>459</b>	<b>429</b>	<b>2653</b>

## UNDETERMINED DEATHS

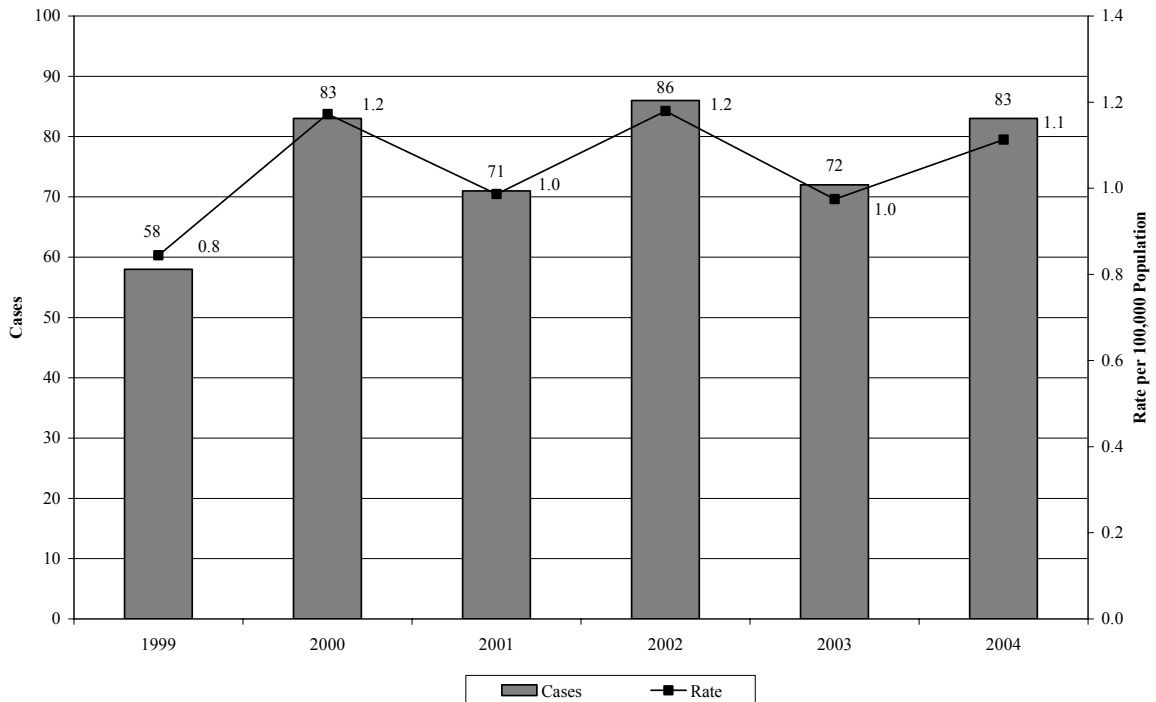
Cause of death was not able to be determined in 67.4 percent of deaths with an undetermined manner. For undetermined deaths where cause of death was subsequently determined, drug use was the most frequently associated cause (29.2%) followed closely by gunshot wound (22.2%). Over 33.7 percent of the undetermined deaths were in those aged less than 1 year.



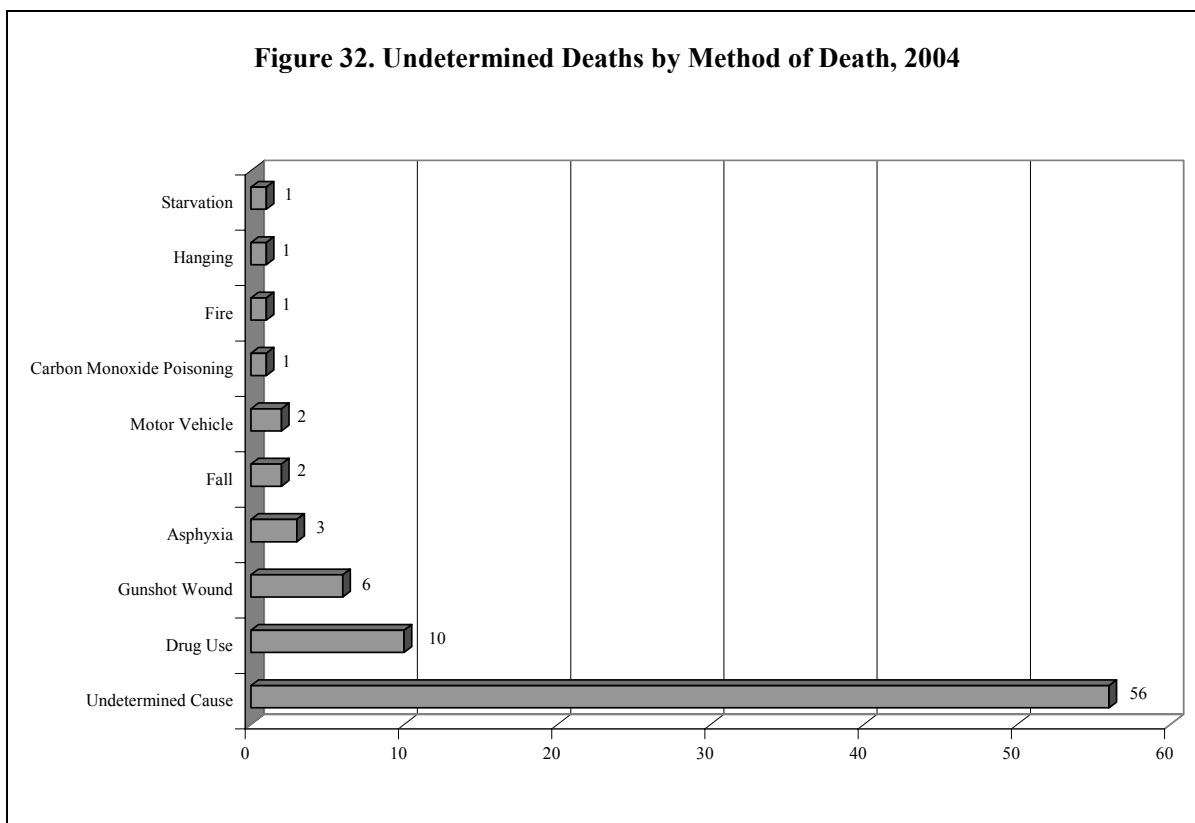
**Figure 30. Undetermined Deaths by Race/Ethnicity, 2004**



**Figure 31. Undetermined Deaths by Year of Death, 1999-2004**



**Figure 32. Undetermined Deaths by Method of Death, 2004**



**Table 16. Undetermined Deaths by Method of Death, 2004**

	Total Cases	Autopsied
<b>Undetermined Method of Death</b>		
Undetermined after autopsy and/or toxicology	17	16
<b>Undetermined but Method Determined</b>		
<i>Asphyxia</i>		
Mechanical/Positional	1	1
Drowning	3	3
<i>Drug Use</i>		
Ingested/Injected medication	10	8
<i>Exposure</i>		
Starvation	1	1
<i>Fall</i>		
Fall from height/same height	2	2
<i>Fire</i>		
Explosion/Victim of fire	1	1
<i>Poisoned</i>		
Inhaled toxic agent	1	1
<i>Traumatic Injury</i>		
Gunshot wound	6	6
<i>Vehicular</i>		
Driver/Passenger/Pedestrian	2	2
<b>Total</b>	<b>83</b>	<b>79</b>



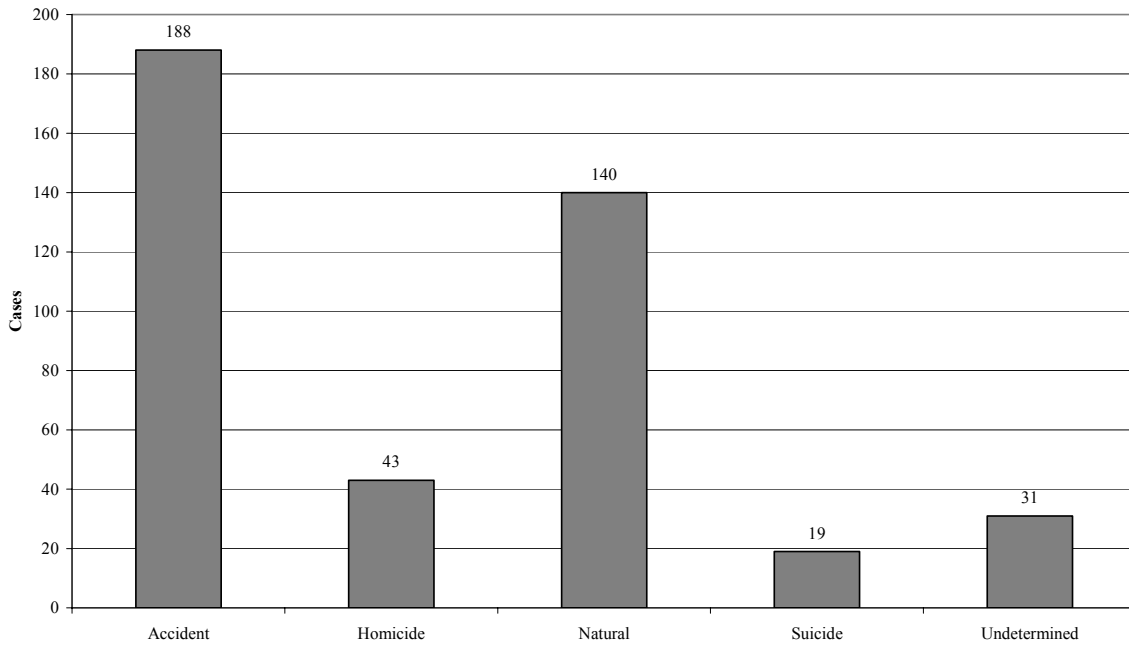
## **SECTION 4: DEATHS OF CHILDREN (17 Years of Age and Younger)**

The 421 deaths of children 17 years of age and younger represented 7.3 percent of all deaths investigated by the OCME in 2004, and a decrease of 11.0 percent from the number of childhood deaths in 2003.

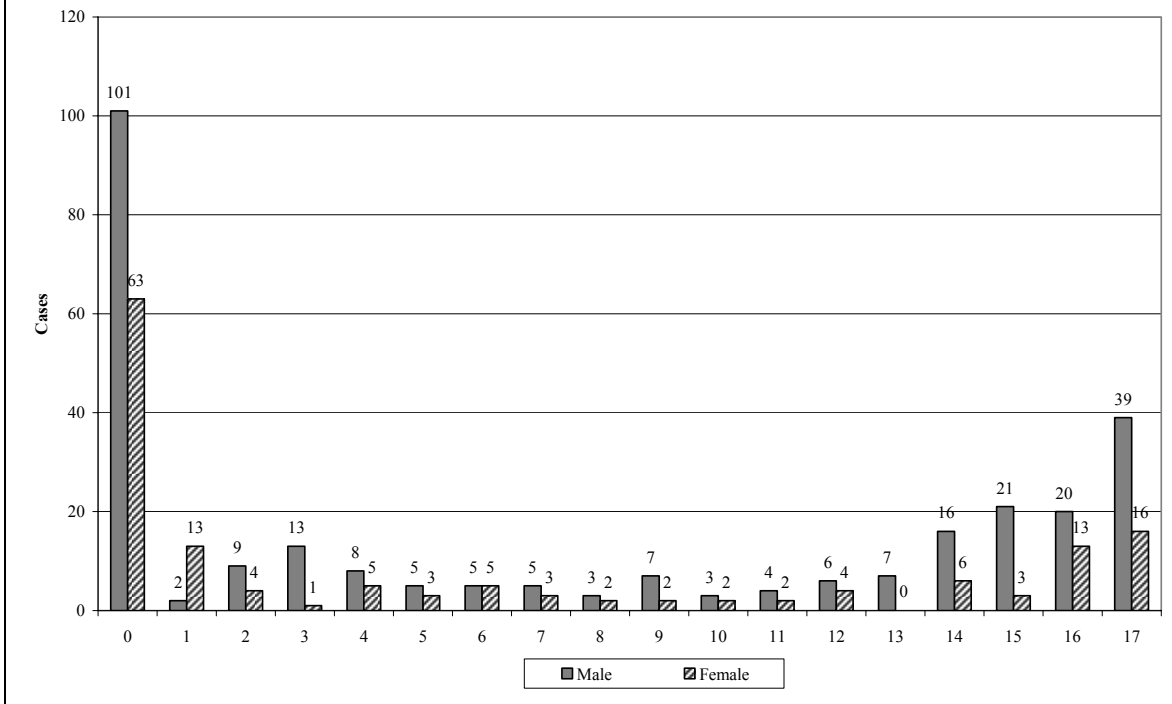
- Male decedents comprised 65.0 percent of the total deaths in children.
- The <1 year old age group had the largest percentage of deaths (39.0%) among children 17 years of age and younger.
- The leading causes of death in children were Sudden Infant Death Syndrome (SIDS) and head and neck injuries which represented 54.2 percent of natural deaths and 26.8 percent of unnatural deaths, respectively, in children.
- Blacks accounted for 65 percent of homicides in children, representing a rate of 6.4 in 100,000 black children compared to 0.9 in 100,000 white children.

The State Child Fatality Review Team is an additional resource for comprehensive information on child death in Virginia. The Team's purpose is to systematically analyze deaths among Virginia's children to make recommendations for the prevention of these deaths. Chaired by the Chief Medical Examiner, the Team is a multi-disciplinary group including representatives from law enforcement, fire, social services departments, state medical associations, and other local and state agencies. Reviewed deaths may include violent and unnatural child deaths, sudden child deaths in the first 18 months of life, and deaths where the cause and manner was not determined with reasonable medical certainty. The Team's reviews are governed by the principles and practices of public health. Published reports are available at the following website: [www.vdh.state.va.us/medexam/Fatalreview.asp](http://www.vdh.state.va.us/medexam/Fatalreview.asp).

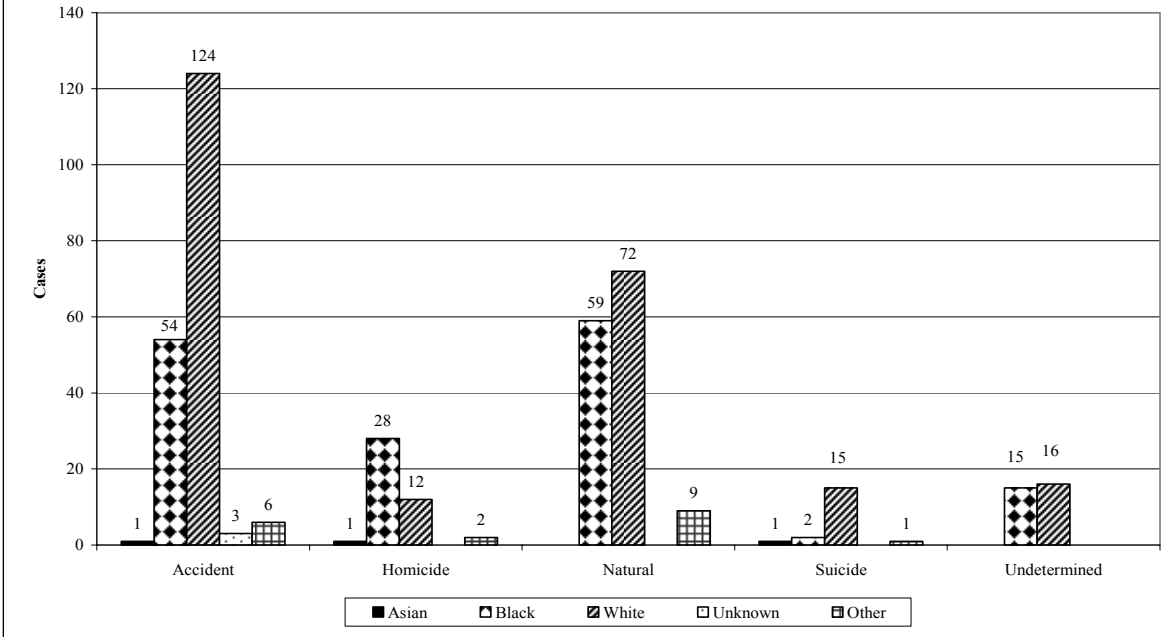
**Figure 33. Deaths of Children, 17 Years and Younger, by Manner of Death, 2004**



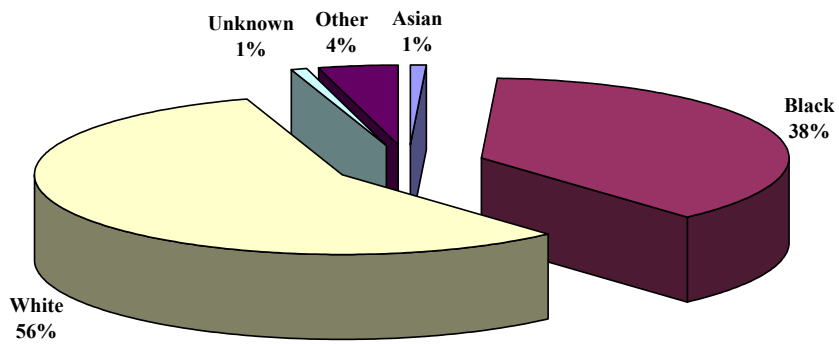
**Figure 34. Deaths of Children, 17 Years and Younger, by Gender by Age, 2004**



**Figure 35. Deaths of Children, 17 Years and Younger, by Manner by Race/Ethnicity, 2004**



**Figure 36. Proportion of Deaths of Children, 17 years and Younger, by Race/Ethnicity, 2004**

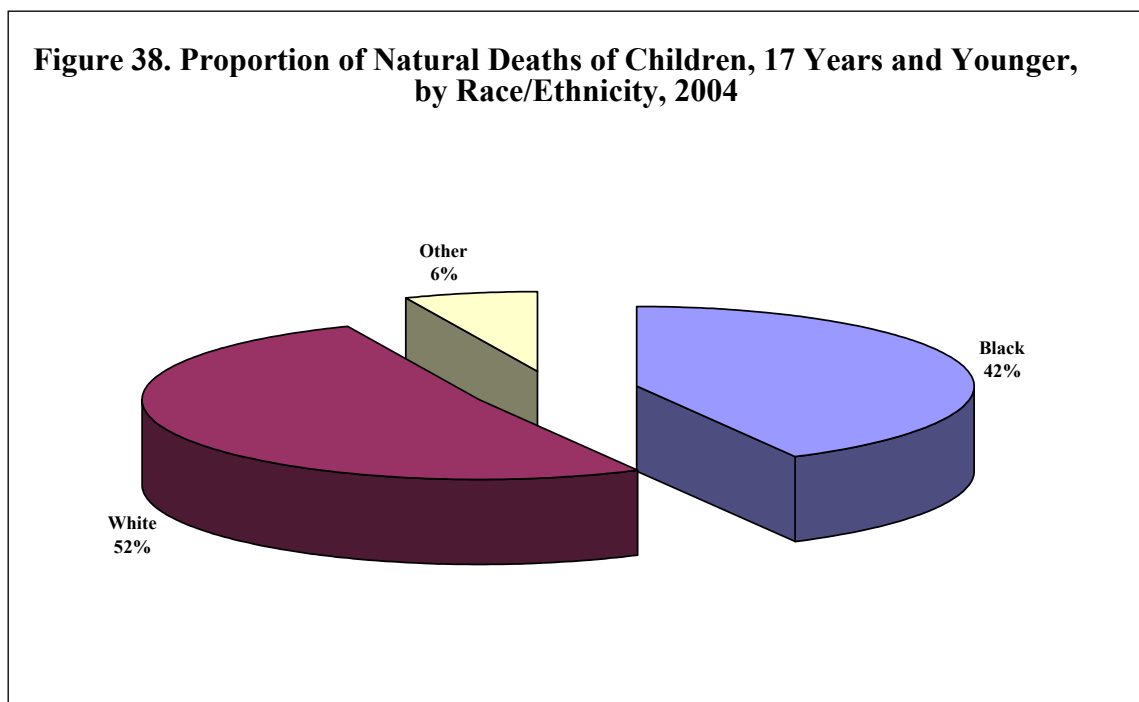
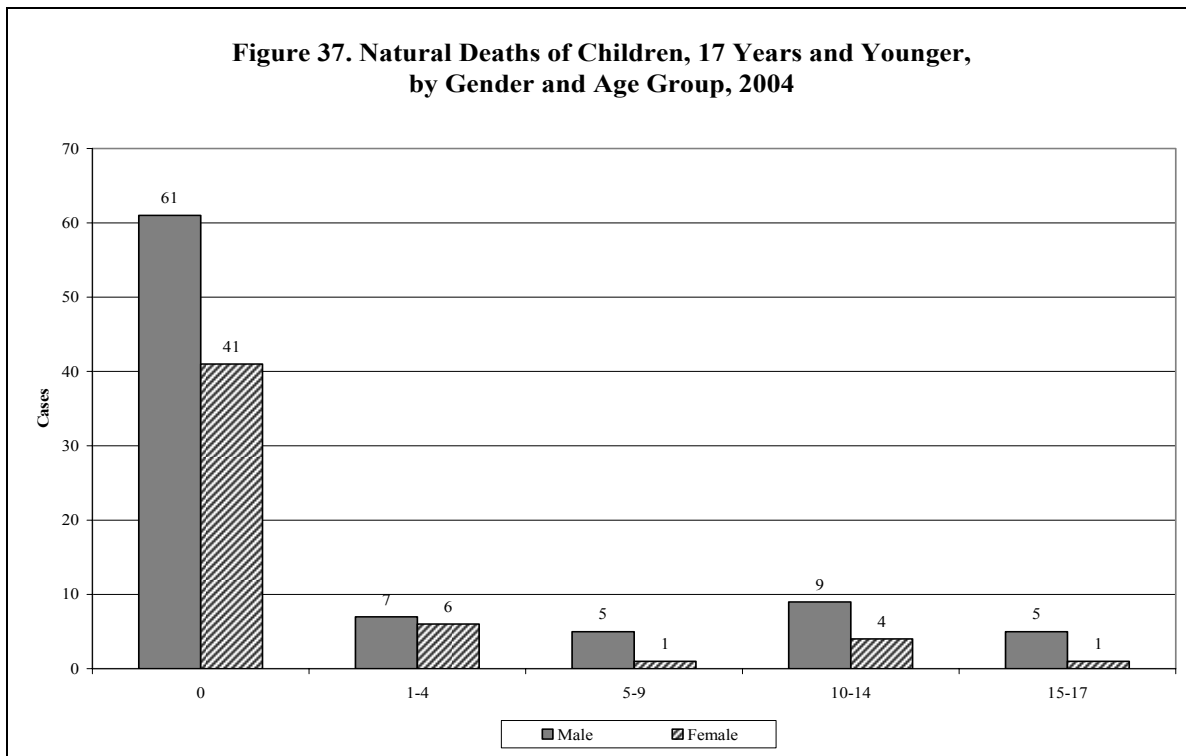


**Table 17. Deaths of Children, 17 Years and Younger, by Cause of Death, 2004**

<b>Natural Deaths</b>	<b>Total Cases</b>	<b>Autopsied</b>
Aneurysm	1	1
Aspiration	1	1
Asthma	1	0
Cerebrovascular	2	2
Congenital Defect	4	3
Dehydration	1	1
Diabetes	1	1
Epilepsy	2	1
Heart Disease	18	17
Hepatic Failure	1	1
Intrauterine Fetal Death	4	3
Meningitis	3	3
Natural - Other	10	9
Obstruction (blockage)	1	1
Pneumonia	11	11
Prematurity	5	3
Sepsis	4	3
Sudden Infant Death Syndrome	83	82
<b><i>Subtotal</i></b>	<b>153</b>	<b>143</b>
<b>Unnatural Deaths</b>		
Asphyxia	23	21
Carbon Monoxide Poisoning	22	18
Child Abuse	7	7
Drowning	25	12
Exposure to cold	1	1
Exposure to heat	1	1
Gunshot Wound	38	37
Hanging	7	4
Head and Neck Injuries	67	12
Multiple Injuries	45	5
Narcotic Abuse	1	1
Stab Wound	1	0
Subdural Hematoma	1	1
Substance Poisoning	5	5
Thermal Injuries (burns)	2	1
Unnatural - Other	4	4
<b><i>Subtotal</i></b>	<b>250</b>	<b>130</b>
Undetermined after Autopsy and/or Investigation	18	18
<b>Total</b>	<b>421</b>	<b>291</b>

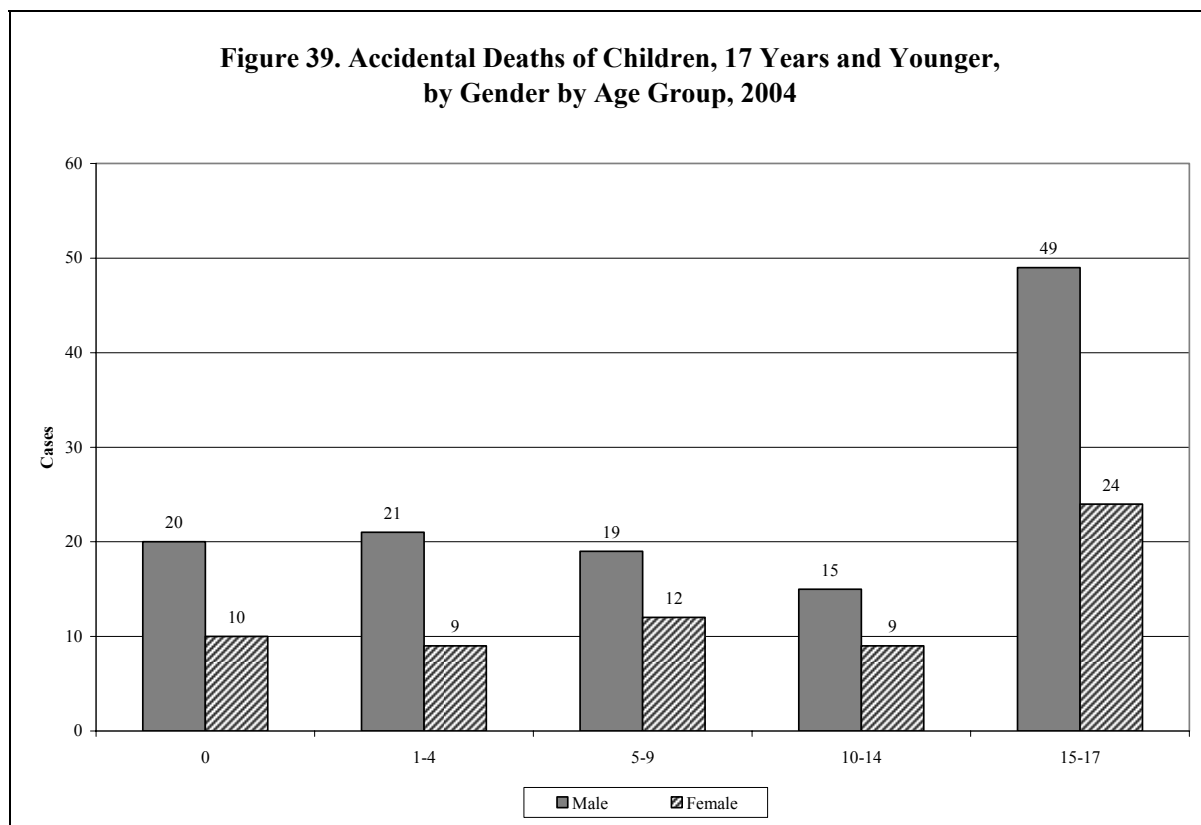
# NATURAL DEATHS OF CHILDREN

The less than 1 year old age group comprised 66.7 percent of all the natural deaths of children.

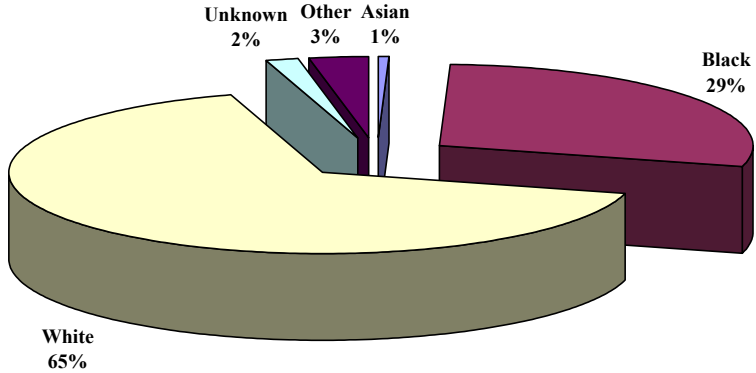


## ACCIDENTAL DEATHS OF CHILDREN

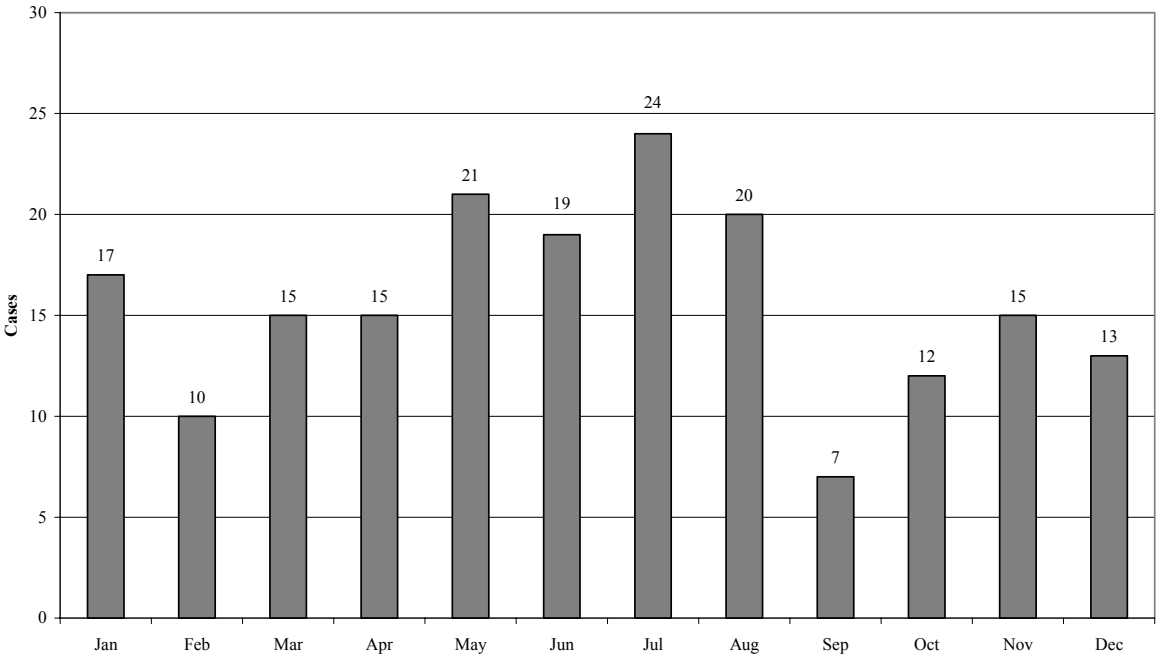
During 2004, the ratio of male to female accidental deaths averaged 1.86 to 1 for children aged 0 to 17 years. More accidental deaths occurred in whites (65.0%), in July (12.8%), and on Saturdays (23.4%). Being a passenger in an automobile accounted for 23.9 percent of all accidental deaths for children, followed by being the driver of an automobile (16.4%), and then by drowning (13.3%).



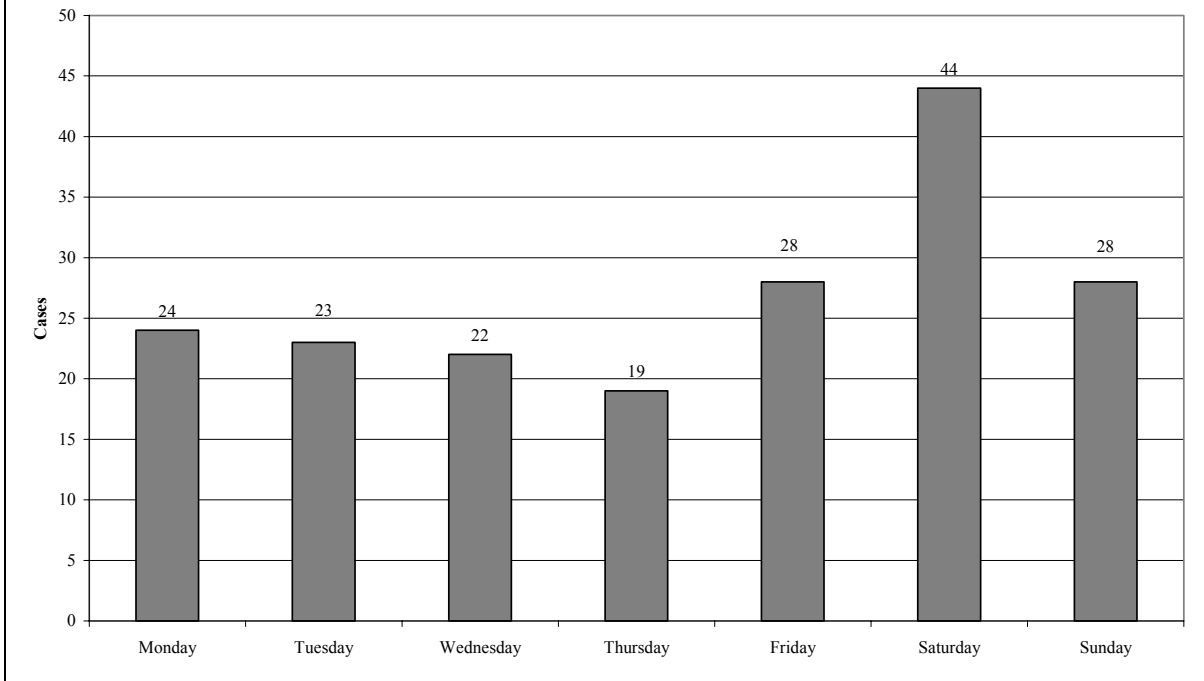
**Figure 40. Proportion of Accidental Deaths of Children, 17 Years and Younger, by Race/Ethnicity, 2004**



**Figure 41. Accidental Deaths of Children, 17 Years and Younger, by Month of Death, 2004**



**Figure 42. Accidental Deaths of Children, 17 Years and Younger,  
by Day of Death, 2004**



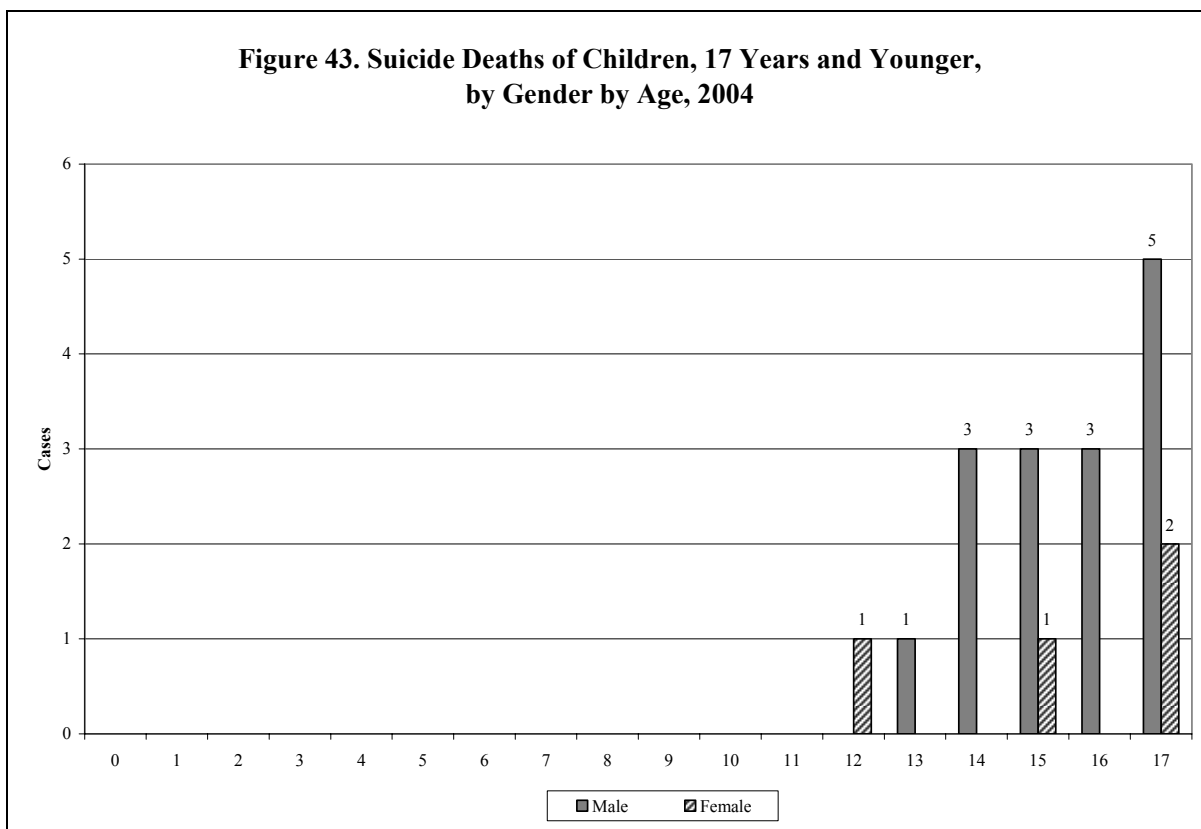


**Table 18. Accidental Deaths of Children, 17 Years and Younger, by Method of Death, 2004**

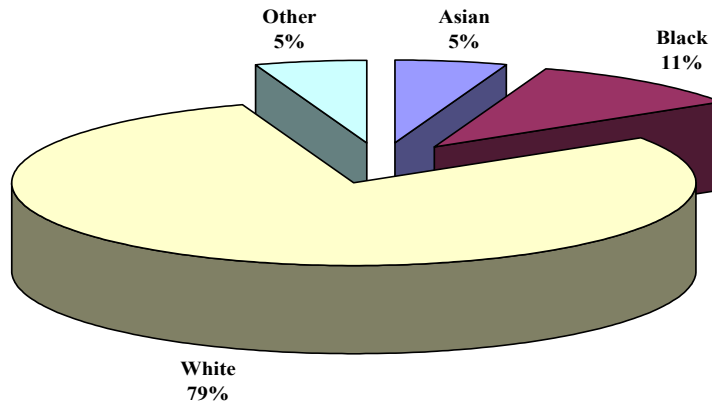
<b>Method of Death</b>	<b>Total Cases</b>	<b>Autopsied</b>
<b><i>Asphyxia</i></b>		
Choked on foreign object	3	3
Crushed/Suffocated	10	10
Drowned	25	12
Mechanical/Positional	7	6
<b><i>Drug Use</i></b>		
Ingested and/or injected medication	4	4
<b><i>Exposure</i></b>		
Exposed to cold	1	1
Exposed to heat	1	1
<b><i>Fall</i></b>		
Fall from height	1	0
<b><i>Fire</i></b>		
Scalded by hot water, hot oil, other agent	1	0
Victim of fire	21	17
<b><i>Traumatic Injury</i></b>		
Accidental gunshot wound	3	2
Machinery related	2	2
Received blow/collided with object	3	1
Other traumatic injury	3	2
<b><i>Vehicular</i></b>		
Driver of automobile	31	2
Passenger in automobile	45	7
Pedestrian struck by automobile	10	1
Vehicular - Other	17	0
<b>Total</b>	<b>188</b>	<b>71</b>

## SUICIDE DEATHS OF CHILDREN

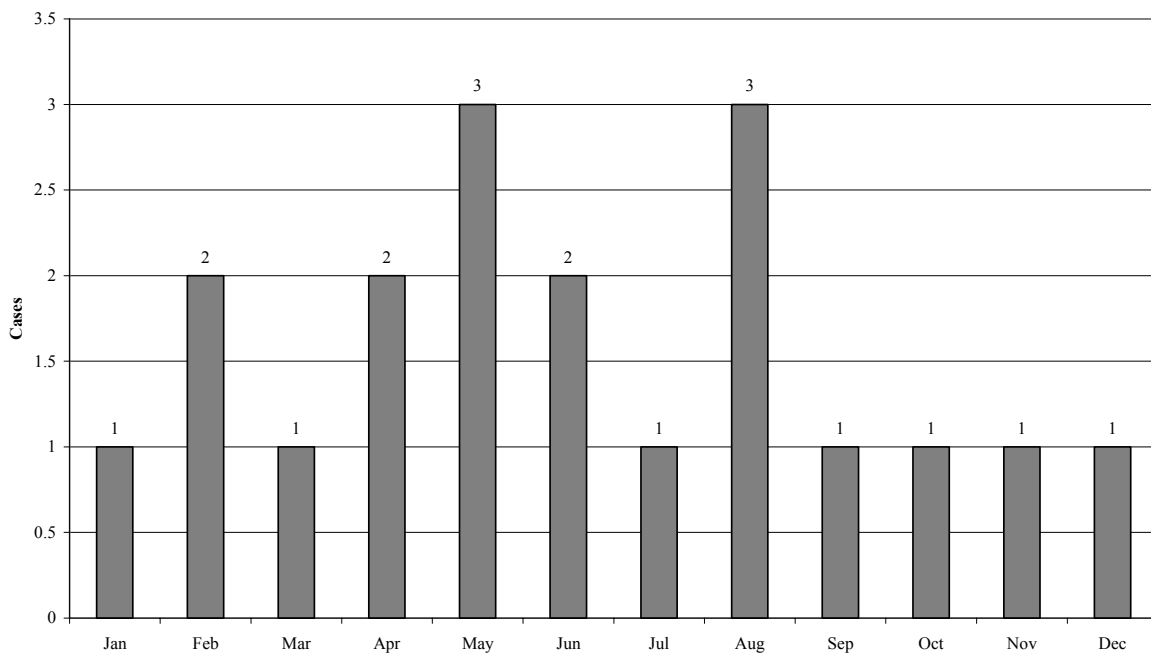
In 2004, the number of suicide deaths of children remained constant from the previous year, but there has been an overall decrease of 17.4 percent for the number of suicides for children over the past 6 years. Suicide was more common among males (78.9%), whites (79.0%), and children aged 17 years (36.8%). Almost one-half of suicides were committed using some type of firearm.



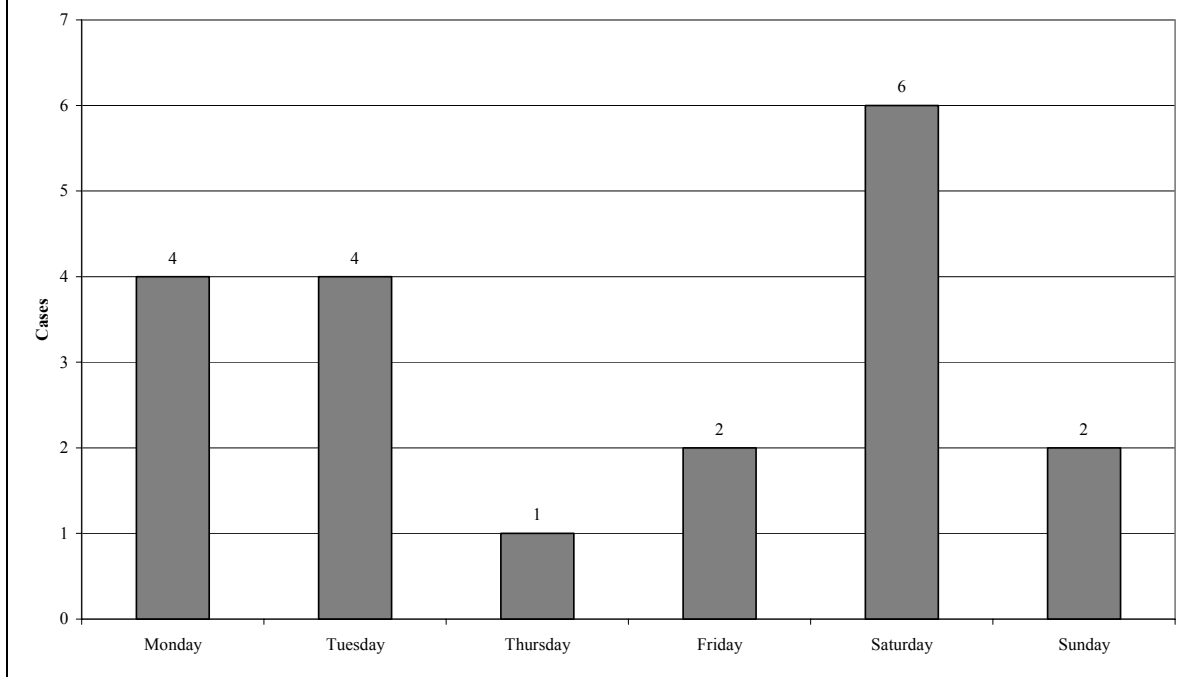
**Figure 44. Proportion of Suicide Deaths of Children, 17 Years and Younger, by Race/Ethnicity, 2004**



**Figure 45. Suicide Deaths of Children, 17 Years and Younger, by Month of Death, 2004**



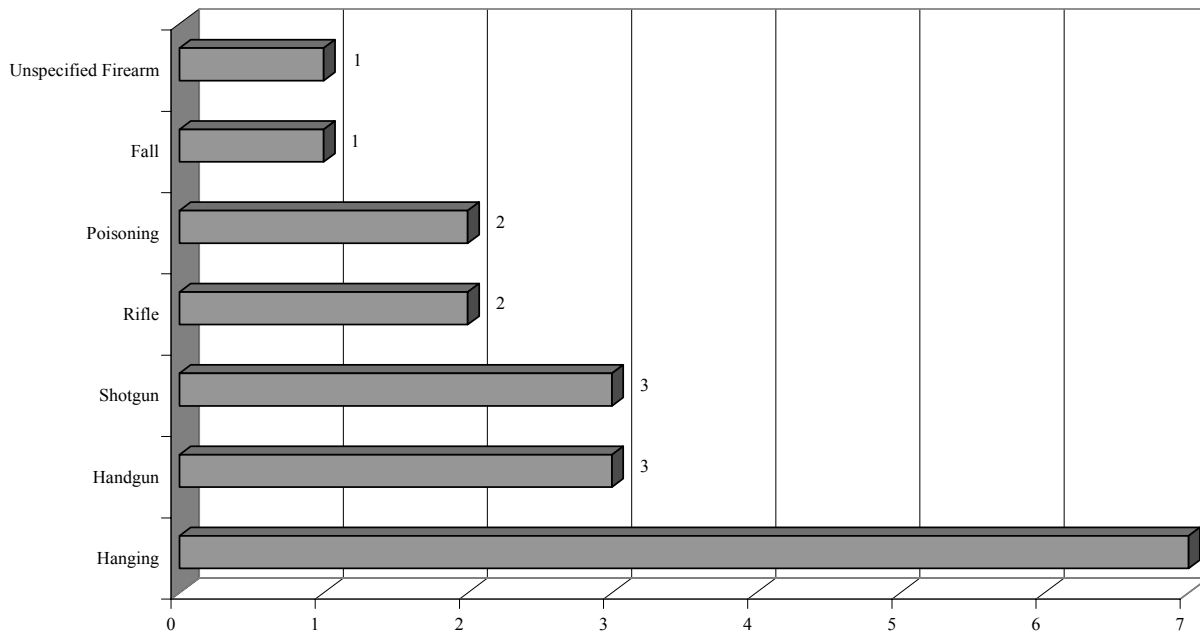
**Figure 46. Suicide Deaths of Children, 17 Years and Younger, by Day of Death, 2004**



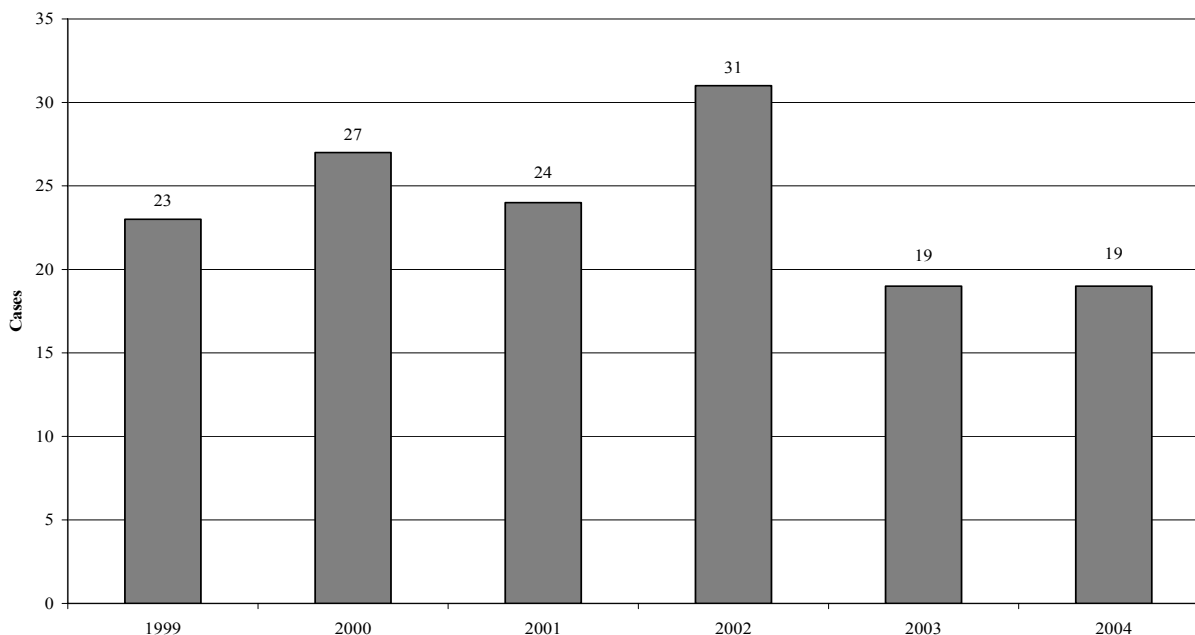
**Table 19. Suicide Deaths of Children, 17 Years and Younger, by Method of Death, 2004**

Method of Death	Total Cases	Autopsied
Shot self with firearm	9	9
- Handgun	(3)	(3)
- Shotgun	(3)	(3)
- Rifle	(2)	(2)
- Unspecified Firearm	(1)	(1)
Hanged self	7	4
Jumped from height	1	0
Poisoned self with drugs	1	1
Carbon Monoxide Poisoning	1	0
<b>Total</b>	<b>19</b>	<b>14</b>

**Figure 47. Suicide Deaths of Children, 17 Years and Younger, by Method of Death, 2004**

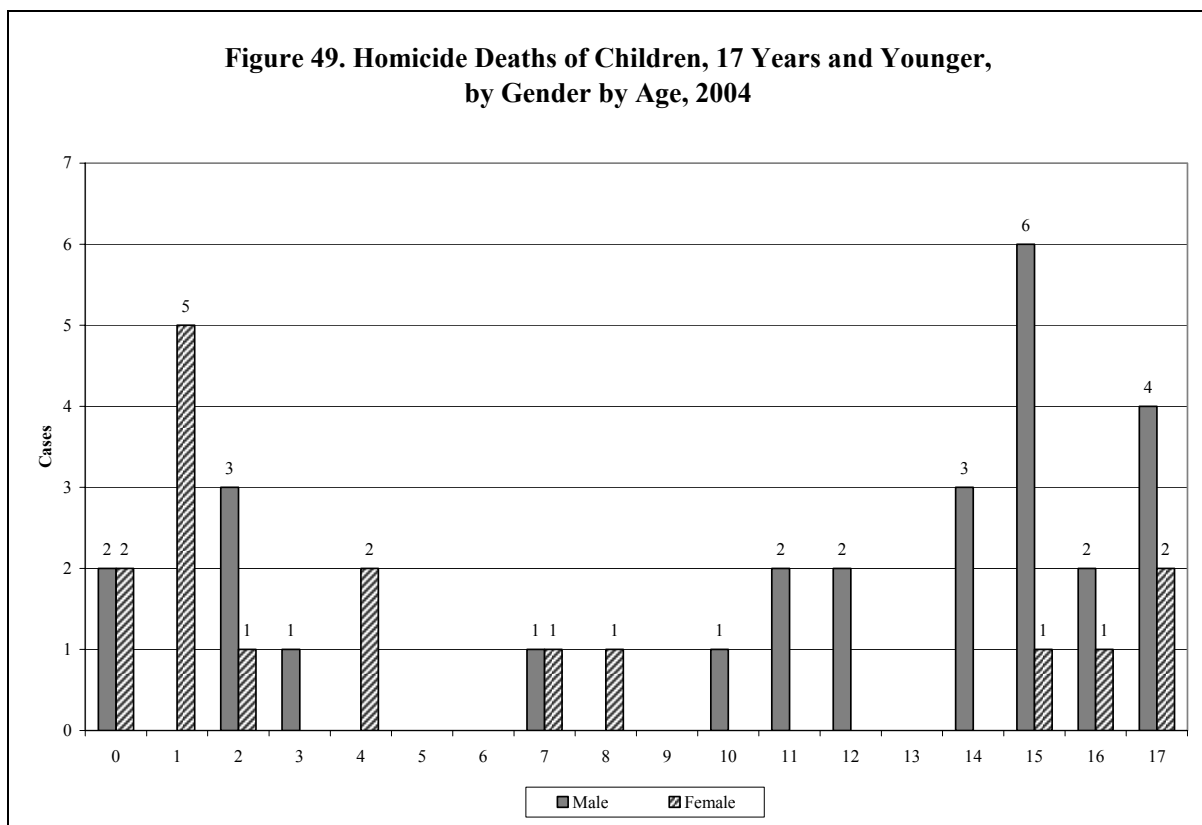


**Figure 48. Suicide Deaths of Children, 17 Years and Younger, by Year of Death, 1999-2004**

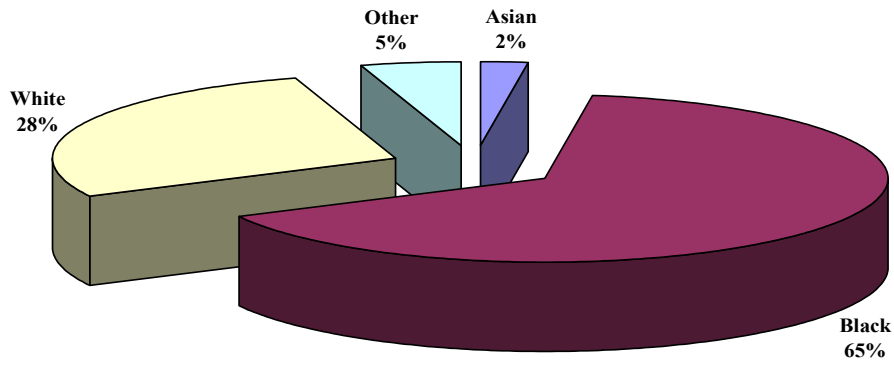


## HOMICIDE DEATHS OF CHILDREN

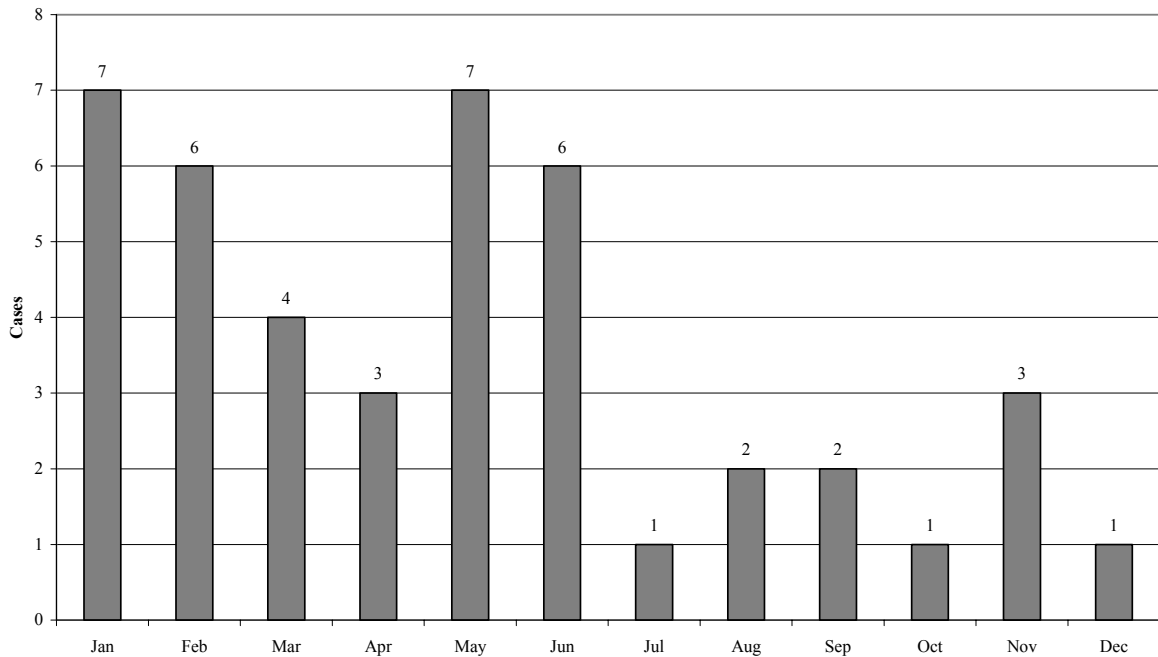
During 2004, Virginia experienced a 10.4 percent decrease of homicide deaths among children from the previous year. Males died from homicides at 1.6 times the rate of females overall, but exceeded 5 times the rate when looking at older children (aged 10-17 years). Homicides occurred more frequently in January and May (32.6%) and on Mondays (23.3%). Of the 43 homicides, black children represented 65.0 percent of these deaths. Firearms were the method of death in 58.1 percent of homicides of children.



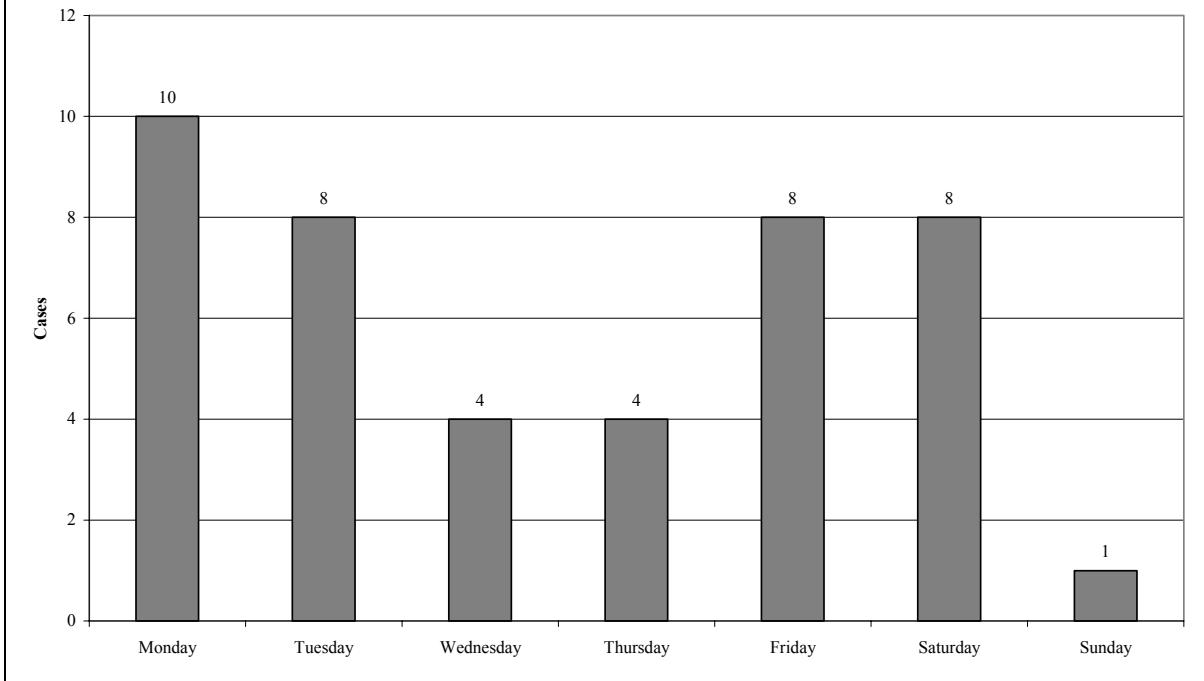
**Figure 50. Proportion of Homicide Deaths of Children, 17 Years and Younger, by Race/Ethnicity, 2004**



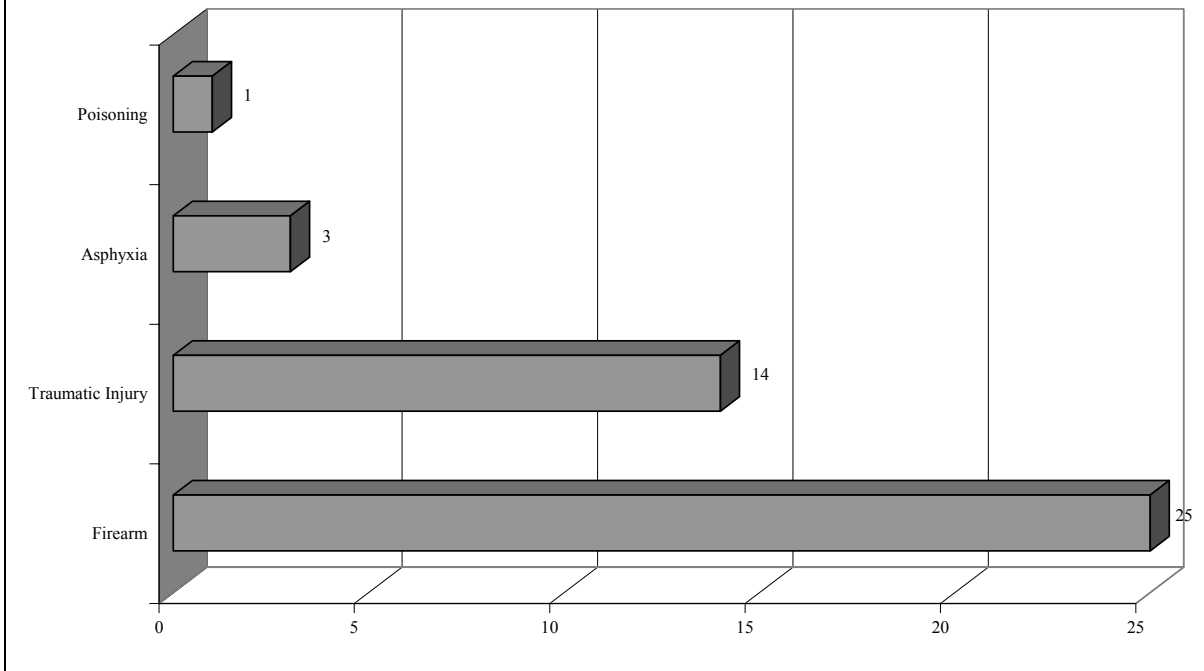
**Figure 51. Homicide Deaths of Children, 17 Years and Younger, by Month of Death, 2004**



**Figure 52. Homicide Deaths of Children, 17 Years and Younger, by Day of Death, 2004**



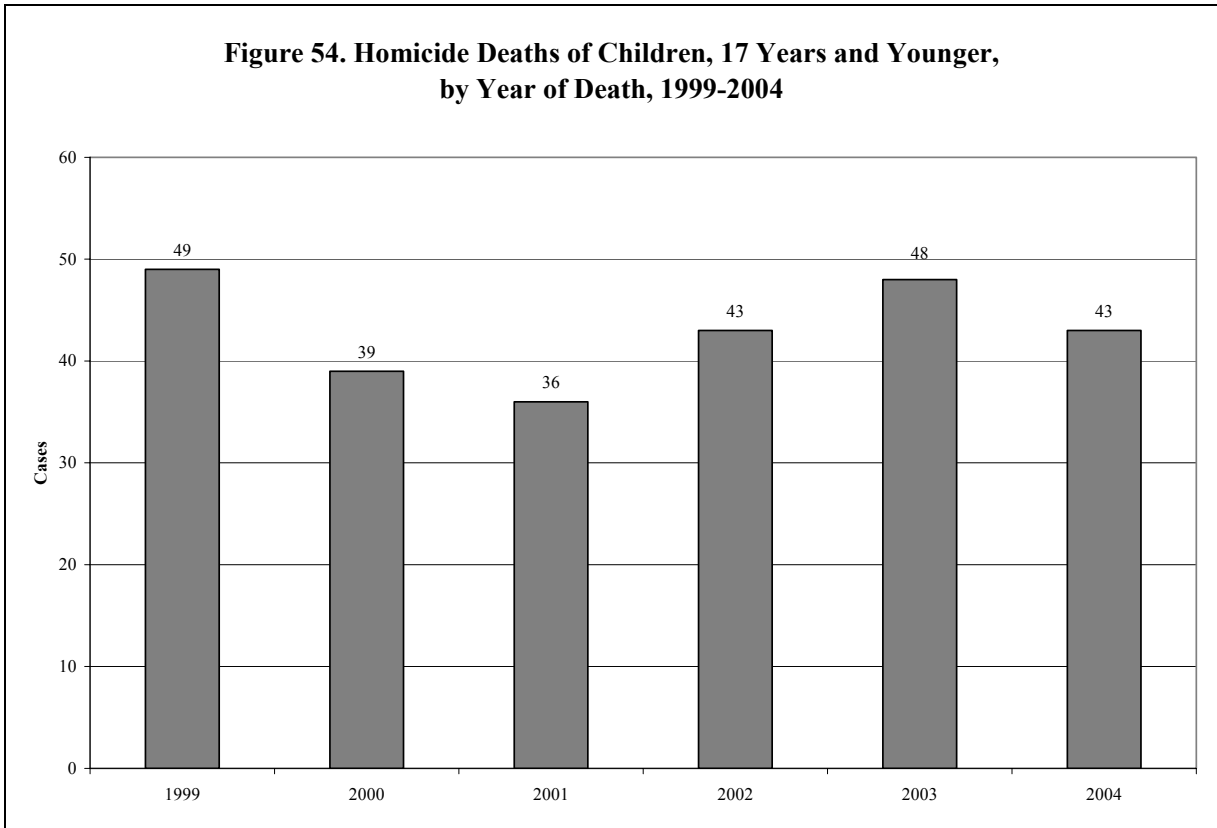
**Figure 53. Homicide Deaths of Children, 17 Years and Younger, by Method of Death, 2004**





**Table 20. Homicide Deaths of Children, 17 Years and Younger, by Method of Death, 2004**

<b>Method of Death</b>	<b>Total Cases</b>	<b>Autopsied</b>
Shot by assailant(s) with firearm	25	25
- Handgun	(17)	(17)
- Rifle	(1)	(1)
- Shotgun	(2)	(2)
- Unspecified Firearm	(5)	(5)
Abused/Beaten by assailant(s)	13	13
Strangled/Smothered by assailant(s)	3	3
Victim of fire/burning	1	1
Undetermined	1	0
<b>Total</b>	<b>43</b>	<b>42</b>



## **UNDETERMINED DEATHS OF CHILDREN**

A total of 31 undetermined deaths of children occurred in 2004. The majority of these undetermined deaths were found in children aged less than 1 year (90.3%).

**Table 21. Undetermined Deaths of Children, 17 Years and Younger, by Method of Death and Age, 2004**

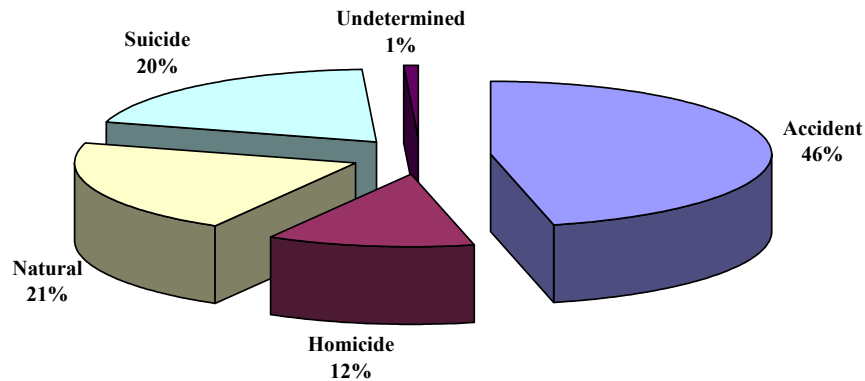
<b>Method</b>	<b>Total Cases</b>	<b>Autopsied</b>
Ingested/Injected medication	1	1
Gunshot wound	1	1
Undetermined after autopsy and/or toxicology	29	29
<b>Age</b>		
0	28	28
15	1	1
16	1	1
17	1	1
<b>Total</b>	<b>31</b>	<b>31</b>

## SECTION 5: ETHANOL RELATED DEATHS

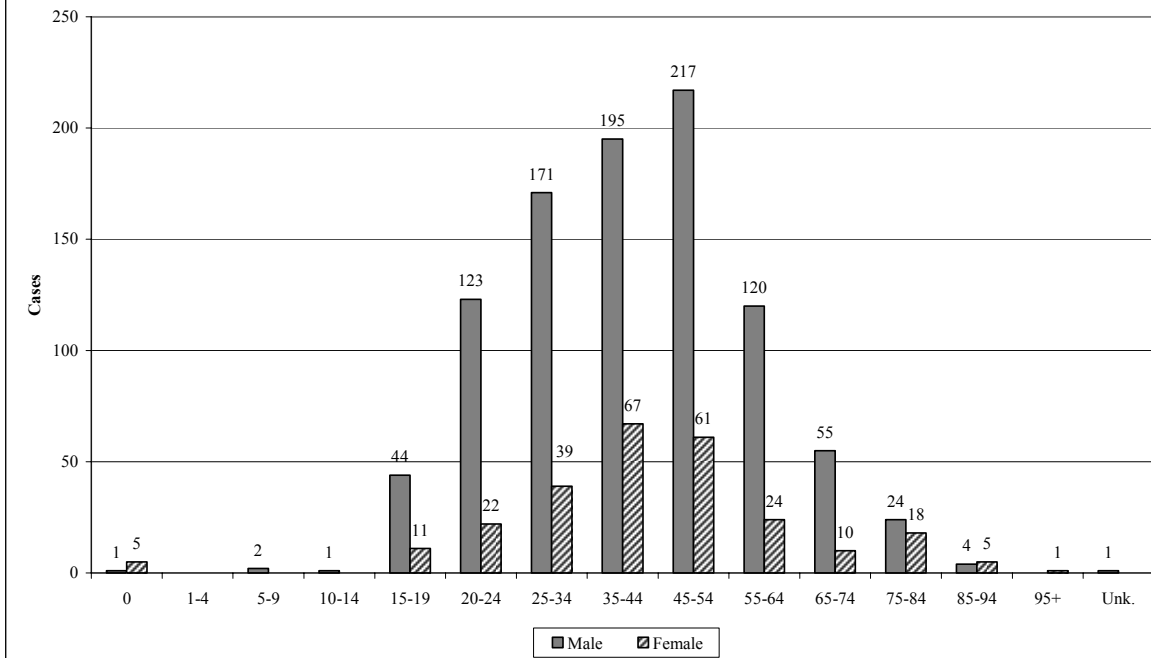
Ethanol, at a level of 0.01 percent by weight by volume (W/V) or greater, was detected in the blood of decedents in 1221 cases (21.1%) in 2004. Of those cases with a detectable ethanol level, 52.0 percent had a measured level at or above 0.08 percent W/V, which is the legal limit for operating a motor vehicle in Virginia.

- Accidents were responsible for 46 percent of all ethanol related deaths.
- Males died from ethanol related deaths 3.8 times the rate of females.
- The rate for ethanol related deaths was 20.6 per 100,000 blacks compared to 15.6 per 100,000 whites.

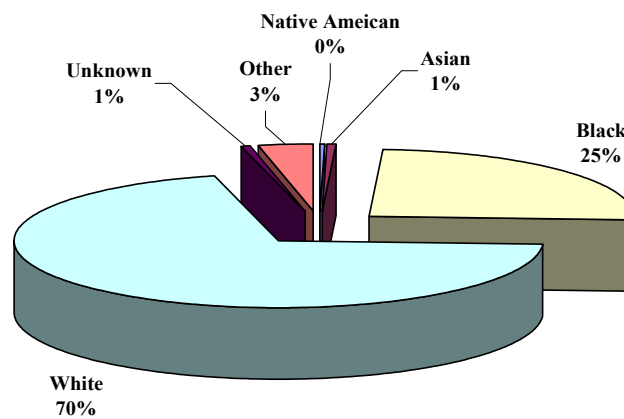
**Figure 55. Ethanol Related Deaths by Manner of Death, 2004**  
Measured Ethanol  $\geq$  0.01% W/V



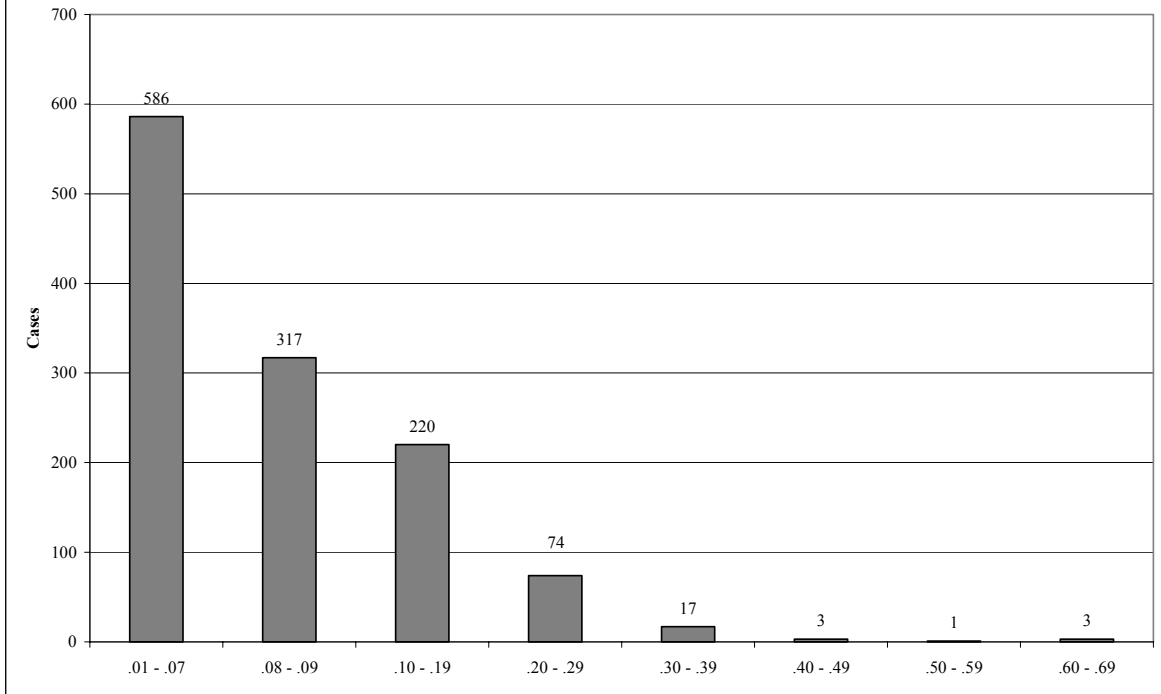
**Figure 56. Ethanol Related Deaths by Gender by Age Group, 2004**  
**Measured Ethanol  $\geq$  0.01% W/V**



**Figure 57. Ethanol Related Deaths by Race/Ethnicity, 2004**  
**Measured Ethanol  $\geq$  0.01% W/V**

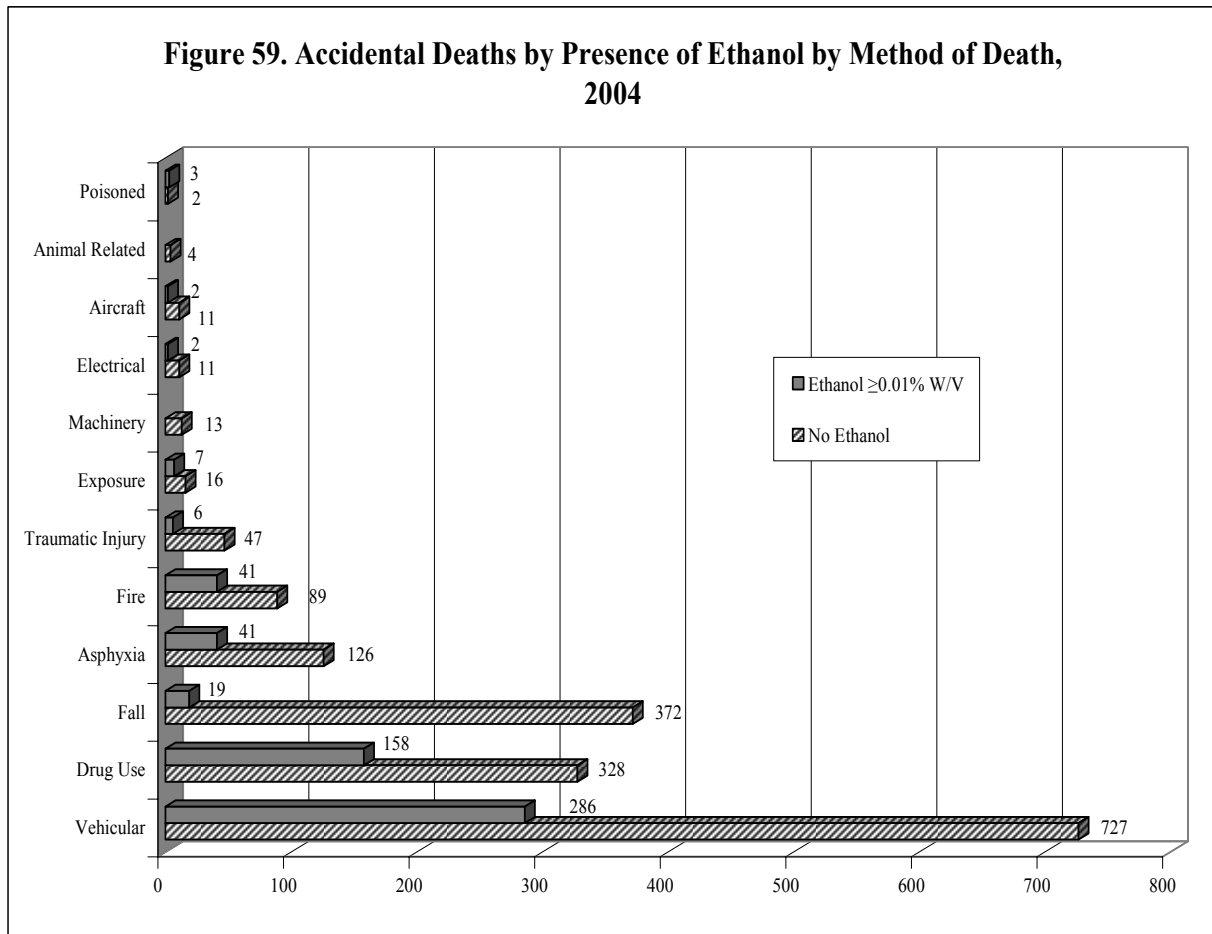


**Figure 58. Ethanol Related Deaths by Measured Ethanol Level, 2004, % W/V**



## ETHANOL RELATED ACCIDENTAL DEATHS

Ethanol was detected in 24.4 percent of all accidental deaths in 2004; this was a 4.1 percent increase from the previous year. Vehicular related accidental deaths had detectable levels of ethanol in 28.2 percent of those deaths. Drug related accidental deaths had detectable levels of ethanol in 28.4 percent of these deaths; an increase of 10.0 percent from the previous year.

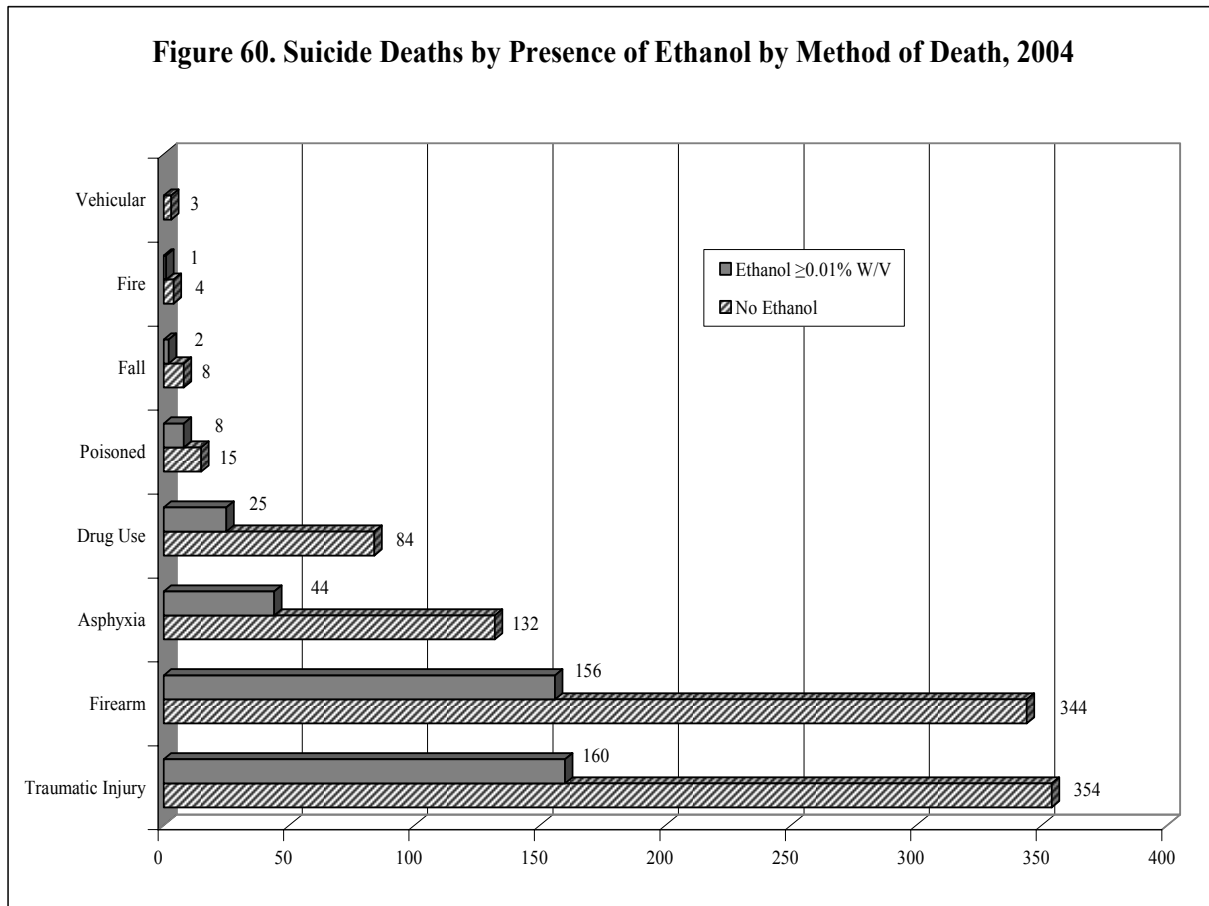


**Table 22. Ethanol Related Accidental Deaths by Method of Death, 2004**

<b>Method of Death</b>	<b>Total</b>	<b>Ethanol <math>\geq 0.01\%</math> W/V</b>	
		<b>Yes</b>	<b>No</b>
<b><i>Aircraft</i></b>			
Passenger/Pilot in aircraft crash	13	2	11
<b><i>Animal Related</i></b>			
Animal related	4	0	4
<b><i>Asphyxia</i></b>			
Accidental ligature strangulation	2	1	1
Choked on foreign object	20	2	18
Crushed/suffocated	16	1	15
Drowned	103	34	69
Mechanical/Positional	26	3	23
<b><i>Drug Use</i></b>			
Ingested alcohol (ethanol)	29	28	1
Ingested and/or injected drugs	457	130	327
<b><i>Electrical</i></b>			
Contacted electrical current	12	1	11
Struck by lightning	1	1	0
<b><i>Exposure</i></b>			
Exposed to cold	18	7	11
Exposed to heat	4	0	4
<b><i>Fall</i></b>			
Fall from height	391	19	372
<b><i>Fire</i></b>			
Scalded by hot water, hot oil, other agent	1	0	1
Smoke inhalation - carbon monoxide	86	29	57
Victim of fire	43	12	31
<b><i>Machinery</i></b>			
Farm or industrial machinery accident	13	0	13
<b><i>Poisoned</i></b>			
Inhaled toxic agent accidentally - carbon monoxide	5	3	2
<b><i>Traumatic Injury</i></b>			
Accidental discharge of firearm	14	4	10
Accidental cutting with cutting instrument	3	0	3
Explosion	3	0	3
Received blow/collided with object	2	0	2
Sports/Athletic	3	0	3
Struck by moving object	11	2	9
Traumatic - other	17	0	17
<b><i>Vehicular</i></b>			
ATV	12	3	9
Auto - driver	559	148	411
Auto - passenger	199	62	137
Auto - pedestrian	99	32	67
Bicycle	4	1	3
Mo-ped	2	1	1
Motorcycle	47	16	31
Tractor/Heavy construction equipment	17	2	15
Train	4	1	3
Other	70	20	50
<b>Total</b>	<b>2311</b>	<b>565</b>	<b>1746</b>

## ETHANOL RELATED SUICIDE DEATHS

Ethanol was detected in 240 or 28.6 percent of all suicides. Of these 240 suicides with ethanol present, the most frequent method of suicide was to shoot oneself with a firearm (65%) followed by hanging oneself (15%).



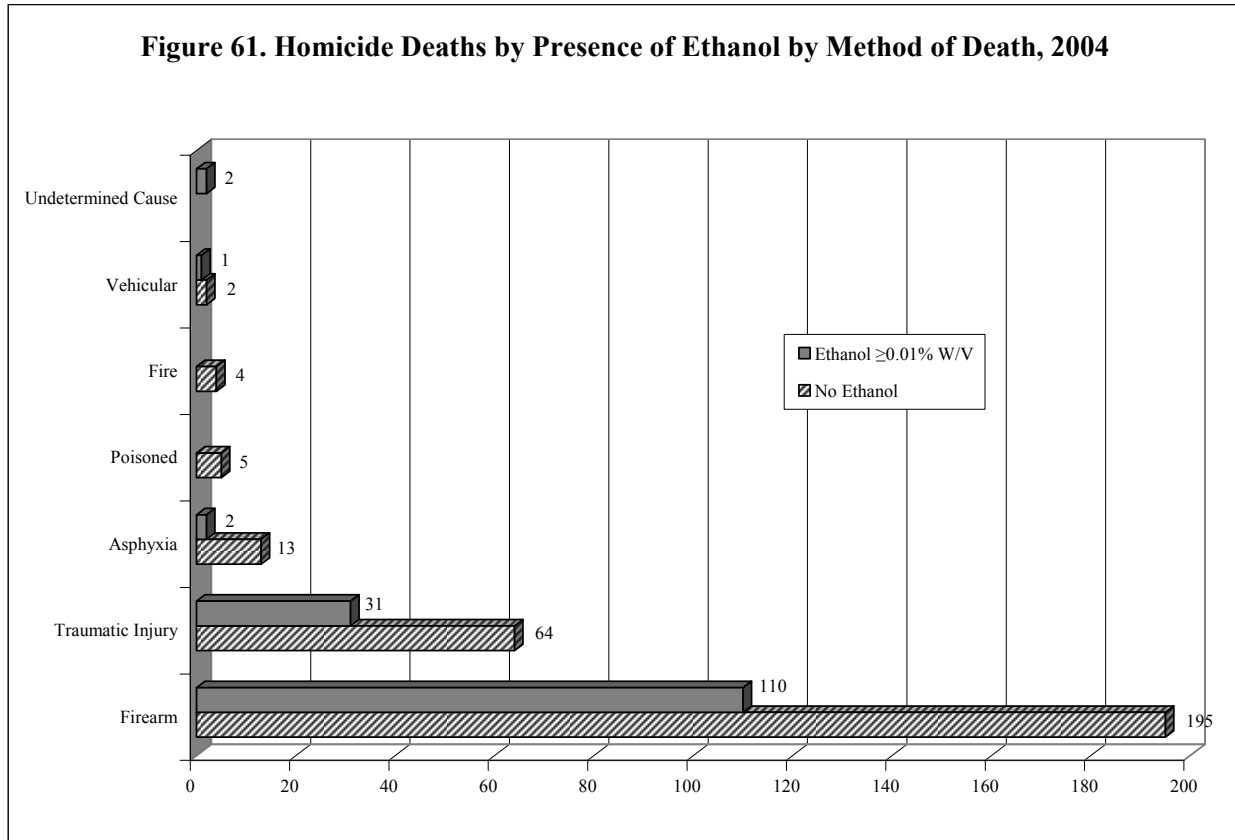


**Table 23. Ethanol Related Suicide Deaths by Method of Death, 2004**

<b>Method of Death</b>	<b>Total</b>	<b>Ethanol ≥0.01% W/V</b>	
		<b>Yes</b>	<b>No</b>
Shot self with firearm	500	156	344
- Handgun	(321)	(96)	(225)
- Rifle	(48)	(17)	(31)
- Shotgun	(78)	(24)	(54)
- Unspecified firearm	(53)	(19)	(34)
Hanged self	151	36	115
Ingested or injected medication	109	25	84
Inhaled toxic agent	20	6	14
Suffocated self	13	7	6
Cut/Slashed self	12	4	8
Drowned self	12	1	11
Jumped from height	10	2	8
Burned self	5	1	4
Alcohol poisoning (ethanol)	3	2	1
Suicide as pedestrian	3	0	3
Suicide - other	2	0	2
<b>Total</b>	<b>840</b>	<b>240</b>	<b>600</b>

## ETHANOL RELATED HOMICIDE DEATHS

Ethanol was detected in 34.0 percent of all homicide deaths in 2004. In homicide deaths involving a firearm, ethanol was detected in 36.1 percent, which was a 5.5 percent increase from the previous year.



**Table 24. Ethanol Related Homicide Deaths by Method of Death, 2004**

Method of Death	Total	Ethanol $\geq 0.01\%$ W/V	
		Yes	No
Shot by assailant(s) with firearm	305	110	195
- Handgun	(190)	(71)	(119)
- Rifle	(9)	(2)	(7)
- Shotgun	(18)	(4)	(14)
- Unspecified firearm	(88)	(33)	(55)
Beaten by assailant(s)	49	14	35
Stabbed by assailant(s)	44	17	27
Strangled by assailant(s)	15	2	13
Judicial execution	5	0	5
Homicide - Other	4	2	2
Victim of intentionally set fire	4	0	4
Struck by auto by assailant(s)	3	1	2
<b>Total</b>	<b>429</b>	<b>146</b>	<b>283</b>

## **ETHANOL RELATED UNDETERMINED DEATHS**

Ethanol was detected in 12.0 percent of all undetermined deaths.

**Table 25. Ethanol Related Undetermined Deaths by Method of Death, 2004**

<b>Method of Death</b>	<b>Total</b>	<b>Ethanol <math>\geq</math>0.01% W/V</b>	
		<b>Yes</b>	<b>No</b>
Undetermined after autopsy and/or toxicology	56	3	53
Ingested/Injected medication	10	2	8
Gunshot wound	6	3	3
Drowning	3	1	2
Driver/Passenger/Pedestrian	2	0	2
Fall from height/same height	2	0	2
Explosion/Victim of fire	1	0	1
Hanged self	1	0	1
Inhaled toxic agent (carbon monoxide)	1	1	0
Starvation	1	0	1
<b>Total</b>	<b>83</b>	<b>10</b>	<b>73</b>

## ETHANOL RELATED CAUSES OF DEATH

Ethanol was detected in 21.1 percent of all causes of deaths in 2004, with ethanol detected in 11.8 percent of all natural deaths and 27.0 percent of all unnatural deaths.

**Table 26. Ethanol Related Natural and Unnatural Deaths by Cause of Death, 2004**

<b>Natural Deaths</b>	<b>Total</b>	<b>Ethanol <math>\geq</math>0.01% W/V</b>	
		<b>Yes</b>	<b>No</b>
AIDS	6	2	4
Alzheimer's Disease	7	0	7
Aneurysm	14	2	12
Aspiration	5	0	5
Asthma	13	2	11
Blood Disorders	2	0	2
Carcinoma	83	7	76
Cerebrovascular	66	3	63
COPD	16	3	13
Congenital Defect	4	0	4
Dehydration	3	0	3
Diabetes	36	9	27
Emboli	56	2	54
Emphysema	6	2	4
Epilepsy	19	1	18
Ethanolism	53	18	35
Gastrointestinal Hemorrhage	41	10	31
Heart Disease	1422	180	1242
Hepatic Failure	6	0	6
History of Illness or Injury	1	0	1
Hypertension	5	0	5
Intrauterine Fetal Death	4	0	4
Leukemia	1	0	1
Medical Treatment	1	0	1
Meningitis	5	1	4
Natural - Other	79	6	73
Obesity	1	0	1
Obstruction (blockage)	3	1	2
Pancreas	3	0	3
Parkinson's Disease	1	0	1
Pathologic Injuries	14	2	12
Pneumonia	99	8	91
Prematurity	5	0	5
Pulmonary Edema	3	0	3
Renal Failure	15	0	15
Respiratory Distress Syndrome	5	0	5
Sepsis	33	1	32
Spontaneous Hemorrhage	2	0	2
Sudden Infant Death Syndrome	84	3	81
<b>Subtotal</b>	<b>2222</b>	<b>263</b>	<b>1959</b>

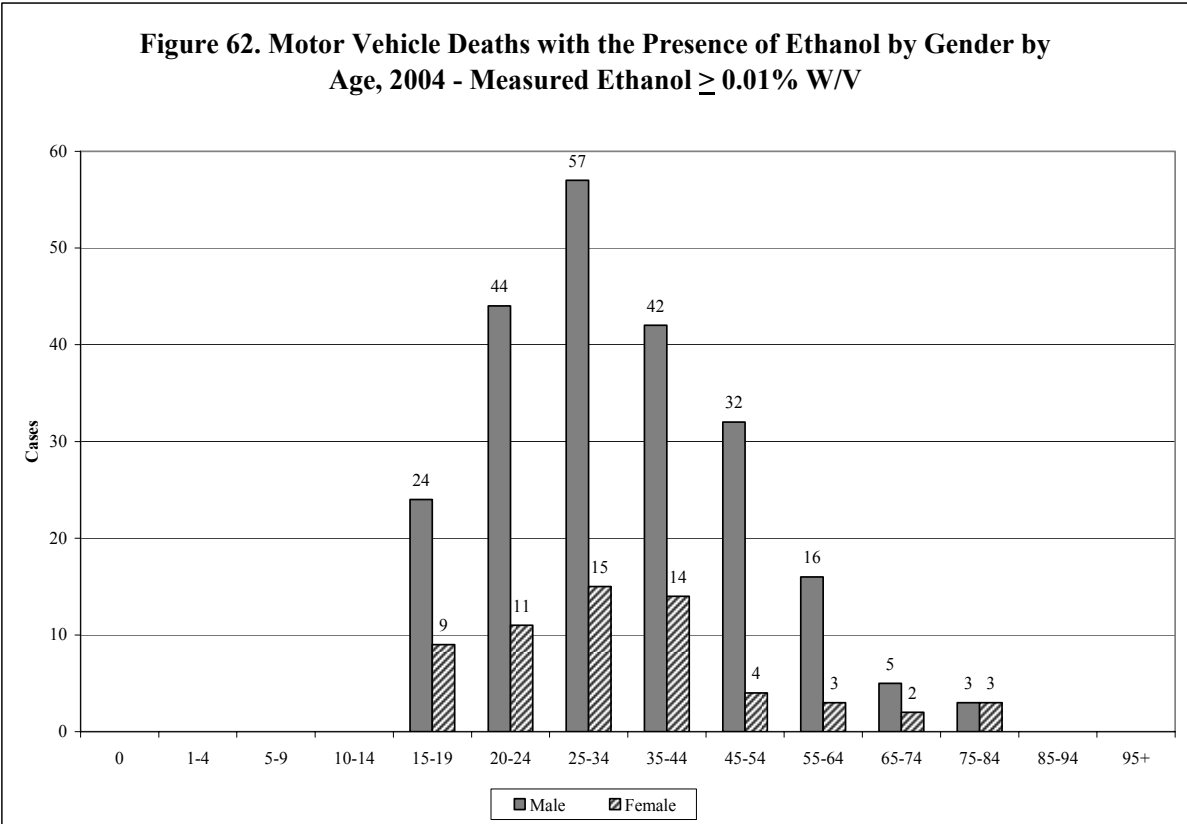
**Table 26. Ethanol Related Natural and Unnatural Deaths by Cause of Death, 2004 ~continued**

<b>Unnatural Deaths</b>	<b>Total</b>	<b>Ethanol <math>\geq</math>0.01% W/V</b>	
		<b>Yes</b>	<b>No</b>
Asphyxia	104	19	85
Carbon Monoxide Poisoning	121	42	79
Child Abuse	7	0	7
Drowning	118	36	82
Electrocution	11	2	9
Ethanol Poisoning	30	29	1
Exposure (cold)	18	7	11
Exposure (heat)	4	0	4
Exsanguination	18	5	13
Gunshot Wound	824	273	551
Hanging	154	37	117
Head and Neck Injuries	649	158	491
Judicial Execution	5	0	5
Multiple Injuries	685	156	529
Narcotic Abuse	216	60	156
Stab Wound	45	17	28
Subdural Hematoma	97	3	94
Substance Poisoning	359	98	261
Thermal Injuries (burns)	46	11	35
Unnatural - Other	30	4	26
Skeletal/Mummified Remains	2	0	2
<b>Subtotal</b>	<b>3543</b>	<b>957</b>	<b>2586</b>
<b>Uncertifiable Deaths</b>			
Undetermined after Autopsy and/or Investigation	34	1	33
<b>Total</b>	<b>5799</b>	<b>1221</b>	<b>4578</b>

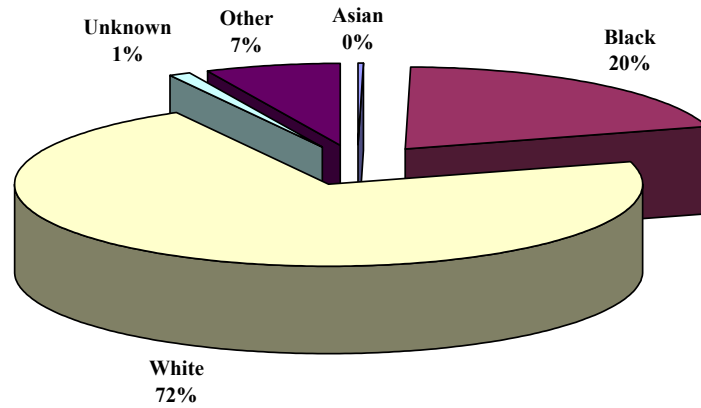
## SECTION 6: MOTOR VEHICLE RELATED DEATHS

The OCME investigated 1,021 motor vehicle related deaths in 2004; and in 22.3 percent of these deaths, the decedent had a measured blood alcohol level at or above the legal limit of 0.08 percent W/V.

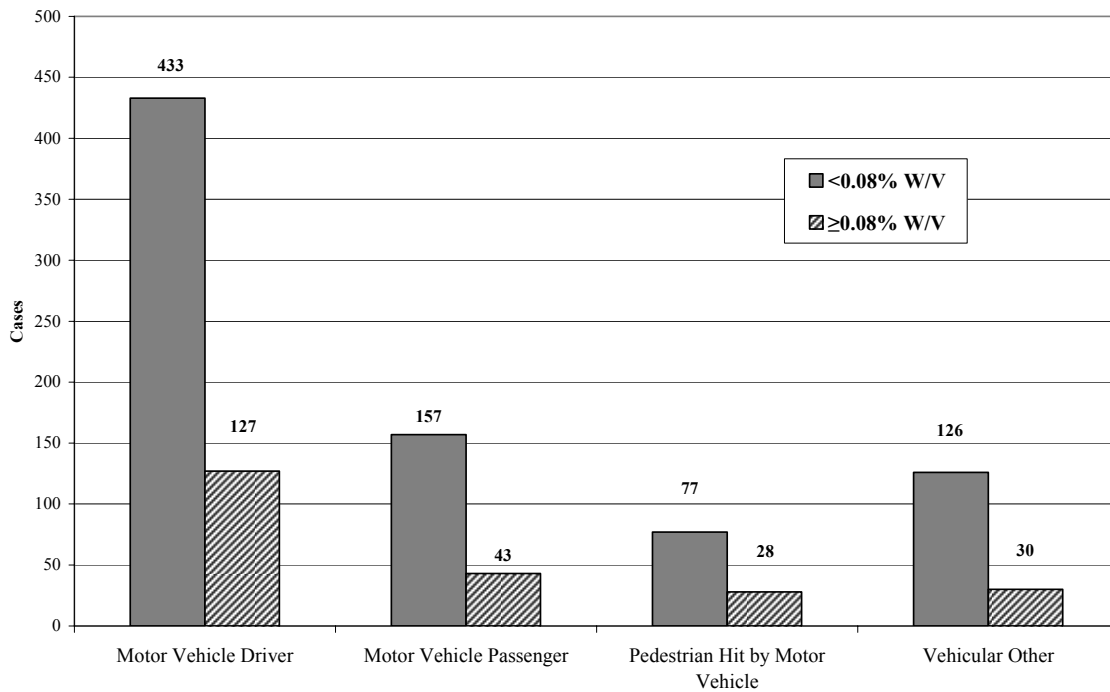
- Whites accounted for approximately three out of four motor vehicle deaths in which the decedent had a measured blood alcohol level at or above 0.01 percent W/V.
- Males died from motor vehicle incidents with the presence of alcohol at 3.8 times that of females (6.1 per 100,000 males compared to 1.6 per 100,000 females).
- Persons aged 25-34 years old had more deaths (31.6%) in motor vehicle incidents with the presence of ethanol in the decedent than any other age group.
- Of all the motor vehicle related deaths, 560 or 54.8 percent of the decedents were the drivers of the vehicle, while 127 or 22.7 percent of these deceased drivers had a measured blood alcohol level at or above 0.08 percent W/V.



**Figure 63. Proportion of Motor Vehicle Deaths with Ethanol Present by Race/Ethnicity, 2004 - Measured Ethanol  $\geq 0.01\%$  W/V**



**Figure 64. Motor Vehicle Related Deaths by Presence Of Ethanol, 2004**



**Table 27. Motor Vehicle Related Deaths by Presence of Ethanol, 2004**

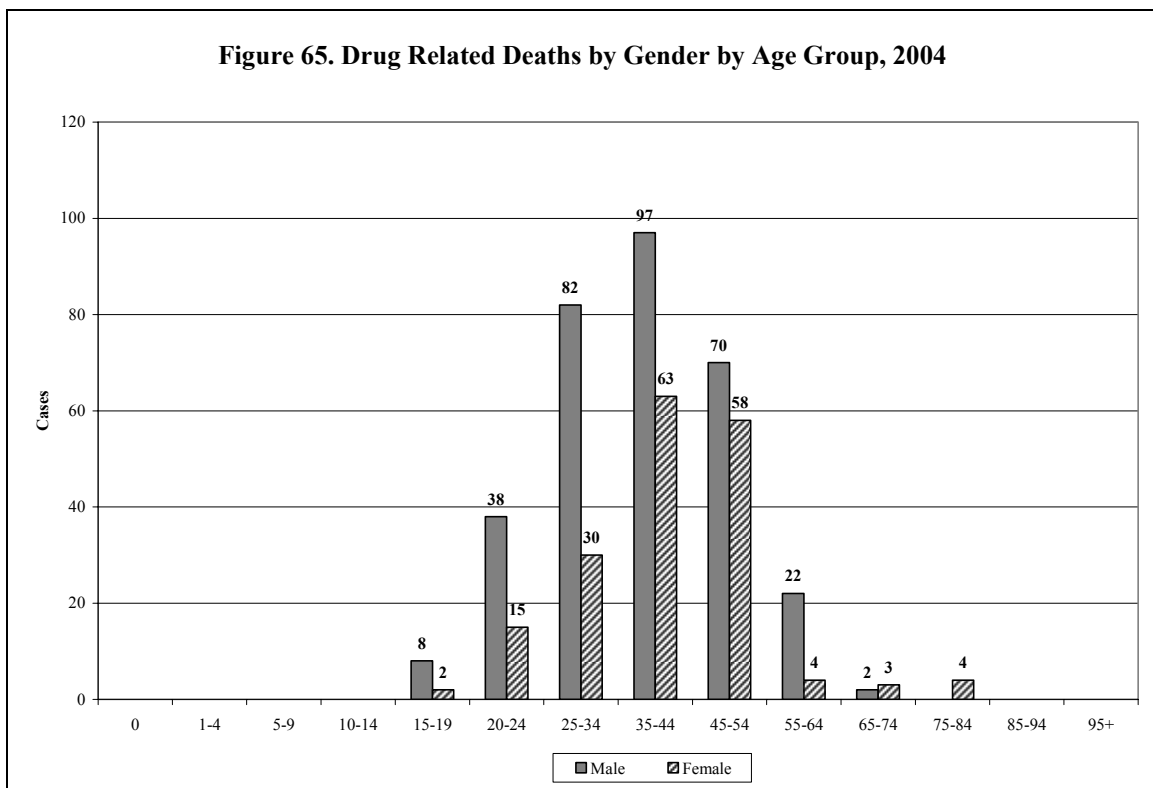
<b>Circumstances</b>	<b>Total</b>	<b>Ethanol <math>\geq</math>0.08% W/V</b>	
		<b>Yes</b>	<b>No</b>
Motor Vehicle Driver	560	127	433
Motor Vehicle Passenger	200	43	157
Pedestrian Hit by Motor Vehicle	105	28	77
Vehicular Other	156	30	126
<b>Total</b>	<b>1021</b>	<b>228</b>	<b>793</b>



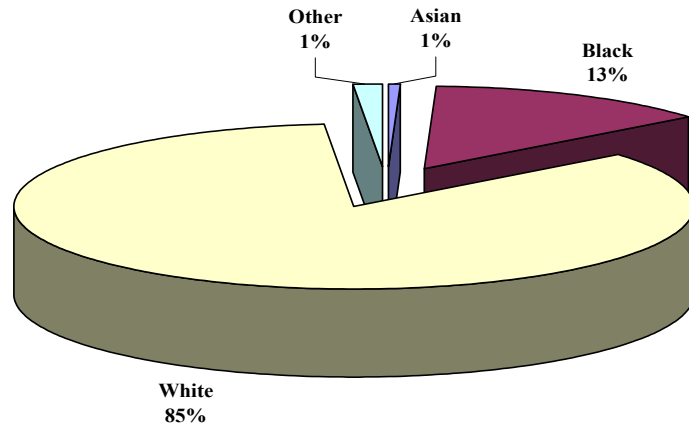
## SECTION 7: DRUG CAUSED DEATHS

In 2004, the 498 drug caused deaths were most frequently assigned as accidents (80.3%) as the manner of death with narcotic abuse and substance intoxication accounting for 97.3 percent of these accidental deaths.

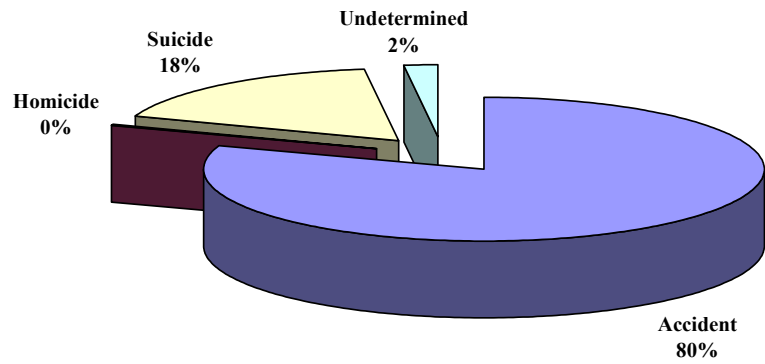
- Drug caused deaths were greatest in males (64.1%), aged 35-44 years (32.1%), and whites (84.5%).
- Narcotics were the most frequently identified class of compounds present in decedents (34.9%) followed by stimulants (17.6%).
- Lee County had the highest rate of 46.1 per 100,000 people for drug related deaths in 2004 by county of residence, while York County had the lowest rate of 1.6 per 100,000 people.



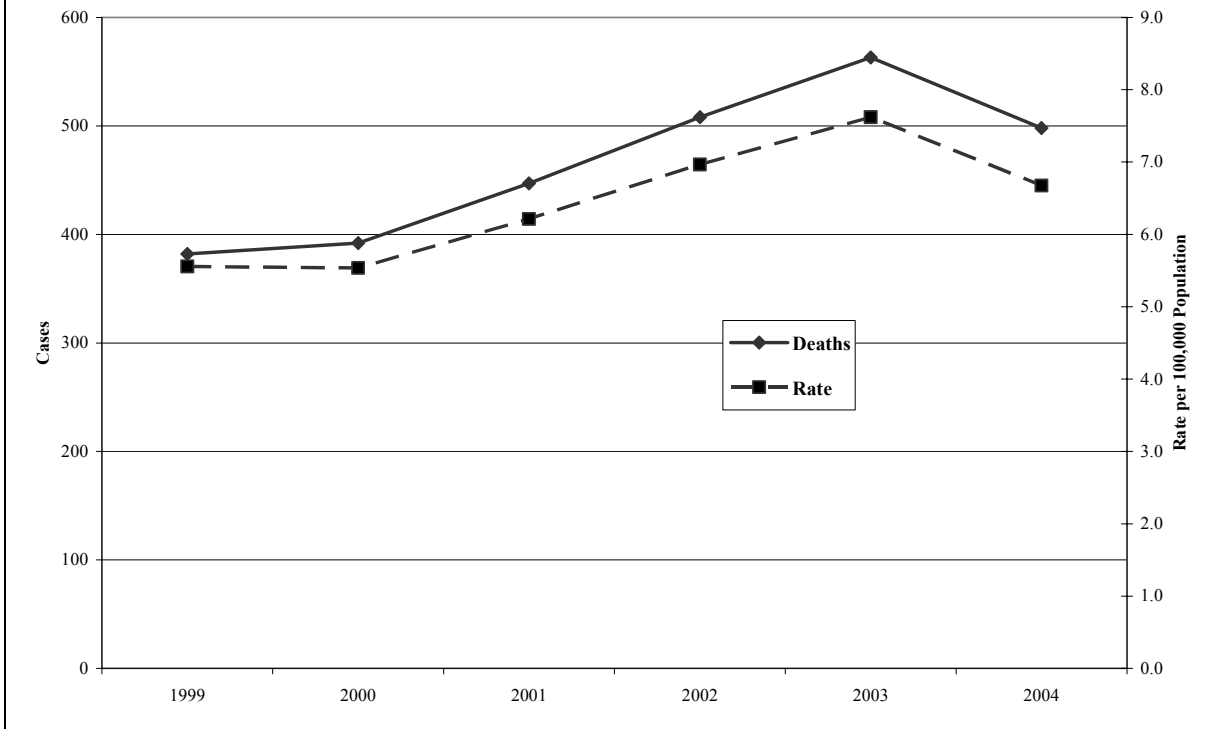
**Figure 66. Proportion of Drug Related Deaths by Race/Ethnicity, 2004**



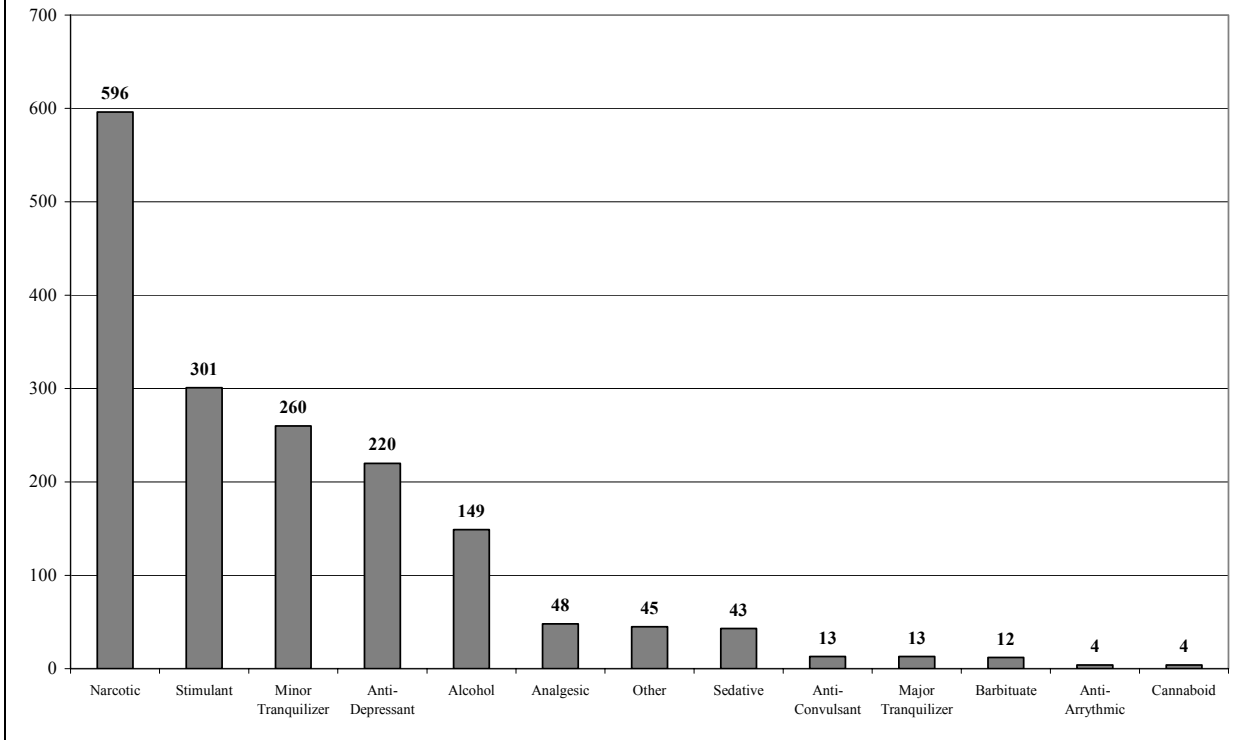
**Figure 67. Proportion of Drug Related Deaths by Manner of Death, 2004**



**Figure 68. Drug Related Deaths Trend, 1999-2004**



**Figure 69. Drug Related Deaths by Class of Compounds Present, 2004**



**Table 28. Drug Related Deaths by Manner of Death by Age Group, 2004**

Age at Death	Manner of Death				Total
	Accident	Homicide*	Suicide	Undetermined	
15-19	8	0	2	0	10
20-24	49	0	4	0	53
25-34	93	0	17	2	112
35-44	129	0	27	4	160
45-54	100	0	26	2	128
55-64	18	0	7	1	26
65-74	1	0	4	0	5
75-84	2	1	1	0	4
<b>Total</b>	<b>400</b>	<b>1</b>	<b>88</b>	<b>9</b>	<b>498</b>

\*excludes judicial execution

**Table 29. Drug Related Deaths by County of Residence, 2004**

County of Residence	Deaths	Rate*	County of Residence	Deaths	Rate*
ACCOMACK	5	12.7	MONTGOMERY	10	11.9
ALBEMARLE	2	2.3	NEWPORT NEWS	9	4.9
ALEXANDRIA	4	3.1	NORFOLK	18	7.6
AMHERST	2	6.3	NORTHAMPTON	1	7.5
ARLINGTON	7	3.8	NORTON	1	26.6
AUGUSTA	5	7.3	NOTTOWAY	1	6.4
BEDFORD	6	9.4	ORANGE	2	6.9
BLAND	3	42.6	PAGE	1	4.2
BOTETOURT	2	6.3	PATRICK	2	10.4
BRISTOL	3	17.3	POQUOSON	1	8.5
BUCHANAN	7	27.8	PORTSMOUTH	14	14.1
BUCKINGHAM	2	12.6	POWHATAN	2	7.7
CARROLL	2	6.8	PRINCE GEORGE	2	5.8
CHARLOTTE	1	8.1	PRINCE WILLIAM	11	3.3
CHESAPEAKE	13	6.1	PULASKI	8	22.8
CHESTERFIELD	16	5.7	RAPPAHANNOCK	1	13.9
CULPEPER	2	5.0	RICHMOND CITY	20	10.4
DANVILLE	8	17.3	ROANOKE CITY	15	16.2
DICKENSON	6	37.1	ROANOKE	5	5.7
DINWIDDIE	1	4.0	ROCKBRIDGE	3	14.2
FAIRFAX	22	2.2	ROCKINGHAM	4	5.7
FAUQUIER	5	7.9	RUSSELL	12	41.5
FLUVANNA	1	4.2	SALEM	5	20.5
FRANKLIN	1	2.0	SCOTT	1	4.4
FREDERICK	7	10.5	SHENANDOAH	4	10.5
FREDERICKSBURG	2	9.8	SMYTH	7	21.5

**Table 29. Drug Related Deaths by County of Residence, 2004**  
~continued

County of Residence	Deaths	Rate*	County of Residence	Deaths	Rate*
GILES	2	11.8	SOUTHAMPTON	3	17.1
GLOUCESTER	1	2.7	SPOTSYLVANIA	6	5.4
GOOCHLAND	1	5.3	STAFFORD	2	1.7
GRAYSON	1	6.1	STAUNTON	2	8.4
GREENE	1	5.9	SUFFOLK	5	6.5
HALIFAX	2	5.5	TAZEWELL	15	33.5
HAMPTON	5	3.4	VIRGINIA BEACH	26	5.9
HANOVER	4	4.2	WARREN	7	20.4
HENRICO	15	5.4	WASHINGTON	8	15.4
HENRY	9	15.8	WAYNESBORO	4	19.3
ISLE OF WIGHT	1	3.1	WESTMORELAND	1	5.9
JAMES CITY	2	3.6	WILLIAMSBURG	1	8.7
LEE	11	<b>46.1</b>	WINCHESTER	2	8.1
LOUDOUN	8	3.3	WISE	13	31.1
LOUISA	1	3.5	WYTHE	9	32.1
LYNCHBURG	3	4.6	YORK	1	1.6
MECKLENBURG	4	12.3	UNKNOWN	1	-
MIDDLESEX	2	19.1	OUT OF STATE	24	-
			<b>Total</b>	<b>498</b>	<b>6.7</b>

\* Rate per 100,000 population

**Table 30. Drug/Physiologically Active Compounds Present in Decedents, 2004**

Drug/Compound	Total
<b>Alcohol</b>	
ETHANOL	147
ISOPROPANOL	2
<b>Alcohol Total</b>	<b>149</b>
<b>Analgesic</b>	
ACETAMINOPHEN	20
DEXTROMETHORPHAN	10
IBUPROFEN	1
METHYL SALICYLATE	1
NAPROXEN	1
ORPHENADRINE	1
PENTAZOCINE	1
SALICYLATE	3
SALICYLIC ACID	2
TRAMADOL	8
<b>Analgesic Total</b>	<b>48</b>
<b>Anti-Arrhythmic/Anti-Hypertensive</b>	
DILTIAZEM	3
VERAPAMIL	1
<b>Anti-Arrhythmic/Anti-Hypertensive Total</b>	<b>4</b>
<b>Anti-Convulsant</b>	
CARBAMAZEPINE	3

**Table 30. Drug/Physiologically Active Compounds Present in Decedents, 2004**

*~continued*

<b>Drug/Compound</b>	<b>Total</b>
CLONAZEPAM	5
PHENYTOIN	2
VALPROIC	3
<b>Anti-Convulsant Total</b>	<b>13</b>
<b>Anti-Depressant</b>	
AMITRIPTYLINE	34
BUPROPION (WELLBUTRIN)	9
CITALOPRAM	35
CLOMIPRAMINE	2
DESALKYFLURAZEPAM	1
DESIPRAMINE	1
DOXEPIN	4
FLUOXETINE	17
FLUVOXAMINE	1
IMIPRAMINE	1
MIRTAZAPINE	7
NORDOXEPIN	1
NORFLUOXETINE	1
NORTRIPTYLENE	33
NORVENLAFAXINE	1
OLANZAPINE	9
PAROXETINE	10
SERTRALINE	17
TRAZODONE	20
VENLAFAXINE	11
ZOLPIDEM	5
<b>Anti-Depressant Total</b>	<b>220</b>
<b>Barbituate</b>	
BUTALBITAL	10
PENTOBARBITAL	1
PHENOBARBITAL	1
<b>Barbituate Total</b>	<b>12</b>
<b>Cannaboid</b>	
TETRAHYDROCANNABINOL	4
<b>Cannaboid Total</b>	<b>4</b>
<b>Major Tranquilizer</b>	
PHENCYCLIDINE	1
QUETIAPINE	11
THIORIDAZINE	1
<b>Major Tranquilizer Total</b>	<b>13</b>
<b>Minor Tranquilizer</b>	
ALPRAZOLAM	53
CARISOPRODOL	6
CHLORDIAZEPOXIDE	3
DIAZEPAM	65
DIPHENHYDRAMINE	52
LORAZEPAM	1
MEPROBAMATE	7
NORDIAZEPAM	68

**Table 30. Drug/Physiologically Active Compounds Present in Decedents, 2004**

*~continued*

<b>Drug/Compound</b>	<b>Total</b>
TEMAZEPAM	5
<b>Minor Tranquilizer Total</b>	<b>260</b>
<b>Narcotic</b>	
CODEINE	64
FENTANYL	37
HYDROCODONE	82
HYDROMORPHONE	12
MEPERIDINE	2
METHADONE	118
MONOACETYLMORPHINE	4
MORPHINE	118
NORMEPRIDINE	2
NORPROPOXYPHENE	24
OXYCODONE	75
OXYMORPHONE	25
PROPOXYPHENE	33
<b>Narcotic Total</b>	<b>596</b>
<b>Other</b>	
CHLORODIFLUOROMETHANE	1
CHLORPHENIRAMINE	14
CLOZAPINE	2
DOXYLAMINE	6
ETHYLENE GLYCOL	3
FENFLURAMINE	1
LAMOTRIGINE	1
LIDOCAINE	6
METAXALONE	1
METHANOL	2
PHENMETRAZINE	1
PROPYLENE GLYCOL	1
QUININE	5
TOLUENE	1
<b>Other Total</b>	<b>45</b>
<b>Sedative</b>	
CYCLOBENZAPRINE	17
MIDAZOLAM	1
PROMETHAZINE	25
<b>Sedative Total</b>	<b>43</b>
<b>Stimulant</b>	
AMPHETAMINE	2
BENZOYL ECGONINE	144
COCAETHYLENE	40
COCAINE	111
EPHEDRINE	1
METHAMPHETAMINE	1
METHYLENEDIOXYAMPHETAMINE	1
METHYLENEDIOXYMETHAMPHETAMINE	1
<b>Stimulant Total</b>	<b>301</b>
<b>Total</b>	<b>1708</b>

**Table 31. Drug Related Deaths by Manner and Method of Death, 2004**

<b>Manner of Death</b>	<b>Deaths</b>
<b>Accident</b>	
Pneumonia	5
Asphyxia	1
Carbon Monoxide Poisoning	1
Ethanol Intoxication	2
Head and Neck Injuries	2
Narcotic Abuse	180
Substance Intoxication	209
<b>Subtotal</b>	<b>400</b>
<b>Homicide</b>	
Head and Neck Injuries	1
<b>Subtotal</b>	<b>1</b>
<b>Suicide</b>	
Ethanol Intoxication	1
Substance Intoxication	87
<b>Subtotal</b>	<b>88</b>
<b>Undetermined</b>	
Drowning	1
Multiple Injuries	1
Substance Intoxication	7
<b>Subtotal</b>	<b>9</b>
<b>Total</b>	<b>498</b>



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## GLOSSARY

**Accident** – The *manner of death* used when, in other than *natural deaths*, there is no evidence of intent.

**Autopsy** – A detailed postmortem external and internal examination of a body to determine cause of death.

**Ethanol Present** – Deaths in which toxicological tests reveal a reportable level of *ethanol* (0.01% W/V or greater) at the time of death.

**Cause of Death** – The agent of effect that results in a physiological derangement or biochemical disturbance that is incompatible with life. The result of post-mortem examination, including autopsy and toxicological findings, combined with information about the medical history of the decedent serves to establish the *cause of death*.

**Children** – Individuals 17 years of age or younger.

**Method of Death** – The situation, setting, or condition present at the time of injury or death.

**County of Death** – The county where the death occurred. The county where the decedent legally resided, the county where the decedent was fatally injured, and the county where the decedent died may be the same or different.

**County of Residence** – The county where a person legally resides. If not a resident of Virginia, the decedent is listed as “out of state”.

**Local Medical Examiner** – A physician appointed by the *Chief Medical Examiner* to assist in the investigation of deaths and determine *jurisdiction* of the Office of the Chief Medical Examiner. There is a local medical examiner in most counties in Virginia.

**Drug Caused Death** – A death caused by a drug or combination of drugs. Deaths caused by poisons and volatile substances are excluded.

**Ethanol** – An alcohol, which is the principal intoxicant in beer, liquor, and wine. A person with an alcohol concentration in blood of 0.08 percent by weight by volume (0.08%) is legally intoxicated in Virginia.

**Homicide** – The *manner of death* in which death results from the intentional harm of one person by another.

**Jurisdiction** – The extent of the Office of the Chief Medical Examiner’s authority over deaths. The OCME authority covers every death which is due or which might reasonably have been due to a violent or traumatic injury or accident, or of public health interest is to be investigated by the Medical Examiner.

**Manner of Death** – The general category of the condition, circumstances, or event, which causes the death. The categories are *accident*, *homicide*, *natural*, *suicide*, and *undetermined*.

**Motor Vehicle Related Death** – A death involving a motor vehicle. Motor vehicles include automobiles, vans, motorcycles, trucks, aircraft, and trains. The decedent is usually a driver of, a passenger in, or a pedestrian who is struck by a motor vehicle. The death of a bicyclist that is struck by a motor vehicle is considered to be a motor vehicle related death.

**Natural** – The *manner of death* used when solely a disease causes death. If death is hastened by an injury, the *manner of death* is not considered natural.

**Office of the Chief Medical Examiner** – The office in the Virginia Department of Health that is responsible for the investigation of sudden, violent, or unexpected death.

**Opiate** – A class of drugs, including morphine, codeine, and heroin, derived from the opium poppy plant (*Papaver somniferum*).

**Chief Medical Examiner** – The head of the *Office of the Chief Medical Examiner*. The Chief Medical Examiner must be a forensic pathologist licensed to practice medicine in Virginia and may appoint *Assistant Medical Examiners* who are forensic pathologists, and *Local Medical Examiners*.

**Assistant Chief Medical Examiner** – A forensic pathologist who has the duty of performing autopsy and investigating deaths that fall under the *jurisdiction* of the *Office of the Chief Medical Examiner*, and determine *cause* and *manner of death*.

**Stimulant** – A class of drugs, including cocaine and oral and indictable amphetamines, whose principal action is the stimulation of the central nervous system.

**Suicide** – The *manner of death* in which death results from the purposeful attempt to end one's life.

**Undetermined** – The *manner of death* for deaths in which there is insufficient information to assign another manner.

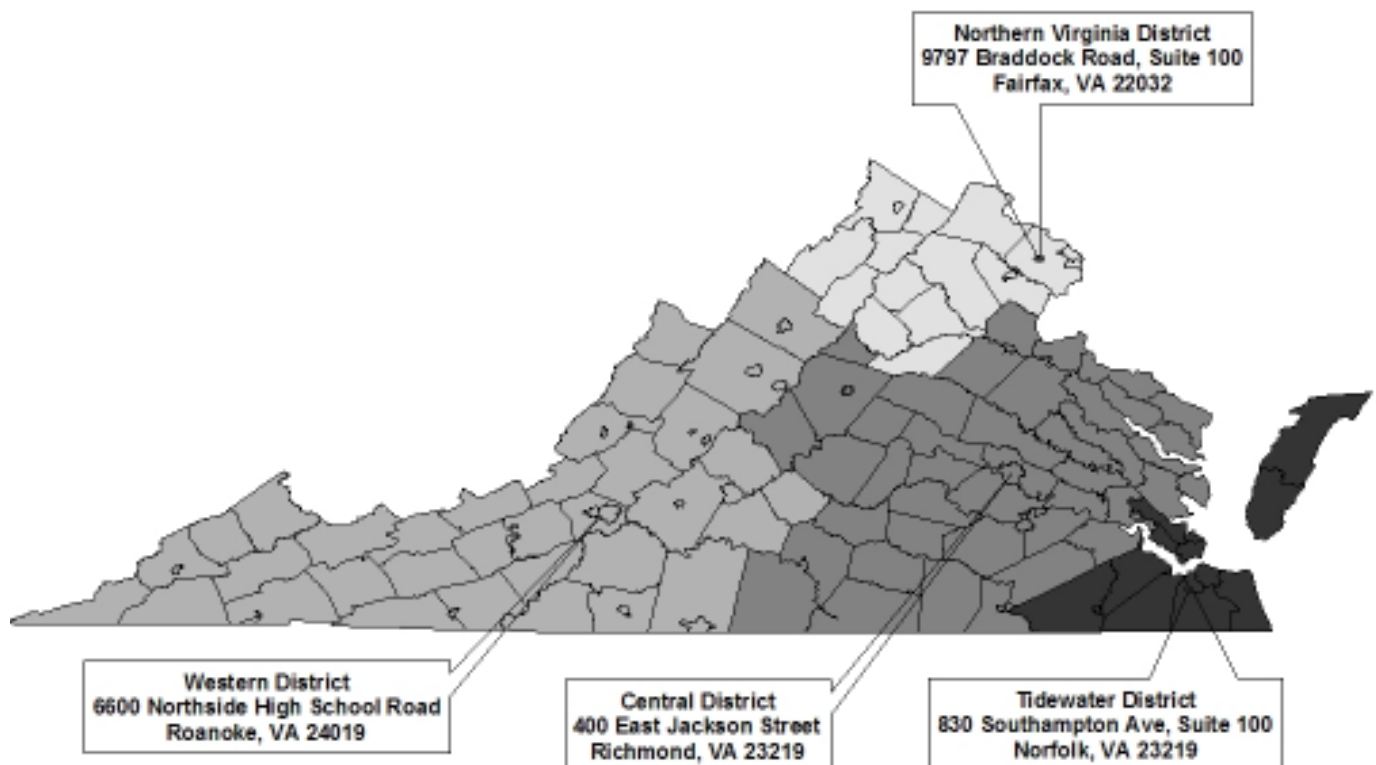
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