

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

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Re _____ Co _____

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By _____

Date _____

REPORT OF INVESTIGATION BY MEDICAL EXAMINER

DECEDENT First-Middle-Last Names (Please avoid use of initials) DALLAS OGLESBY	Age 70	Birth Date 07/06/1935	Race WHITE	Sex M
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HOME ADDRESS - No. - Street, City, State
9 WEST ALTIN DRIVE, OKLAHOMA CITY, OK

EXAMINER NOTIFIED BY - NAME - TITLE (AGENCY, INSTITUTION, OR ADDRESS) RACHEL WITH LIFESHARE	DATE 05/20/2006	TIME 21:20
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INJURED OR BECAME ILL AT (ADDRESS) OKLAHOMA COUNTY JAIL	CITY OKLAHOMA CITY	COUNTY OKLAHOMA	TYPE OF PREMISES JAIL	DATE 05/19/2006	TIME 13:00
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LOCATION OF DEATH OU MEDICAL CENTER PRESBYTERIAN TOWER	CITY OKLAHOMA CITY	COUNTY OKLAHOMA	TYPE OF PREMISES HOSPITAL	DATE 05/20/2006	TIME 20:00
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BODY VIEWED BY MEDICAL EXAMINER 901 NORTH STONEWALL	CITY OKLAHOMA CITY	COUNTY OKLAHOMA	TYPE OF PREMISES MORGUE	DATE 05/22/2006	TIME 09:40
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IF MOTOR VEHICLE ACCIDENT: 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	
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 type="checkbox"/>	Color _____ Lateral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Regional _____	Beard _____ Hair _____ Eyes: Color _____ Mustache _____ Opacities _____ Pupils: R _____ L _____ Body Length _____ Body Weight _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Probable Cause of Death:
HEAD TRAUMA, BLUNT FORCE

Other Significant Medical Conditions:

Manner of Death:

Natural Accident
Suicide Homicide
Unknown Pending

Case disposition:

Autopsy Yes No
Authorized by MEDICAL EXAMINER
Pathologist CHAI S. CHOI M.D.
Not a medical examiner case

MEDICAL EXAMINER:

Name, Address and Telephone No.

CHAI S. CHOI M.D.
901 N. STONEWALL
OKLAHOMA CITY, OK 73117

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.

Chai S. Choi, M.D.

Signature of Medical Examiner

CHAI S. CHOI M.D.

06/26/2006

Date

Computer generated report

0601103



Board of Medicolegal Investigations
Office of the Chief Medical Examiner
901 N. Stonewall
Oklahoma City, Oklahoma 73117
(405) 239-7141 Voice
(405) 239-2430 Fax

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

REPORT OF AUTOPSY

Decedent DALLAS OGLESBY	Age 70	Birth Date 7/6/1935	Race WH	Sex M	Autopsy No 425-06	Case No 0601103
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Type of Death Violent, unusual or unnatural	Means	ID By TOE TAG	Authority for Autopsy CHAI S. CHOI, M.D.
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Present at Autopsy
STEVE MULLINS

PATHOLOGICAL DIAGNOSIS

- I. Head trauma, blunt force:
- A. Extensive subscalpular contusion over the left fronto-parietal temporal region, and right temporal occipital region with cutaneous abraded contusions over the left forehead, including the upper cheek, right ear lobe and behind the right ear lobe, acute
 - B. Regional subgaleal hemorrhages on the right and contusion of the left temple muscle
 - C. Diffuse subdural hematoma, bilateral (approximately 0.3 cm in maximum thickness) and thick subarachnoid hemorrhages, bilateral, mainly over the frontal lobes (approximately up to 1 cm in thickness)
 - D. Diffuse cerebral edema with multifocal microscopic cortical contusions extending through the centrum (weight 1610 gm)
 - E. Hemocephalus, mainly on the right

Continued on Pathological Diagnosis Page 2

CAUSE OF DEATH:

HEAD TRAUMA, BLUNT FORCE
OSC: ATHEROSCLEROTIC HEART DISEASE WITH CORONARY ARTERY BYPASS GRAFT, REMOTE

The facts stated herein are true and correct to the best of my knowledge and belief.

Chai S. Choi, M.D.

OCME Central Division

5/22/2006 9:40 AM

CHAI S. CHOI, M.D.

Pathologist

Location of Autopsy

Date and Time of Autopsy

PATHOLOGICAL DIAGNOSIS
(Continued)

AUTOPSY NO. ML 425-06

CASE NO. 0601103

-
- II. Extensive subpleural contusion, left thoracic cavity (posterior lateral surface)

 - III. Multifocal abraded contusions over both right and left arms including forearm, and dorsum of the left hand, epigastrium, thighs and left back, acute

 - IV. Cardiomegaly with diffuse ventricular hypertrophy (weight 620 gm):
 - A. Severe occlusive atherosclerotic coronary artery disease with status-post coronary artery bypass surgery, remote
 - B. Myocardium with microscopic interstitial fibrosis

 - V. Acute pulmonary congestion with edema (combined weight 2360 gm):
 - A. Severe anthracosis with bullous emphysema, bilateral

 - VI. Cholelithiasis and bilateral hydrocele, moderate

Comment: This 70 year old white male died as a result of being assaulted in jail by another inmate. The decedent was admitted to Oklahoma University Medical Center with the diagnosis of head trauma with innumerable foci of subarachnoid hemorrhages, bilateral, in association with several small apparent contusions involving the frontal lobes, right parietal lobe and right cerebellar hemisphere with hemocephalus and 5 mm subdural hemorrhages overlying the left frontal lobe and soft tissue hematoma / contusion involving the left base and scalp. A complete autopsy confirmed the clinical diagnosis of blunt force head injury with subdural and subarachnoid hemorrhages along with focal cortical contusions and severe cerebral edema. In addition, there is an extensive contusion over the subpleural surface on the left thoracic cavity at the posterior lateral surface. There is a natural underlying condition of severe atherosclerotic heart disease with coronary artery bypass surgery and severe anthracosis with bullous emphysema of the lungs. It is felt that the cause of death is blunt force head trauma. The underlying natural disease of atherosclerotic heart disease and emphysema would be the participating factor to speed his death. The manner of death is homicide.

June 21, 2006
CSC/ns

Chai S. Choi, M.D.

CHAI S. CHOI, M.D.

EXTERNAL EXAMINATION

AUTOPSY NO. ML 425-06

CASE NO. 0601103

DESCRIPTION								
Height	Weight	Eyes	Pupils	Opacities, Etc.	Hair	Beard	Mustache	Circumcised
72 in.	83 kg.	BLUE	R 3 mm L 3 mm		GRAY-BROWN	N	N	
RIGOR (jaw, neck, back, legs, arm, chest, abd., complete)				LIVOR (color, anterior, posterior, lateral, regional)			Body Heat	
COMPLETE				PURPLE-POSTERIOR			COOL	

The body is that of a well developed, well nourished, elderly white male. The conjunctivae are white and show no petechiae. Over the right frontal region, there is an intracranial pressure monitor in place. There is no blood in the nose, mouth or ear canals. There is a nasogastric tube and cannula in place through the nose and an endotracheal tube through the mouth. The inside of the mouth is edentulous and unremarkable. Over the left eye and cheek, including the left temple, there are abraded contusions, which will be described below. The right ear lobe shows a red abraded contusion as well. The neck is unremarkable. There is a cervical collar in place. The chest is of normal contour and shows a vertical midline thoracotomy incision down to the epigastrium measuring overall 38 cm. There are several needle puncture marks over the left subclavian region. There is a greenish to red mark over the precordium. The abdomen is flat and shows somewhat patterned purplish-greenish contusions, which will be described below as well. Over the left pubic region there is a brown mole measuring approximately 1 cm. The genitalia are those of a normal adult male and show a Foley catheter in place. The extremities are symmetric and show multiple contusions and abrasions, which will be described below. There is multiple purplish senile ectasia over both forearms. There are two identification bands around the right wrist. There is a vertical linear surgical scar over the right forearm at the inner aspect measuring approximately 12 cm and a vertical surgical scar over the inner aspect of the right lower leg measuring approximately 30 cm and multiple linear and rounded scars over the left arm, forearm, including the dorsum of the hand and leg. There are small brown scabs over the dorsum of the left hand. There is needle placement over the dorsum of the right hand. Both lower legs are wrapped with an air pressure bag. The back is unremarkable.

Evidence of Injuries:

- I. Head: there is a reddish-purple, edematous contusion over the left forehead down to the left upper cheek, including the left upper and lower eyelids measuring overall 13 x 11 cm. Just above the eyebrow, there is a 1 x 0.3 cm red scab. The left ear lobe is intact. The right ear lobe shows a 1 x 0.3 cm red-purple contusion over the anterior surface of the ear lobe, along with a 2.5 x 1 cm red abraded contusion over the ear lobe at the middle third level. Behind the ear lobe, there are diffuse purple hemorrhages down to the back of the head measuring overall 4 x 6 cm. It is associated with a 3 x 0.3 cm vertical red abrasion at the insertion of the ear lobe.

- II. Thoraco-abdomen: over the left lateral chest, there is a purplish-green contusion measuring 2 x 1 cm over the epigastrium. There are symmetrical, somewhat patterned purplish-green contusions (x 5), measuring between 1.5 cm and 5 x 5.5 cm. The contusion is somewhat rectangular measuring 4 x 1.5 cm having five vertical purplish contusions being separated by 0.5 cm.

Continued on External Exam Page 2

- III. Extremities: over the right arm at the anterior lateral surface, there are two reddish-purple contusions measuring 4 x 4 cm, and 5 x 3.5 cm. The inner aspect of the right arm shows a reddish-purple contusion. There are small scabs and abrasions over the right forearm and left elbow, left wrist, and dorsum of the left hand measuring between 0.8 and 2.0 cm. There are also small red contusions (x 2), over the anterior surface of the right thigh and a bluish contusion over the left thigh at the anterior surface. There is a somewhat yellow-brown recent contusion over the right hip measuring 3 x 2 cm.
- IV. Back: there are two red-purple contusions over the left middle back measuring 3 x 2 cm and back of the left hip measuring 2 cm in greatest dimension.

The multiple cutaneous abraded contusions show only hemorrhages in the subcutaneous tissue.

GROSS EXAMINATION

AUTOPSY NO. ML 425-06

CASE NO. 0601103

The body is opened through the customary "Y" shaped incision.

Subcutaneous fat is normally distributed, moist, and bright yellow. The musculature through the chest and abdomen is rubbery, maroon, and shows no gross abnormality.

The sternum is removed in the customary fashion. The organs of the chest and abdomen are in normal position and relationship. The liver edge extends 0 cm below the right costal margin at the midclavicular line. The diaphragms are intact bilaterally.

PARIETAL PLEURA:

Smooth, glistening membrane without associated adhesions or abnormal effusions.

PERICARDIUM:

There are dense fibrous adhesions with minimal yellow-brown fluid in the cavity.

PERITONEUM:

Smooth, glistening membrane in both the abdominal and pelvic cavities. The peritoneal cavity contains dense fibrous adhesions in the hepatic flexure.

HEART:

Weights 620 gm. It has a normal configuration and location. There are extensive dense fibrous adhesions between the parietal and visceral pericardium, mainly over the right anterior surface. The coronary arteries arise and distribute normally with multisegmental occlusive and calcific atherosclerosis with luminal narrowing nearly 100% of the right and anterior descending branch of the left coronary artery. The circumflex branch of the left coronary artery is likewise sclerotic with luminal narrowing up to 50%. There is a venous graft running over the anterior surface around the right anterior surface showing a patent lumen. The coronary ostia are normally located and widely patent. The chambers and atrial appendages are dilated. The valves are normally formed and measure as follows: tricuspid 15.5 cm, pulmonic 8.5 cm, mitral 11.5 cm, and aortic 7.5 cm. The endocardium is a smooth, gray, glistening, translucent membrane uniformly. The myocardium is intact, flabby, and red-tan, with the left ventricle measuring 1.8 cm, the septum measuring 1.4 cm, and the right ventricle measuring 0.5 cm. The papillary muscles and chordae tendineae are intact and unremarkable. The arch of the aorta is classically formed with moderate atherosclerosis. Other great vessels also arise and distribute normally and are widely patent.

NECK ORGANS:

Musculature is normal, rubbery, and maroon, and the organs are freely movable in a midline position. The tongue is intact and normally papillated, without evidence of tumor or hemorrhage. The hyoid bone is intact. The thyroid cartilage is intact and without abnormality. The thyroid gland is symmetric, rubbery, light tan to maroon, and in its normal position without evidence of neoplasm. The epiglottis is a characteristic plate-like structure which shows no evidence of edema, trauma, or other gross pathology. The larynx is comprised of unremarkable vocal cords and folds, is widely patent without foreign material, and is lined by a smooth, glistening membrane. There are no petechiae of the epiglottis, laryngeal mucosa, or thyroid capsule.

THYMUS:

No significant tissue is identified grossly.

LUNGS:

The right lung weighs 1180 gm, and the left weighs 1180 gm. Visceral pleurae are finely granular, and emphysematous with severe anthracosis and approximately 4 cm in diameter single bulla located on the lower lobe of the right lung. The overall configuration is hyperinflated. The trachea is widely patent and lined by characteristic pink membrane. Likewise, the major bronchi and bronchioles bilaterally are patent, normally formed, and contain no significant occlusive material. The pulmonary arterial tree is free of emboli or thrombi. The parenchyma is uniformly spongy, with extensive honeycomb emphysematous changes on cut surface, along with exuding large amounts of blood and clear, frothy edema fluid from its cut surfaces. There is no evidence of consolidation, granulomatous, or neoplastic disease. Hilar lymph nodes are within normal limits with relation to size, color, and consistency.

G.I. TRACT:

The esophagus shows an unremarkable mucosa, a patent lumen, and no evidence of gross pathology. The esophagogastric junction is unremarkable. The stomach is of normal configuration, is lined by a smooth, glistening, intact mucosa, has an unremarkable wall and serosa, and contains approximately 50 mL of grayish-brown-green vegetable-like food material which has partly passed to the duodenum. The duodenum, itself, is patent, shows an unremarkable mucosa and no evidence of acute or chronic ulceration. Jejunum and ileum are unremarkable and contain soft brown fecal material. There is no Meckel's diverticulum. The ileocecal valve is intact and unremarkable. The appendix is unremarkable. The colon is examined segmentally and shows no evidence of neoplasm or trauma. There are no diverticula. Anus and rectum are unremarkable.

LIVER:

Weights 1900 gm. It is of normal configuration, rubbery, tan, and intact. Cut surface shows no pathology.

GALLBLADDER:

Lies in its usual position, contains numerous yellow-green, multifaceted calculi measuring up to 0.4 cm in greatest dimension and shows a normal mucosa. The biliary tree is intact and patent without evidence of neoplasm or calculi.

PANCREAS:

Lies in its normal position, shows a normal configuration, and is pink-tan and characteristically lobulated with no apparent gross pathology.

SPLEEN:

Weights 320 gm. The capsule is intact but finely granular with white plaques. The organ is rubbery, maroon, and shows characteristic follicular pattern.

ADRENALS:

Lie in their usual location, show yellow cortices and tan to gray medullae.

KIDNEYS:

The right kidney weighs 160 gm and the left weighs 170 gm. Both are configured normally with several retention cysts over the right kidney measuring up to 1.5 cm and a single retention cyst over the left cortical surface measuring 1 cm in diameter. Sections show the organs to be moderately congested with unremarkable cortices, medullae and pelves. Ureters and blood vessels are patent and unremarkable.

URINARY BLADDER:

Contains no urine. Its serosa and mucosa are unremarkable.

MALE GENITALIA:

The prostate is symmetric, rubbery, gray-tan, and of normal size. The prostatic urethra is unremarkable. The testes are bilaterally present and show no evidence of tumor, trauma, or inflammation. The investing membranes are unremarkable other than bilateral hydrocele, moderate.

BRAIN AND MENINGES:

The scalp is opened through the customary intermastoid incision and shows an extensive subscalpular contusion over the left frontoparietal temporal region measuring approximately 15 x 10 cm and subscalpular contusion over the right temporo-occipital region measuring approximately 5 cm in greatest dimension, along with regional subgaleal hemorrhages on the right and contusion of the left temple muscle. The calvarium is removed through the use of an oscillating saw and is intact without evidence of osseous disease. The brain weighs 1610 gm. Dura and leptomeninges show diffuse subdural hematoma, bilateral, with approximately 0.3 cm maximum thickness along with a thin layer of subdural hematoma overlying the base of the skull, bilateral, mainly on the left and diffuse and thick subarachnoid hemorrhages, bilateral, mainly over the frontal lobes with approximately 1 cm in maximum thickness. Cranial nerves and circle of Willis arise and distribute normally and show no significant pathology. Externally the brain is diffusely edematous with malacia and sections show central hemorrhagic necrosis of both frontal lobes measuring approximately 5.5 and 3.5 cm on the right and left, and central hemorrhagic necrosis of the right temporal and occipital lobes measuring approximately 3 and 2 cm respectively. The ventricular system is obliterated by parenchymal edema with malacia and shows diffuse hemocephalus, mainly on the right. The base of the skull is intact without osseous abnormality.

RIBS:

Intact. There is an extensive reddish-purple contusion over the subpleural tissue, overlying the left thoracic cavity at the posterior lateral surface.

PELVIS:

Intact.

VERTEBRAE:

Intact.

BONE MARROW:

Moist and dark red. Unremarkable.

MICROSCOPIC EXAMINATION

AUTOPSY NO. ML 425-06

CASE NO. 0601103

Brain:

Sections of the brain and meninges confirm the gross diagnosis of acute subdural hematoma and subarachnoid hemorrhages with focal cortical contusions along with diffuse cerebral edema and focal parenchymal hemorrhages. The subdural and subarachnoid hemorrhages show no evidence of organization.

Heart:

Sections show multifocal interstitial fibrosis and frequent hypertrophic myocardial fibers. The venous graft shows a mild sclerotic wall.

Liver:

Sections show acute sinusoidal congestion and unremarkable portal space.

Lungs:

Sections show emphysematous changes with irregular fibrotic thickening with focal mononuclear cells infiltration.

Kidney:

Sections show no significant pathology other than congestion.

Cutaneous contusions (slide K through N):

Sections show acute hemorrhages with no acute inflammation other than temple muscle contusion and contusion of the left elbow that shows acute inflammation in the hemorrhagic area.

June 21, 2006
CSC/ns

Chai S. Choi, M.D.

CHAI S. CHOI, M.D.

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

901 N.Stonewall
Oklahoma City, Oklahoma 73117

REPORT OF LABORATORY ANALYSIS

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By _____

Date _____

ME CASE NUMBER: 0601103

LABORATORY NUMBER: 061631

DECEDENT'S NAME: DALLAS OGLESBY

DATE RECEIVED: 05/22/2006

MATERIAL SUBMITTED BLOOD, VITREOUS, LIVER, HOSPITAL
SPECIMENS

HOLD STATUS: 5 YEARS

SUBMITTED BY: CHAI S. CHOI M.D.

MEDICAL EXAMINER: CHAI S. CHOI M.D.

NOTES:

ETHYL ALCOHOL:

Blood: NEGATIVE (HOSPITAL; 5-19-06 at 1744 hrs)

Vitreous:

Other:

CARBON MONOXIDE

Blood:


TESTS PERFORMED:

NO OTHER TESTS PERFORMED

RESULTS:

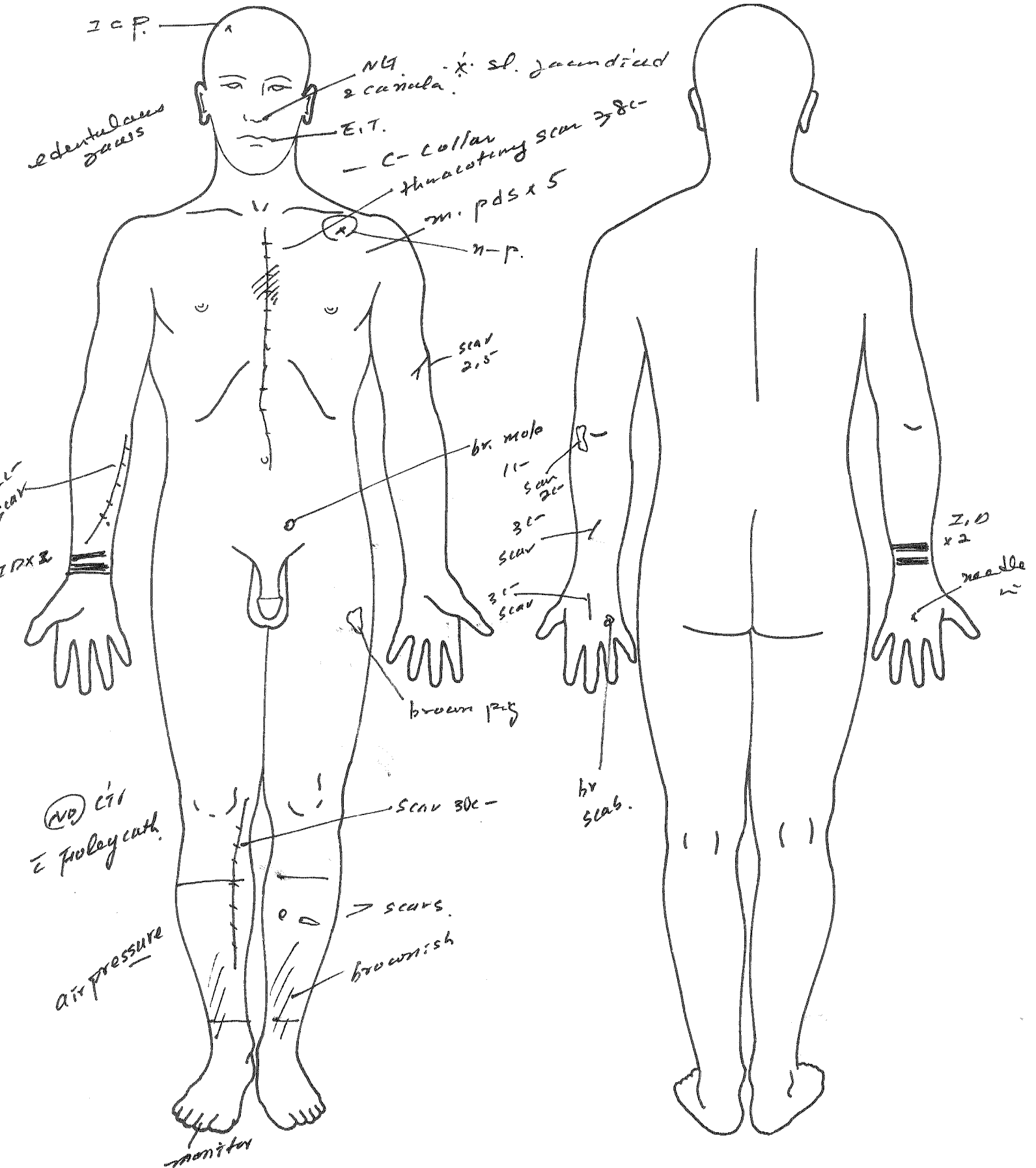
06/05/2006

DATE



BYRON CURTIS, Ph.D., Deputy Chief Forensic Toxicologist

FULL BODY, MALE - ANTERIOR AND POSTERIOR VIEWS (VENTRAL AND DORSAL)

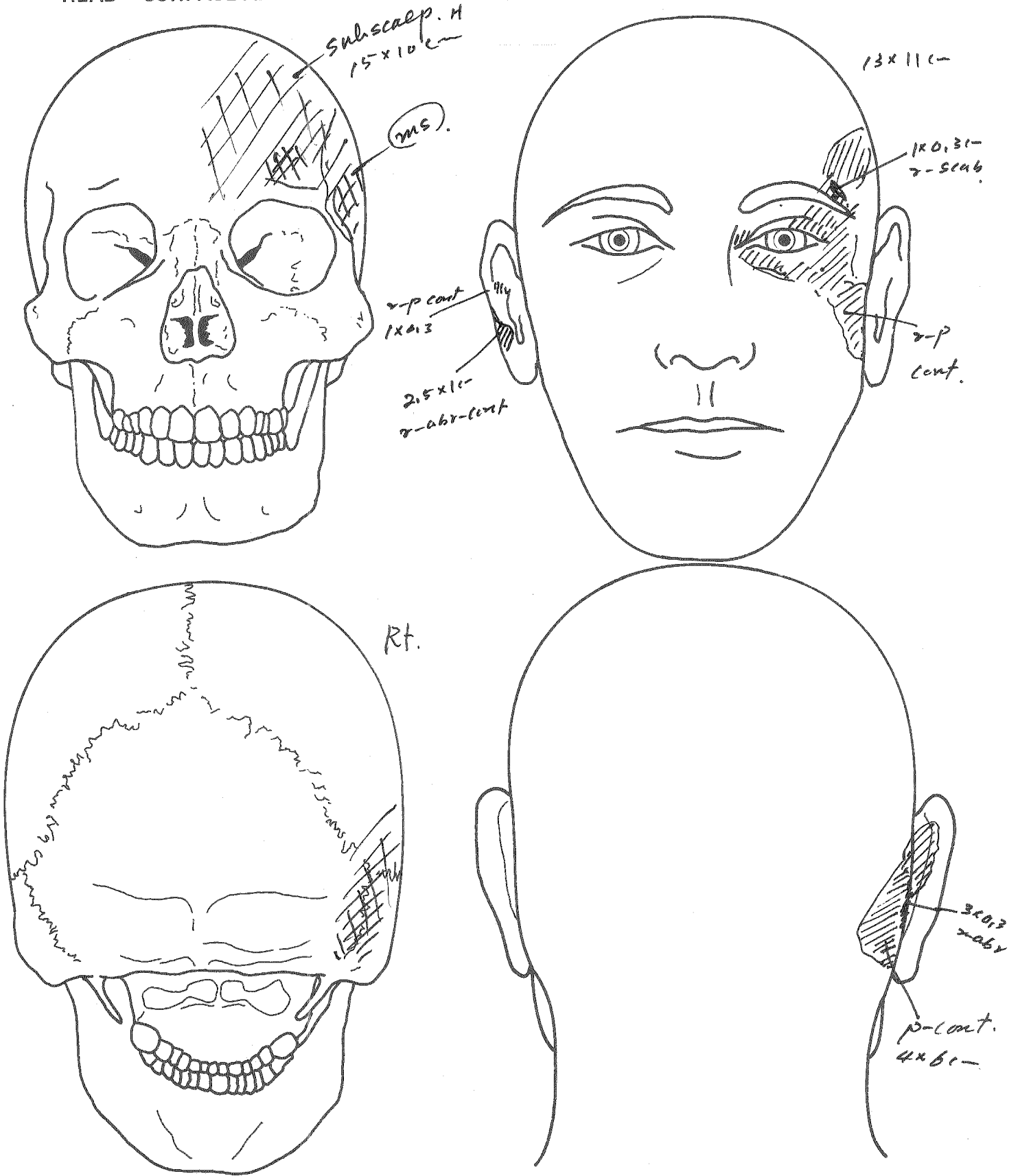


Name Dallas Oglesby

Case No. 0601103

Date 5-22-06

HEAD - SURFACE AND SKELETAL ANATOMY, ANTERIOR AND POSTERIOR VIEWS



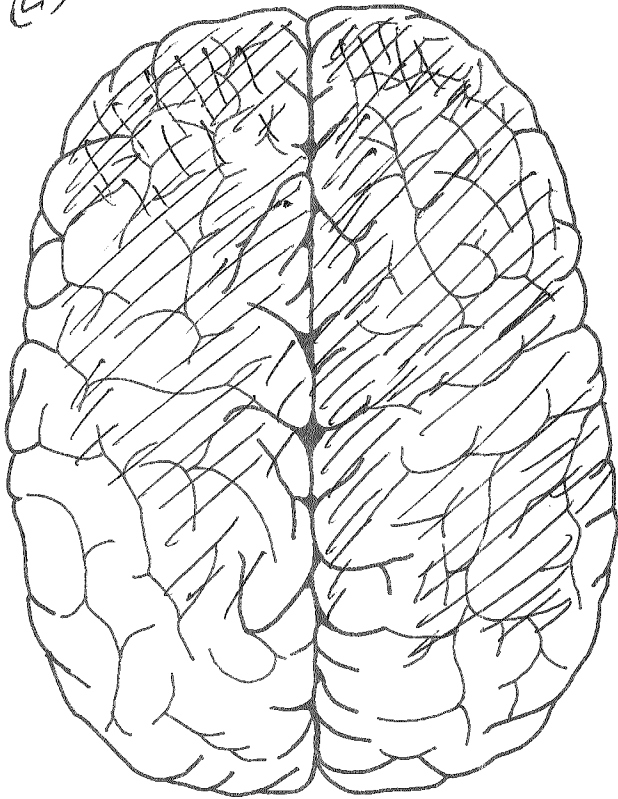
Name Dallas Oglesby

Case No. 0601103

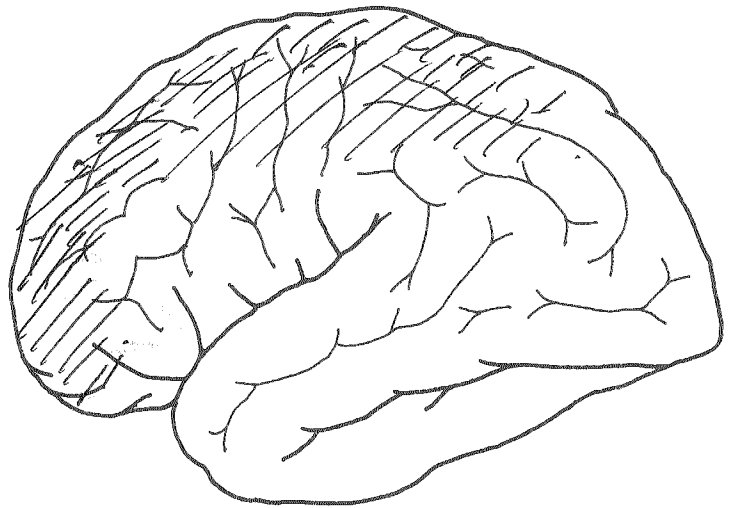
Date 5-22-06

BRAIN – SUPERIOR, INFERIOR, AND LATERAL VIEWS

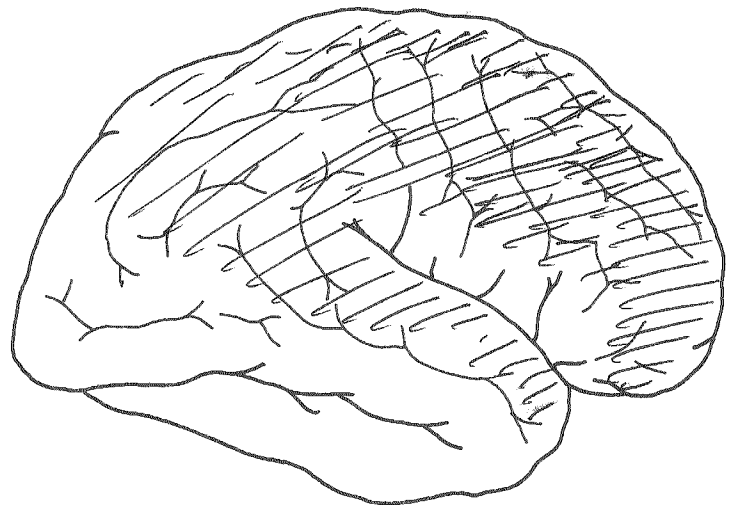
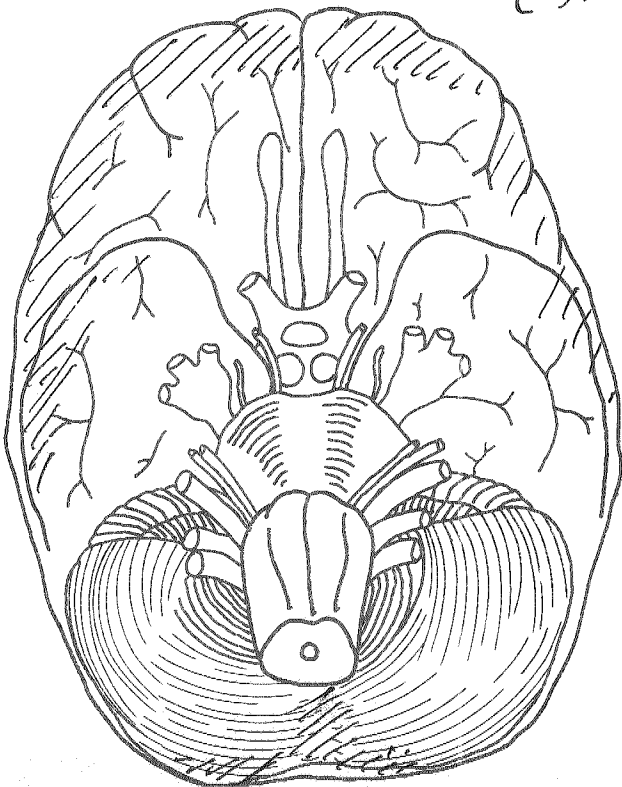
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Name Dallas Oglesby

Case No. 0601103

CME-1B18 (Series 1978)

Date 5-22-06