MISSOURI HOUSE OF REPRESENTATIVES

WITNESS APPEARANCE FORM

BILL NUMBER: **HB 1122**	DATE: **2/20/2025**
COMMITTEE: **Local Government**	

TESTIFYING: ☑ IN SUPPORT OF ☐ IN OPPOSITION TO ☐ FOR INFORMATIONAL PURPOSES

WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **ARNIE C."HONEST-ABE" DIENOFF-STATE PUBLIC ADVOCATE**	PHONE NUMBER:	
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I Support this Bill. What has happened in Cape Girardeau County, shall never happen to any Missouri Family. Action needs to be taken. But how are we going to pay for the $3.5-Million in Training Costs and Salary Increase?

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WITNESS NAME

BUSINESS/ORGANIZATION:

WITNESS NAME: **BENJAMIN PURSIFULL**	PHONE NUMBER: **573-453-4751**	
BUSINESS/ORGANIZATION NAME: **MISSOURI CORONERS AND MEDICAL EXAMINERS ASSOCIATION**	TITLE: **EXECUTIVE BOARD MEMBER**	
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CITY: **MARSHFIELD**	STATE: **MO**	ZIP: **65706**
EMAIL:	ATTENDANCE:	SUBMIT DATE: **2/20/2025 12:00 AM**

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WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **CHERYL REINAGEL**	PHONE NUMBER:	
BUSINESS/ORGANIZATION NAME:	TITLE:	
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CITY:	STATE:	ZIP:

EMAIL: **creinagel@semo.edu**	ATTENDANCE: **Written**	SUBMIT DATE: **2/18/2025 4:59 PM**

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HB112 Online Testimony - February 18, 2025My support, for this legislation, is summarized in one heartfelt sentence.I just want to make sure that no one else ever has to go through what we, and other families, have endured due to incompetent, inexperienced Missouri coroners. September 18, 20239:24 a.m.- 911 called for my brother, Thomas R. Nations, collapsed at home Transported to hospital by ambulance 10:37 a.m. - time of death at Southeast Hospital ER, Cape GirardeauApproximately two hours after his death, the Cape Girardeau County Coroner called to confirm Tom's medical condition with his wife. The coroner mentioned diabetes and possible respiratory issue. Tom's widow informed the coroner that Tom was never diagnosed with diabetes. We contacted the funeral home, instructing them not to file the death certificate until the cause of death was corrected as shown on the Emergency Room report. The cause of death and underlying causes (from the Emergency Room Report)Chronic obstructive lung diseaseDyslipidemiaEnd-stage renal diseaseHTN (hypertension)Ischemic heart diseaseVery difficult to bag despite endotracheal intubation due to extensive pulmonary hemorrhage despite suctioning.My relentless pursuit of information regarding death certificate issues in the State of Missouri began when no death certificate, for my brother, was filed by the state mandated deadline of five days. I was appalled to learn, through researching news stories, that many Missouri county coroners have little-to-no medical training and only a low percentage of these coroner offices are certified by accrediting organizations.?It was concerning to me that the only requirements to be elected as coroner are: 1. be a citizen of the United States 2. over the age of twenty-one years 3. shall have resided within the state one whole year 4. and within the county for which he is elected, six months next preceding the election. Source: Mo. Ann. Stat. § 58.030.Additional concerns arose when I found the article from February 2022 on the web site Missouri Independent …The coroner — Wavis Jordan, a Republican who took office in January 2021 — has worked as a school security guard, hearse driver and funeral florist but has no prior training or experience handling the dead. He has a long-running policy of requiring families provide proof of a recent, positive PCR test of COVID-19 to his office before labeling a death COVID, which goes against CDC guidance. As a result, many likely COVID-19 deaths don't get counted as such. Put another way, the coroner "doesn't do Covid deaths," he told the Documenting COVID-19 project and the USA TODAY network for its series on death certificate inaccuracies called "Uncounted."I soon realized we were faced with a very serious problem. If the CDC couldn't force this coroner to report deaths correctly, how could we?It was also challenging to learn that the Cape Girardeau County Coroner only answers to the voters. No county official has any authority over one of the highest paid positions in the county. During a time when my focus should have been grieving the loss of my brother (my only remaining family member) I decided to do my very best to seek justice for our family, and to the other families impacted by incompetence of the coroner.The coroner repeatedly refused to put the correct information on Tom's death certificate, as reflected on the Emergency Room report. Our advocate, at the funeral home, contacted Tom's

pulmonologist. He was very willing to file the death certificate, listing pulmonary hemorrhage as cause of death with underlying causes listed as heart disease and renal failure. Date issued: November 13, 2023My brother proudly served in the United States Navy during the Vietnam War. I contacted these offices to express our concerns of the delay in getting a veteran's death certificate finalized — with the correct information.Cape Girardeau VA Office - Robert Fisher, VA Patient Advocate & Outreach/. Enrollment Coordinator Senator Holly Thompson RehderMO Office of Vital Records - Sebastian Starrett The coroner's offensive and harassing comment on October 19th, 2023, left me no choice but to file complaints with these county and state officials:Attorney General's Office - November 2023 Cape Girardeau County Commissioners - January 2024MO Board of of Coroners & Medical Examiners Executive Directors - January 2024 In January 2024 I was interviewed by Carl Schwartze, the Attorney General's Office Investigator. It was a one-hour recorded interview regarding my brother and the coroner issues.After watching every coroner news story of KFVS-12's investigative reporter, Kathy Sweeney, I knew I had to something to make a difference. Listening to heartbreaking stories of families who lost a loved one and then dealing with significant coroner issues; seeing these families speak at an October 30th public forum hosted by the Cape Girardeau County Commissioners…all of this could have been preventable, in my opinion. It was so incredibly sad. How could this been preventable? The Coroner Standards and Training Commission never had enough members appointed to be able to convene. Hundreds of thousands of taxpayer dollars remain in this fund, derived from a small percentage of death certificate fees. Signed into law on Aug. 28, 2020, House Bill 2046 created the Coroner Standards and Training Commission within the Department of Health and Senior Services. After the commission develops new coroner standards, they will be published on a state website and coroners will not be able to assume office until the required training is completed and a certificate issued. Source: Missouri Independent February 1, 2022Mission: The Coroner Standards and Training Commissiin shall establish training standards, by rule, relating to the office of county coroner. These standards shall relate to the operation of the office, the legal responsibilities of the office, and the technical skills and knowledge required of the office.To me, it's such an injustice, and disservice, to the voters of Cape Girardeau County that these new coroner standards were not developed and implemented prior to Wavis Jordon assuming office in January 2021. I am very grateful to Representative John Voss for taking a leadership role in this important legislation. It's nearly been 79 years since Missouri Statue 58.030 became effective., on August 28, 1945. This antiquated statute must be revised and changes implemented.My friend, Linda, summarized it best."It's an important change that needs to happen. Too many people have had issues at a time when people grieving should not have to deal with them. I'd never realized how important that position was until I saw how incompetence can hurt grieving families and not give them the answers they need. It has happened to so many families."Respectfully submitted,Cheryl A. Reinagel

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WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **CHRISTY YOUNG CLOVER**	PHONE NUMBER:	
BUSINESS/ORGANIZATION NAME:	TITLE:	
ADDRESS:		
CITY:	STATE:	ZIP:

EMAIL: **christyclover@yahoo.com**	ATTENDANCE: **Written**	SUBMIT DATE: **2/18/2025 5:06 PM**

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I would like to testify in support of HB1122 submitted by Representative Voss. There needs to be drastic changes made regarding Coroners in Missouri. There needs to be requirements in place for anyone seeking to hold the office of coroner and proper training along with confirmation of retaining this information of procedures and guidelines. There also needs to be accountability! My son, Christopher Kight, died January 8, 2022. ELEVEN MONTHS LATER!!It wasn't until December11th, 2022 that a friend (in another state) came across my sons' "announcement" on a funeral home site and notified me. It consisted only 2 sentences that did not have accurate information, nor did it even complete the spelling of Missouri. In the midst of my heart shattering and my world crumbling around me, I find out my son was ordered by the coroner to be cremated within days of his passing, claiming he had no family even though there was plenty of family as well as myself that would have easily been located with minimal efforts. Then I discover my sons remains had been "stored" at the funeral home until September when someone at the funeral home came across a distant ex-family member that happened had the same last name. This person did not know my son but "claimed his remains". I never got to see my son one last time. I never had the opportunity to say goodbye or have a funeral service for my son, nor will I ever get any form of closure due to a coroner who was completely incompetent in doing his job. There was absolutely no reason that a properly trained coroner would have not been successful locating or contacting me or any other close family member. We all have resided in the same town, and no contact information has ever changed. Every document regarding my son's death had incorrect or incomplete information. At some point in our lives, every single person will have to have some type of encounter with a Coroner. Each one of us have a child, grandchild, parent, grandparent, sibling, aunts, uncles, spouse or someone we truly love.... why would we not want to learn from what has recently transpired in Cape Girardeau County and make things better for the future?! I've always been told since a young age that "History is guaranteed to repeat itself in time if we do not take a stand and make drastic changes to prevent the same outcome".I ask you to please pass HB1122. Please make changes needed for anyone that wants to hold the title as Coroner. We all need to do our part to ensure that no other families will have to relive the earth-altering heartbreak due to incompetence of an elected official or battle for the justice and accountability that myself, my family, and other families have been forced to endure. Thank you for reviewing my testimony. Sincerely, Christy Young-Clover

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WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **DANA MUELLER**	PHONE NUMBER:	
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CITY:	STATE:	ZIP:

EMAIL: **danalwk@yahoo.com**	ATTENDANCE: **Written**	SUBMIT DATE: **2/18/2025 5:37 PM**

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I am in support of this Bill requiring Coroners to have training & experience. A coroner must be able to determine manner & cause of death. Due to the lack of training from Cape County's Coroner, me & my family will never know what happened to my sister in July 2021. My sister was a mother, grandmother, sister & daughter. Her children & our mother should not have to wonder what happened to her. A simple tox screen could have given us these answers. I was told on scene that a tox screen would be done & to call the coroner office in 2 days. I called & Mr Jordon said, "I must have gotten things mixed up, I didn't do it, sorry." By then my sister had been cremated so it was too late. We suspect that it was possibly a suicide & this was told to our coroner but yet he ruled it a myocardial infarction with unknown etiology. She had just turned 50. We are left to wonder & speculate for the rest of our lives. I am here to try to prevent this from happening to anyone else. Please consider passing this Bill so no other family has to go through what my family continues to go through because of incompetence.

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WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **DANIEL ROSE**	PHONE NUMBER:	
BUSINESS/ORGANIZATION NAME:	TITLE:	
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CITY:	STATE:	ZIP:

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On June 27, 2023, my wife Robin and I, lost our daughter Scarlett, one week after her 24th birthday. Her passing was unexpected and tragic. The evening she passed, our home was filled with many professionals, from police, fire/EMS etc. The coroner was not one of those professionals. The coroner for Cape Girardeau County did arrive at our home, but professional, is not a word I would use to describe him. We quickly found him to be ill equipped to possess this role. He lacked the ability to listen and comprehend information and details that were shared with him. He did not have a grasp of basic medical knowledge or medical conditions. For context, my wife is a nurse, and I am a former combat medic. In addition, our friend came to be with us and she is a pediatric medivac flight nurse. All of us were stunned to witness the coroner's lack of competence for this elected role. In the middle of the most traumatic situation of our lives, we did not encounter and knowledgeable individual, a competent one, or a compassionate one. We were told that they were going to place our daughter in a body bag. He asked if we wanted to have her embalmed or cremated. This was not a decision we needed to make right then. Days later, as I dug into the coroner's background, I was stunned to discover that he didn't have any medical, investigative or other experience that one would expect a person in an important role such as this, to possess. As I explored further, into Missouri's requirements to be a coroner, I couldn't believe what I was reading. Virtually anyone could be elected for this position, as the requirements were so dreadfully inadequate. No basic medical knowledge or certification is required, No investigative skills. This must change. What my wife and I experienced that night in June was unacceptable. What we have since discovered, was what had happened to other families by this same coroner were even more egregious. Sadly, the requirements to be a coroner, that allowed this individual to have this role, are still in place today. The citizens of Missouri deserve better. Perhaps the members of this committee were unaware of this issue until now. However, now you are aware and your constituents are counting on you to do the right thing. No one should ever have to go through what my wife and I, along with many others have had to endure. Thank youDaniel Rose

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TESTIFYING: ☑ IN SUPPORT OF ☐ IN OPPOSITION TO ☐ FOR INFORMATIONAL PURPOSES

WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **JESSIE GRIFFIN**	PHONE NUMBER:	
BUSINESS/ORGANIZATION NAME:	TITLE:	
ADDRESS:		
CITY:	STATE:	ZIP:

EMAIL: **jessie.griffin@hannibalregional.org**	ATTENDANCE: **In-Person**	SUBMIT DATE: **2/19/2025 1:40 PM**

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My name is Jessie Griffin. I am a registered nurse from Pike county, Missouri. I am in support of the coroner bill sponsored by State Representative John Voss. In 2022, my husband and I fostered a special needs newborn baby boy. He was born with receiving little prenatal care and born with multiple drugs in his system. He was diagnosed with Down Syndrome. For the first several months he remained in the hospital awaiting cardiac surgery to repair his AV canal defect. He had this surgery at the end of November and was able to come home with us at the beginning of December of 2022. KJ passed away on March 3rd of 2023 at our home. He had been ill with GI symptoms prior to his death. We had been in contact with the pediatrician throughout this bout of illness to ensure he was receiving adequate care. That evening my husband took over caring for KJ to allow me to rest. He was rocking him in the recliner, giving KJ a slow feed through his feeding tube while watching a show. My husband felt KJ go limp, turn him around to look at him and noticed his color did not look good. He unhooked the feeding tube and ran back to our bedroom with the baby. I immediately took KJ from my husband's arms. He was agonally breathing and did not have a pulse. I began CPR and instructed my husband to call 911. Within minutes, first responders arrived and took over care. He was transported to our local hospital where they continued to work on him but were never able to get a pulse back. The deputy coroner was covering and arrived to speak with us at the hospital. We explained the situation. The next day he arrived with a group of men to complete a reenactment. We went over the series of events again. Our county did not have much experience with infant deaths so they brought in a neighboring county to assist.Throughout the next year, I frequently reached out to the coroner to ask him if he had any updates to provide us from the medical examiner. During multiple conversations, the coroner would tell me different preliminary causes of death from medical examiner in which none of them made any sense. He first told me they were leaning towards SIDS. I am a registered nurse and have worked in the ICU for majority of my career. I have been a part in numerous codes. I know the differences between a cardiac and respiratory arrest. I should not have to educate the coroner on topics such as this. However, I reiterated that was impossible as KJ suffered a cardiac arrest not a respiratory arrest and was not sleeping. Another time we spoke, the coroner mentioned positional asphyxiation. A third time, accidental suffocation. Again, I reminded him the baby lost a pulse first and was agonally breathing. That cause of death would imply a respiratory arrest which objectively did not fit the situation. I questioned what information the deputy coroner submitted to the county coroner and medical examiner to continue down the respiratory path. I was told the deputy coroner had his notes and the coroner was not sure. Upon requesting those documents, it was found there was no throughout death investigation paperwork completed. I was able to get some notes made by the deputy coroner that were scribbled on a blank piece of paper. Upon completing my own investigation, I found the hand-written document completed during the reenactment that is submitted to the CDC did not reflect what was entering electronically. For example, oxycodone was listed as a medication we as parents were

taking when in fact it was KJ's post op medication that he never had taken. While this doesn't solely fall on the coroner's shoulders, we went over the events of that evening many times and many facts were either omitted or changed. The coroner's notes had several inaccuracies and misspelled words. We were never asked to give written statements and I regrettably wish we had asked to do so. At the time we trusted the system and those elected into positions to serve us. Medical examiners cannot do an adequate job if they aren't given objective and evidentiary information. We put trust in those that are elected to perform their duties to the best of their ability and with proper knowledge and training. They have one chance to get it right for the deceased and the families left behind. The lack of qualifications and education required for this position is a dis-service to us all. Thank you.

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WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **JIM AKERS CORONER -ABMDI**	PHONE NUMBER:	
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CITY:	STATE:	ZIP:

EMAIL: **Butlercountycoroner@gmail.com**	ATTENDANCE: **Written**	SUBMIT DATE: **2/19/2025 8:08 PM**

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Testimonial Report of Jim Akers on HB 1122Presented Before the Missouri House Committee on Local Government---IntroductionHonorable Representatives,My name is Jim Akers, and I have served as the Coroner of Butler County since 2009, following my tenure as Chief Deputy Coroner from 2007-2008. Prior to this role, I worked extensively in law enforcement as a detective across multiple Missouri counties, holding positions as Drug investigator, Crime Scene Investigator, K9 deputy, MOSMART investigator, conducting numerous criminal investigations. My education is extensive, Associate of Science in law enforcement, 1992 TRCC, Bachelors of science psychology & criminal justice, 1996 College of the Ozarks, Law enforcement academy 1995 Mineral Area C.C. and 1000s upon 1000s of hrs of continuing education.This diverse background has equipped me with a comprehensive understanding of the unique responsibilities and legal obligations of the coroner's office in Missouri.I appreciate the opportunity to provide my insights on HB 1122, a bill aimed at reforming Missouri's coroner system. To be clear i support this bill 100%. While the bill introduces several commendable provisions, I believe it adopts a "one-size-fits-all" approach that does not adequately address the specific duties and statutory requirements of Missouri coroners. To ensure the legislation effectively serves our state, I would like to see Missouri coroner specific criteria, that reflect the distinct nature of our responsibilities.Most of the public and even those here have a misconception of what we do. First,we do not pronounce death. Rsmo 58.451 says when someone is determined to be dead we are to be called to take charge fully investigate, collect evidence, interview and interrogate and make a determination if the death was a crime. Second we don't help with funerals unless the body is abandoned. 58.380 says it is the job of the coroner in a death by felony to find a judge and get an arrest warrant. Most of the public believes the body belongs to the coroner and the scene to the police. This is taught in our police academy's but it is against statute. And sadly most coroners don't know it's thier job as the training is insufficient. Gentlemen and ladies we have a great system that just needs updating. ---Support for Key Provisions in HB 1122I commend the inclusion of mandatory training requirements in HB 1122. Structured education is essential for maintaining professionalism and ensuring that coroners can accurately conduct death investigations, collaborate with forensic experts, and determine causes of death. We should consider a basic death academy similar to our law enforcement academy. Sadly in Missouri law enforcement officers get 8 hrs of training in death investigation and only 1 hr of that is about homicide.And nearly zero is about the role of the coroner.Positive Aspects of HB 1122:Mandatory Training Requirements: Establishing structured training ensures that all coroners receive standardized instruction on death investigations, forensic procedures, and administrative responsibilities.Financial Assistance for Training: Providing state funding and grants for smaller counties ensures that coroners in rural areas can access necessary training without financial barriers.Pay Parity for Coroners: Aligning coroner compensation with other county officials helps attract qualified professionals and ensures fair remuneration for their expertise

and responsibilities. Historically the coroner pay was low as a hold back to its origins. The King appointed a wealthy well educated Royal Knight to protect the crown. To be one of the original checks and balance over the Sheriff. The coroner should be paid on par with the Sheriff, PA, or Judge. He is required to be one call 24/7/365. Most deaths occur between 8pm and 8am, yet we must be available during the day to the public, funeral homes, families, courts etc...These reforms will strengthen public confidence in Missouri's coroner system and promote consistency in death investigations across all counties.---Concerns and Areas Requiring RevisionWhile HB 1122 is a step in the right direction, it includes provisions that must be addressed to align with Missouri's specific legal framework governing coroners. The 19 topics came from the National Institute of Justice, guidelines for death investigations, which is broad covering all states, jurisdictions and sadly focusing more on the medical examiner investigators than the Missouri Coroner. While it is certain future and some current Missouri coroners need this training I feel it needs to expand to the actual duties established in statute. However if revisions to HB1122 can not happen please continue with it as written. I would also like to see some guidelines on who can provide the training outside of the Missouri Coroners Association, (no monopoly).1. Expansion of Training to Include Missouri-Specific Legal and Investigative ResponsibilitiesHB 1122 emphasizes medical aspects of death investigations. However, in Missouri, coroners are vested with distinct legal and investigative duties that extend beyond medical examination. Training must encompass:Conservators of the Peace: Under Missouri law, coroners are designated as conservators of the peace within their counties, granting them authority to arrest felons and execute process when the sheriff is disqualified or the office is vacant.Of the first half dozen duties laid out in statute, all involve the duties of law enforcement and performing the job of sheriff. The position of coroner is part judicial and part law enforcement. We should not fall under the department of HHS. We historically have answered directly to the King, Governor or The People. If the Missouri Coroners must be placed under a division it should be judicial or public safety. Conducting Inquests and Summoning Juries: Missouri statutes authorize coroners to hold inquests, issue warrants to summon juries, administer oaths to jurors, and issue subpoenas for witnesses.Assuming Duties of the Sheriff: In situations where the sheriff's office is vacant due to death or other reasons, the coroner is authorized to perform all duties required of the sheriff until a new appointment is made.Certifying Causes and Manners of Death: Coroners in Missouri are responsible for certifying the cause and manner of death on death certificates, especially in cases without medical attendance or where the attending physician is unavailable.---Slightly off HB1122* but a real problem.2. Revision of Oversight Provisions in RSMo 193.145, Paragraph 11The current language in RSMo 193.145, Paragraph 11 suggests that if a coroner fails to meet annual training requirements, their authority to certify death certificates is revoked, and the county sheriff appoints a medical professional to assume this responsibility. This provision raises significant concerns:Separation of Powers: Granting the sheriff authority over the coroner's duties undermines the independence of the coroner's office and disrupts the balance of power intended by Missouri law. This changes centuries long checks and balance. The sheriff will appoint a medical professional (not specific). Bottom line neither the Sheriff or the medical professional conducted the investigation, attended the required training, or have any experience certifying death certificates. This is bad and should be stricken. Investigative Continuity: The coroner is the elected official responsible for death investigations. Removing their authority disrupts investigative processes and may compromise the integrity of criminal investigations.I recognize that RSMo 193.145, Paragraph 11, is not currently addressed in HB 1122. However, while working on coroner statutes, this is a gross oversight that must be addressed. Failing to correct this issue leaves a major flaw in the coroner system that could impact death investigations across Missouri. Thank you.Recommended Revision: If a coroner fails to meet training requirements, oversight should not transfer to the sheriff. Instead, a circuit judge should appoint the forensic pathologist used by the county for autopsies to do death certificates until the coroner achieves compliance. This approach maintains the coroner's independence and ensures continued investigative integrity.---3. Ensuring Training Compliance Without Compromising InvestigationsWhile emphasizing training compliance is essential, the penalties for non-compliance—such as revoking the coroner's certification authority—could inadvertently hinder death investigations.Recommended Approach:Provisional Status for Non-Compliant Coroners: Implement a system where coroners who miss training deadlines are placed on provisional status, allowing them to continue their duties under judicial oversight until they fulfill training requirements.Incentives for Exceeding Training Standards: Offer benefits such as access to additional resources or funding for coroners who surpass training expectations, promoting continuous professional development.---Conclusion & RecommendationsI support the intent of HB 1122 to enhance the professionalism and effectiveness of Missouri's coroner system. However, to ensure the legislation aligns with the unique responsibilities and legal framework of Missouri coroners, I recommend the following:1. Expand Training to Include Missouri-Specific Legal and Investigative Duties: Ensure training programs encompass the full scope of coroner responsibilities as defined by Missouri law.2. Revise Oversight Provisions to Maintain Coroner Independence: Amend RSMo 193.145,

Paragraph 11, to prevent the transfer of coroner duties to the sheriff, preserving the separation of powers.3. Implement Balanced Measures for Training Compliance: Establish systems that encourage compliance without disrupting essential death investigations.By incorporating these revisions, HB 1122 can effectively strengthen Missouri's coroner system, ensuring it meets the specific needs and legal standards of our state.Thank you for your time and consideration. I welcome any questions or further discussion on this matter.Jim AkersCoroner, Butler County573-686-7884

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WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **PAMELA J JOHNSON**	PHONE NUMBER:	
BUSINESS/ORGANIZATION NAME:	TITLE:	
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CITY:	STATE:	ZIP:

EMAIL: **pamelajohnson573@gmail.com**	ATTENDANCE: **Written**	SUBMIT DATE: **2/17/2025 7:14 PM**

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I am very much in support of mandatory annual training for coroners and deputies. This is something, as a citizen , I really thought was already in place. I had no idea, until this happened in my family, the lack of training and experience needed to be coroner. This is a very major issue that needs to be changed.The person handling the most vulnerable time in a persons life needs to be knowledgeable in pathology, toxicology and the best practices. This is very important for so many families to be able to get answers and some sort of closer. This can not be dealt with by someone that has no training.

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WITNESS NAME

INDIVIDUAL:

WITNESS NAME: **WILLIAM W. "WILLIE" HARLOW**	PHONE NUMBER:	
BUSINESS/ORGANIZATION NAME:	TITLE:	
ADDRESS:		
CITY:	STATE:	ZIP:

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As an elected coroner of over 20 years, I strongly feel that this legislation is long overdue. This legislation provides opportunity for smaller counties to be provided with funds desperately needed to keep up with newer and more efficient technological advancements as larger and more metropolitan counties currently have. Providing grant opportunities will be a major turning point, for the good, for county coroners. This legislation requires that coroners meet specific criteria prior to running for the office and that is much needed. As an example, in the 2024 election, there was a coroner elected that did not have a valid drivers license because it had been revoked due to DWI charges. How can a person serve as coroner when they can't even drive themselves to the scene? It's time that we do better in providing candidates that have skills and education germane to the occupation. It also requires more training in pathology, toxicology, and practical applications.Probably one of the most contested parts of this legislation will be the pay increase. While this increase seems excessive, the office of coroner has been left to fight for itself with outdated laws, outdated information, and outdated pay. The salary of the coroners office has long been left out of most base salary increases of other elected officeholders. This office requires 24 hours a day, 7 days a week, 365 days a year worth of attention. At 2:00 a.m. on Christmas morning when a motor vehicle accident occurs, the coroner goes. On Thanksgiving Day at 11:30 a.m. when the vast majority of people are sitting down for a family meal, the coroner is on a death call at a residence. The coroner is expected to provide full time coverage for less than part time pay. In many counties, the coroner is a one person show with no deputies, no secretary, no office, yet this office is the least compensated office in each county.At the end of the day, the culmination of this legislation does the most good for the citizens of Missouri. It allows for technological advancements, educational opportunity, candidates that are qualified for the job, and ensuring that every citizen in every county knows that they have someone competent and qualified to help them in one of the most trying times of their lives. When you have someone dealing with a deceased loved one, you want nothing but the best. This legislation helps provide that for the citizens of Missouri.