

Species: _____ Age _____ Sex _____ Weight: _____

Date and time of death: _____ Date and time of PM: _____

History: _____

1. External examination	7. Spleen, thymus, bursa of Fabricius
2. Skin and feathers	8. Kidneys
3. Body cavity	9. Adrenals, thyroids
4. Trachea, lungs and airsacs	10. Muscles, bones, joints
5. Heart	11. Eyes, nervous system
6. Gastro-intestinal tract	12. Ovary, Testes

Checklist (☑ = no gross lesions; H = histopathology; B = bacteriology; V = virology)

<input type="checkbox"/> Skin	<input type="checkbox"/> Crop	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Kidneys
<input type="checkbox"/> Feathers	<input type="checkbox"/> Thymus	<input type="checkbox"/> Spleen	<input type="checkbox"/> Ureters
<input type="checkbox"/> Beaks	<input type="checkbox"/> Parathyroids	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Adrenals
<input type="checkbox"/> Eyes	<input type="checkbox"/> Thorax	<input type="checkbox"/> Airsacs	<input type="checkbox"/> Testes
<input type="checkbox"/> Ears	<input type="checkbox"/> Bronchi	<input type="checkbox"/> Gizzard	<input type="checkbox"/> Ovary
<input type="checkbox"/> Mouth	<input type="checkbox"/> Pericardium	<input type="checkbox"/> Proventriculus	<input type="checkbox"/> Brain
<input type="checkbox"/> Tongue	<input type="checkbox"/> Heart	<input type="checkbox"/> S. intestine	<input type="checkbox"/> Spinal cord
<input type="checkbox"/> Choana	<input type="checkbox"/> Lungs	<input type="checkbox"/> L. intestine	<input type="checkbox"/> Muscles
<input type="checkbox"/> Trachea	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Caeca	<input type="checkbox"/> Bones
<input type="checkbox"/> Oesophagus	<input type="checkbox"/> Liver	<input type="checkbox"/> Cloaca	<input type="checkbox"/> Joints