

The seal of the Fresno County Sheriff's Office is partially visible on the left side of the cover. It features a five-pointed star with a central circular emblem depicting a landscape with a ship and a figure. The text "SHERIFF OF FRESNO COUNTY" is written around the star, and "Established 1856" is at the bottom.

FRESNO COUNTY SHERIFF'S OFFICE

CORONER UNIT

2025

STATISTICS & TRENDS

John Zanoni
Sheriff-Coroner

Lt. Kathy Curtice
Coroner Unit Commander

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CORONER UNIT

OVERVIEW

The 2025 Fresno County Sheriff's Office Coroner Unit Statistics & Trends Report provides a statistical overview of death investigations conducted during calendar year 2025. The information presented is derived from the Fresno County Sheriff's Office Coroner Unit Records Management System (CME) and summarizes investigative activity, mortality trends, demographic data, and historical comparisons. This report is intended to promote transparency, support informed decision-making, and provide an accurate overview of the Coroner Unit's operations. Statistics reflect completed investigations available at the time of publication and may be revised as additional information becomes available.



CORONER UNIT

OVERVIEW

8,949**DEATHS IN COUNTY**

Total deaths that occurred in Fresno County in 2025.

3,975**CASES REPORTED**

Reported deaths received by the Coroner Unit in 2025.

1,013**CORONER CASES**

Cases that met statutory criteria for Coroner investigation in 2025.

CORONER UNIT STAFF

Commander

Lt. Kathy Curtice

Forensic Pathologist

Dr. Michael Chambliss

Additional contract forensic pathologists utilized as needed.

Deputy Coroner Supervisor

Kelly Matlock

Office Assistant

PaNyia Thao

Program Technician

Kimberly Lopez

Deputy Coroners

Imron Ramos
Loretta Andrews
Jeffrey Gentry
Catherine Ruiz
Christian Acosta
Bianca Torres
Cristobal Aquino

Forensic Technicians

Marcella Halverson
Sean Magray
Naomi Garcia
Mario Hernandez
Yvonne Wilson
Hayli Sebastian

SUMMARY

The Fresno County Sheriff's Office Coroner Unit is responsible for investigating deaths that fall under the jurisdiction of the coroner, including suspicious, violent, unnatural, sudden, and unexpected deaths occurring throughout Fresno County. Deputy Coroner Investigators conduct investigations across the County's 6,011 square miles, while forensic pathologists determine the cause and manner of death for cases accepted under Coroner jurisdiction.

During 2025, 8,949 deaths occurred in Fresno County. Of those deaths, 3,975 were reported to the Coroner Unit for evaluation. Following review, 1,013 cases met the statutory criteria for Coroner investigation, requiring examinations, toxicology testing, medical record review, and other investigative procedures necessary to determine the cause and manner of death.

CORONER UNIT

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2025

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CORONER UNIT

OVERALL

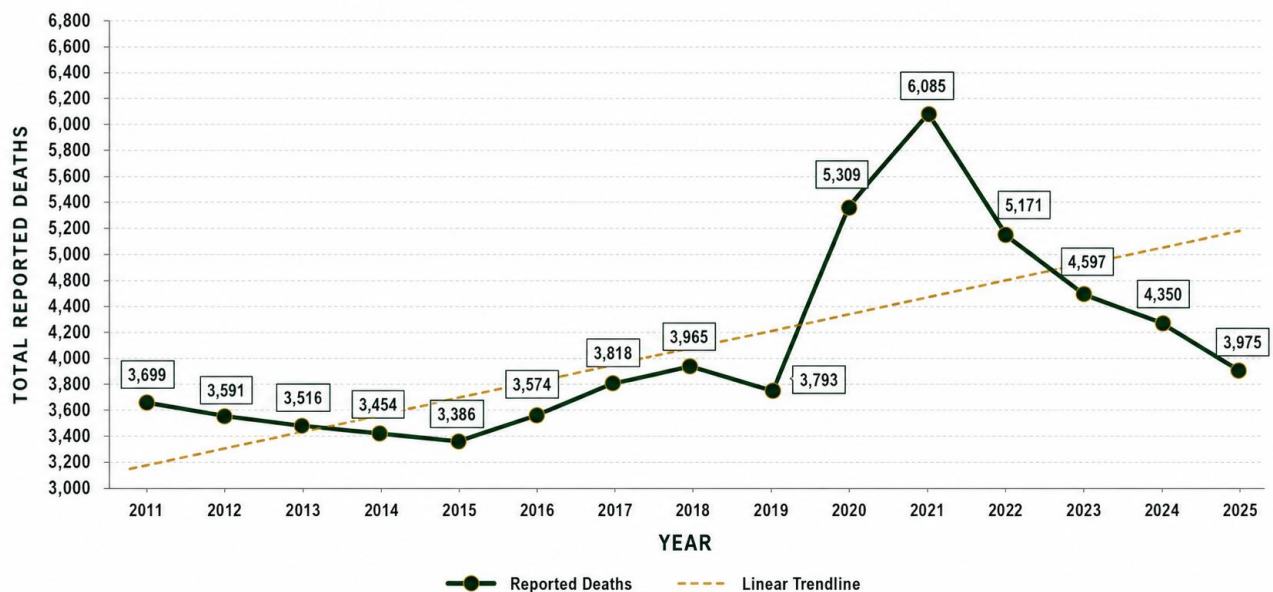
FRESNO COUNTY DEATHS BY YEAR

— 2008–2025 —



CORONER REPORTED DEATHS BY YEAR

— 2011–2025 —



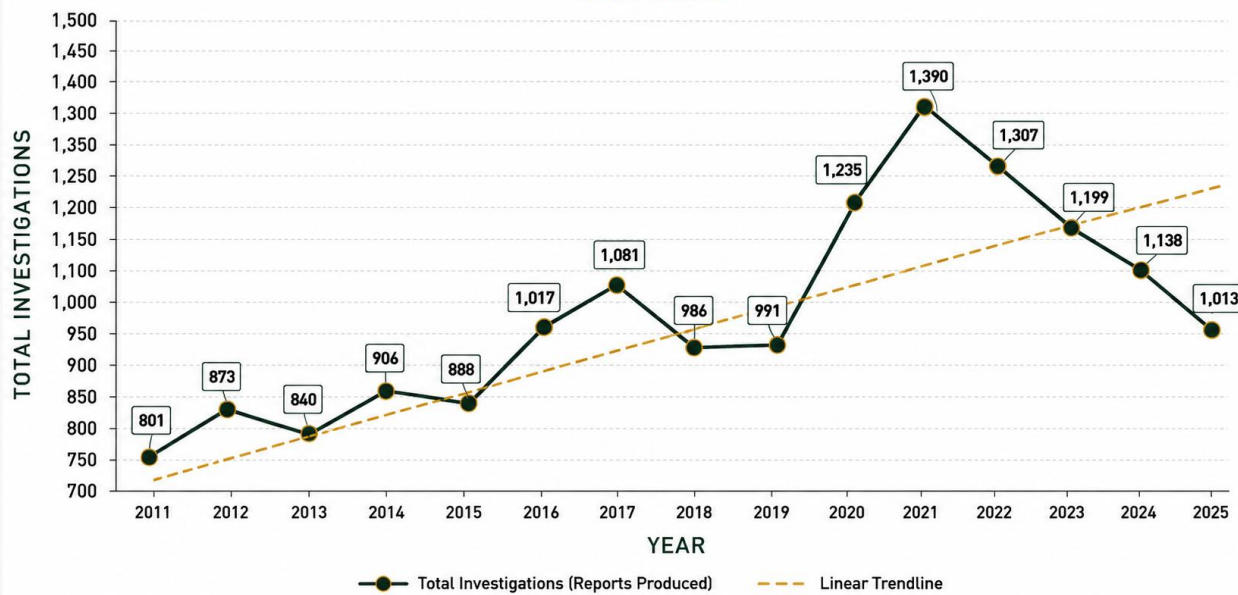
CORONER UNIT

OVERALL

A coroner case investigation is conducted to determine the cause and manner of death, with a formal investigative report produced for each case.

CORONER CASE INVESTIGATIONS (REPORTS PRODUCED) BY YEAR

2011-2025



BODIES TRANSPORTED TO THE CORONER MORGUE BY YEAR

2012-2025

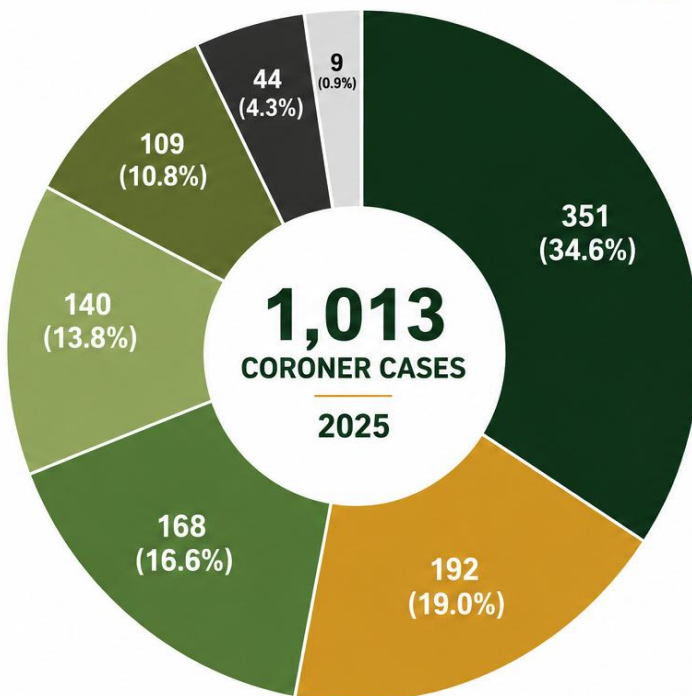


CORONER UNIT

OVERALL

Manner of death is the medicolegal classification that describes the circumstances surrounding how a death occurred. Coroner cases are classified as Natural, Accident, Suicide, Homicide, or Undetermined. The manner of death is determined by considering the circumstances of the death together with the investigative findings, medical history, scene information, autopsy or external examination findings, and toxicology or other laboratory results when applicable. Unlike cause of death, which identifies the specific disease, injury, or condition responsible for death, manner of death places that cause within the broader circumstances in which it occurred. These classifications provide a standardized framework for death investigation and for reporting and analyzing public health and public safety trends.

CORONER CASES BY MANNER OF DEATH 2025



MANNER OF DEATH	CASES	PERCENT
Natural	351	34.6%
Accident – Overdose	192	19.0%
Accident – MVC	168	16.6%
Other Accidents	140	13.8%
Suicide	109	10.8%
Homicide	44	4.3%
Undetermined	9	0.9%
TOTAL	1,013	100.0%

CORONER UNIT

OVERALL

Forensic pathologists are physicians specially trained in forensic medicine who determine the cause of death in Coroner cases. Depending on the circumstances, they may perform a complete autopsy, which includes both an internal and external examination, or conduct an external examination, which may include toxicology testing and a review of medical records when an autopsy is not necessary.

FORENSIC PATHOLOGIST EXAMINATIONS (2025)

TOTAL EXAMINATIONS

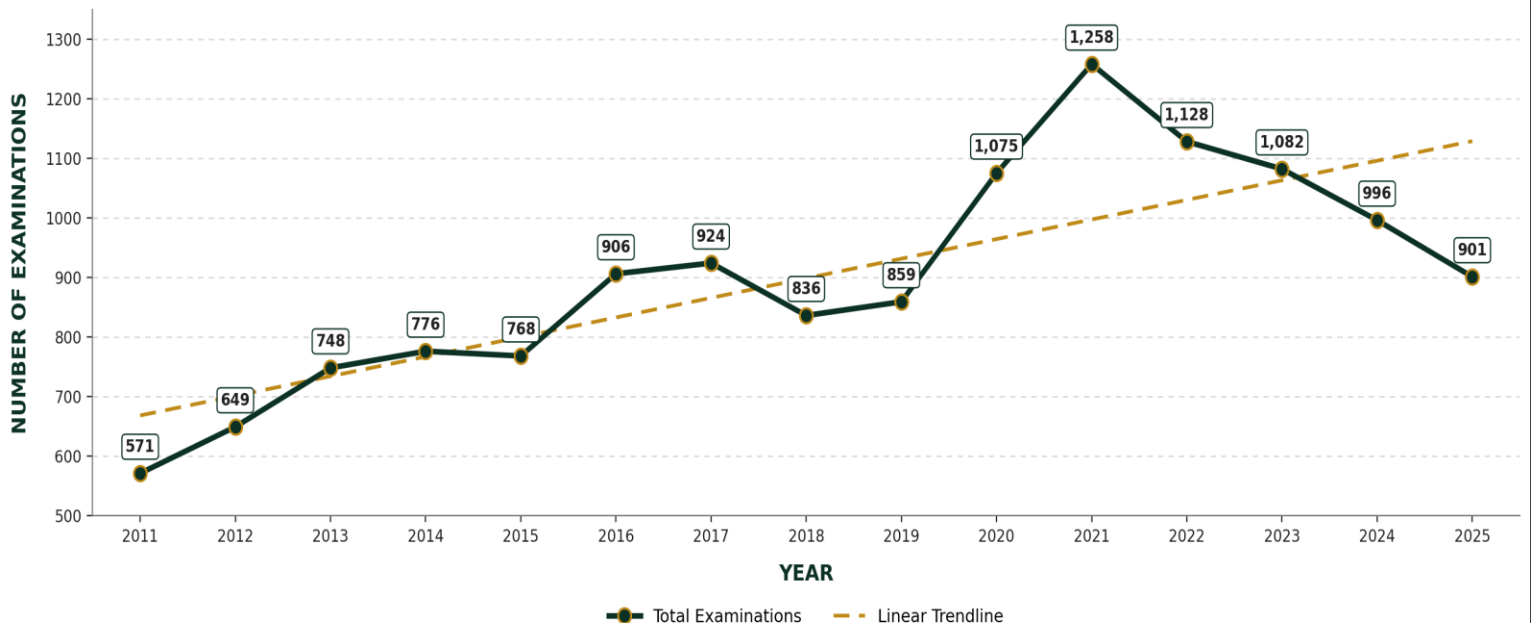
901

AUTOPSY EXAMINATIONS

255 (28.3%)EXTERNAL EXAMINATIONS,
TOXICOLOGY & MEDICAL
RECORD REVIEWS**646** (71.7%)

FORENSIC PATHOLOGIST EXAMINATIONS BY YEAR

2011-2025



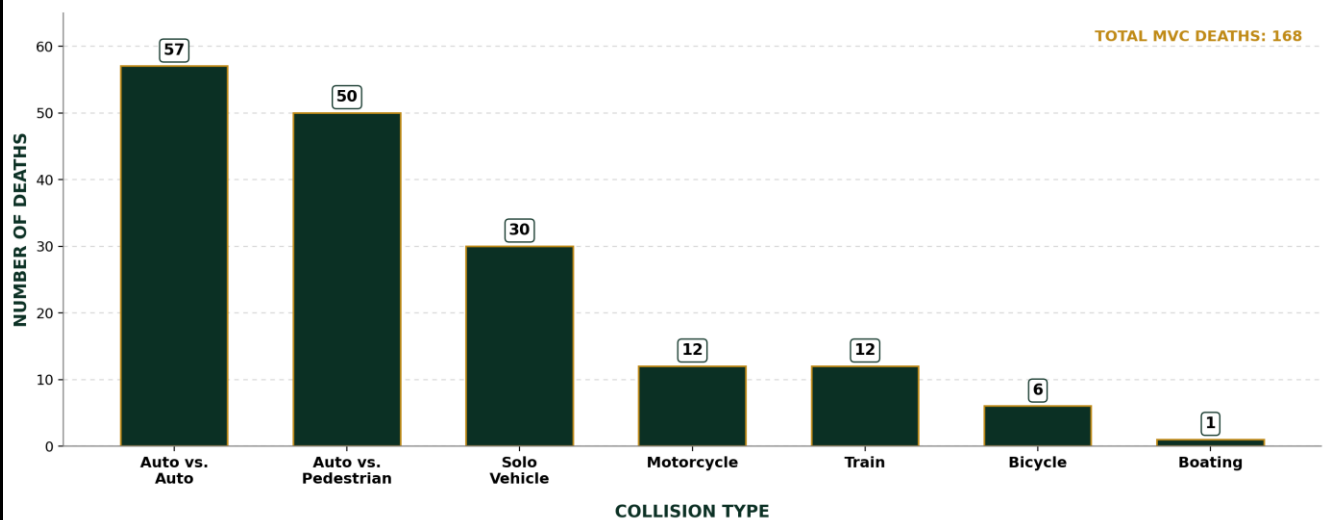
CORONER UNIT

ACCIDENT - OVERALL

An accidental death is a death resulting from an unintentional injury or event, occurring without evidence of intent to cause harm to oneself or another.

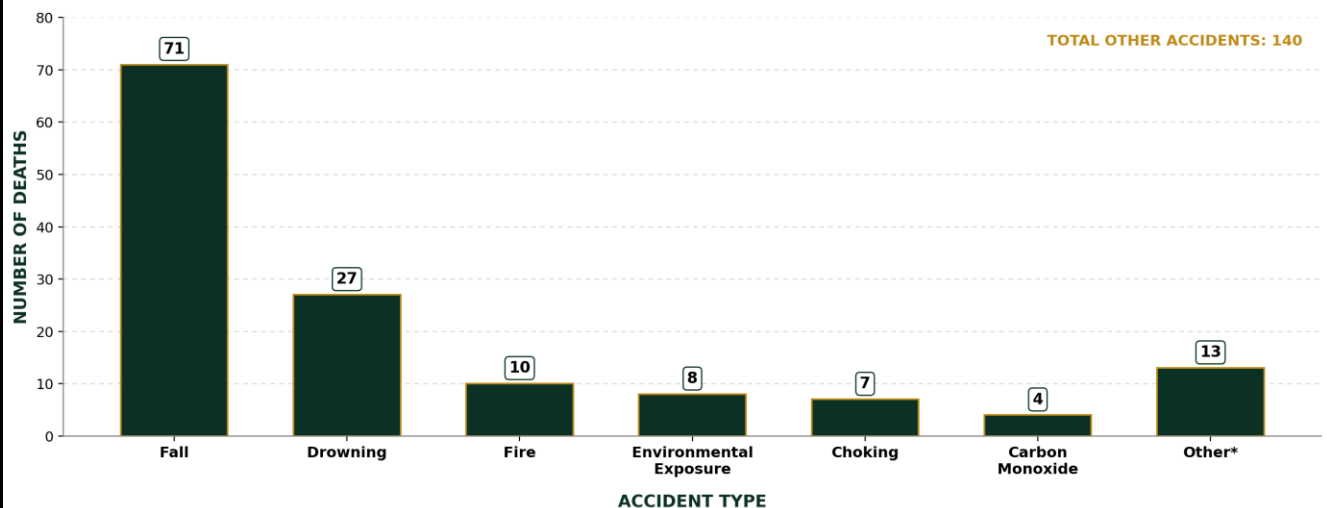
MOTOR VEHICLE COLLISION DEATHS

2025



OTHER ACCIDENTAL DEATHS

2025



*Other includes crushing, asphyxiation, electrocution, industrial incidents, anaphylaxis, inhalant-related deaths, alcohol-related accidents, and accidental gunshot wounds.

CORONER UNIT

ACCIDENT - OVERDOSE

ACCIDENTAL OVERDOSE DEATHS

2025

OVERALL ACCIDENTAL OVERDOSE DEATHS

192

Accidental overdose deaths occur when an individual dies from the toxic effects of one or more drugs without evidence that the overdose was intentional.

SINGLE DRUG OVERDOSE DEATHS – Fatal toxicity attributed to one drug.

COMBINED DRUG OVERDOSE DEATHS – Fatal toxicity resulting from the combined effects of two or more drugs.

SINGLE DRUG
OVERDOSE DEATHS

120

COMBINED DRUG
OVERDOSE DEATHS

72

ACCIDENTAL OVERDOSE DEATHS BY YEAR

2009-2025

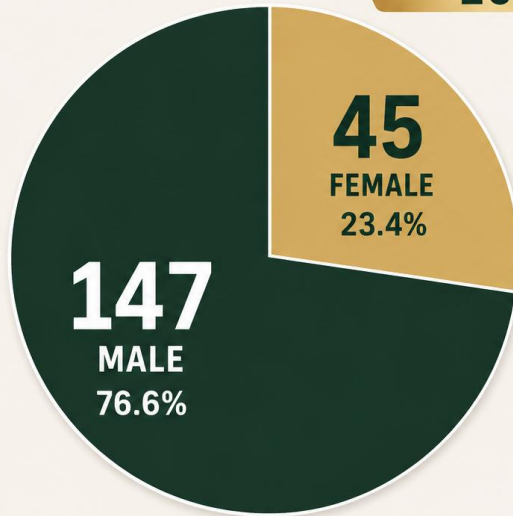


CORONER UNIT

ACCIDENT - OVERDOSE

OVERALL ACCIDENTAL OVERDOSE GENDER DISTRIBUTION

2025



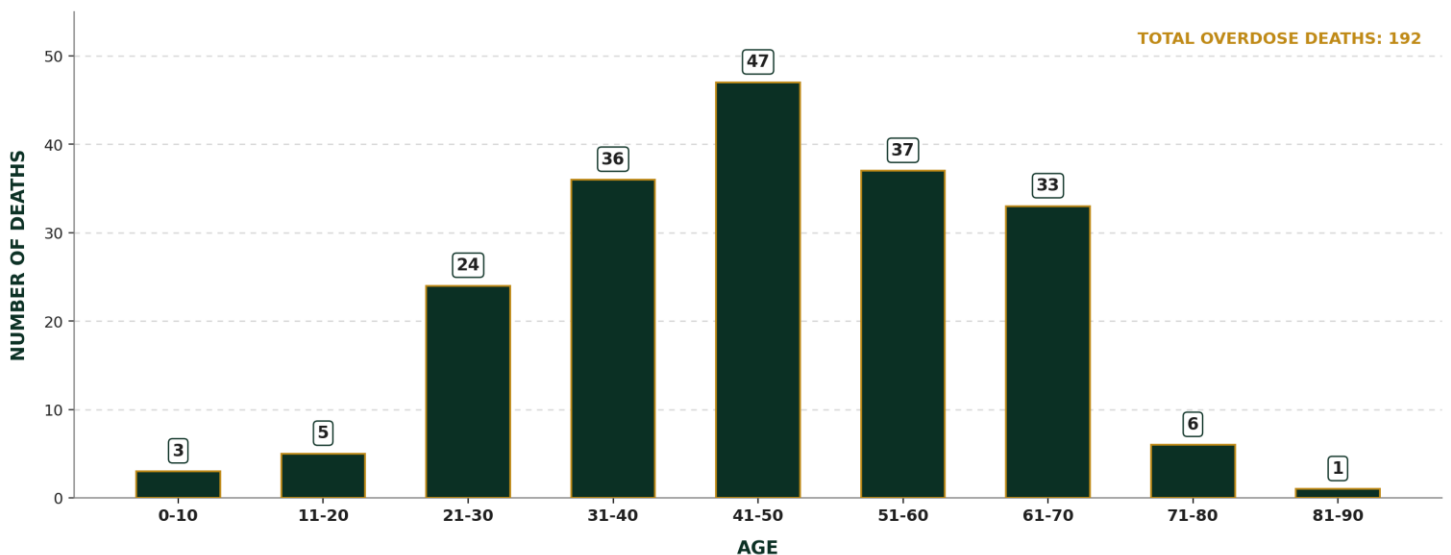
TOTAL OVERDOSE DEATHS

192

MALE	147 (76.6%)
FEMALE	45 (23.4%)

OVERALL ACCIDENTAL OVERDOSE AGE DISTRIBUTION

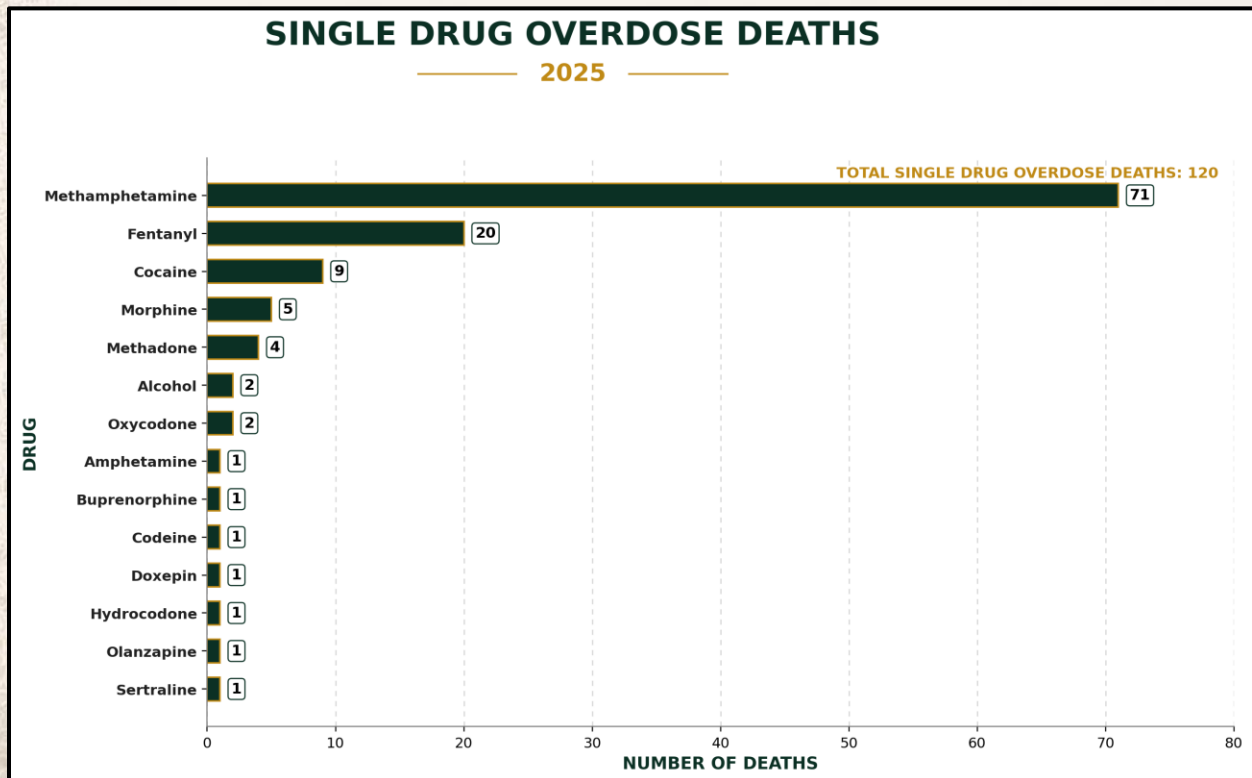
2025



CORONER UNIT

ACCIDENT - OVERDOSE

A single-drug overdose death occurs when the toxic effects of one drug alone are determined to have caused the death.



PRIMARY DRUGS IDENTIFIED IN SINGLE DRUG OVERDOSE DEATHS

METHAMPHETAMINE

71

(59.2%)

of the 120 single-drug overdose deaths

FENTANYL

20

(16.7%)

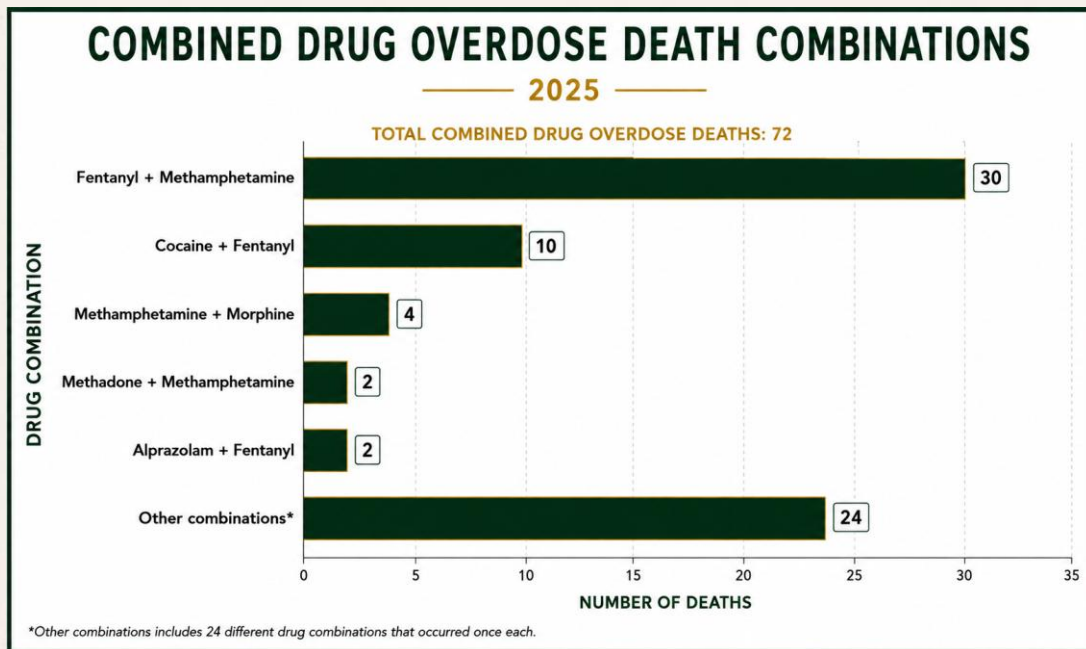
of the 120 single-drug overdose deaths

Together, methamphetamine and fentanyl were identified in **75.8%** of all accidental single-drug overdose deaths.

CORONER UNIT

ACCIDENT - OVERDOSE

A combined-drug overdose death occurs when the toxic effects of two or more drugs together are determined to have caused the death.



PRIMARY DRUGS IDENTIFIED IN COMBINED DRUG OVERDOSE DEATHS

METHAMPHETAMINE

44

(61.1%)

of the 72 combined drug overdose deaths

FENTANYL

49

(68.1%)

of the 72 combined drug overdose deaths

COCAINE

15

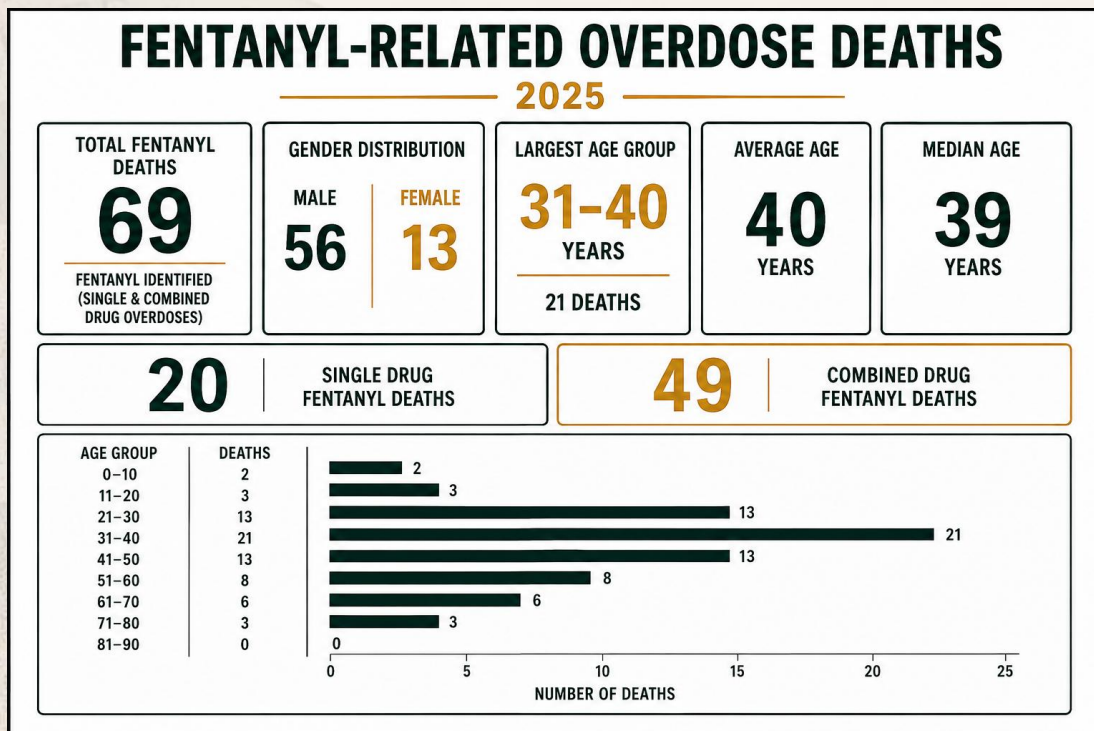
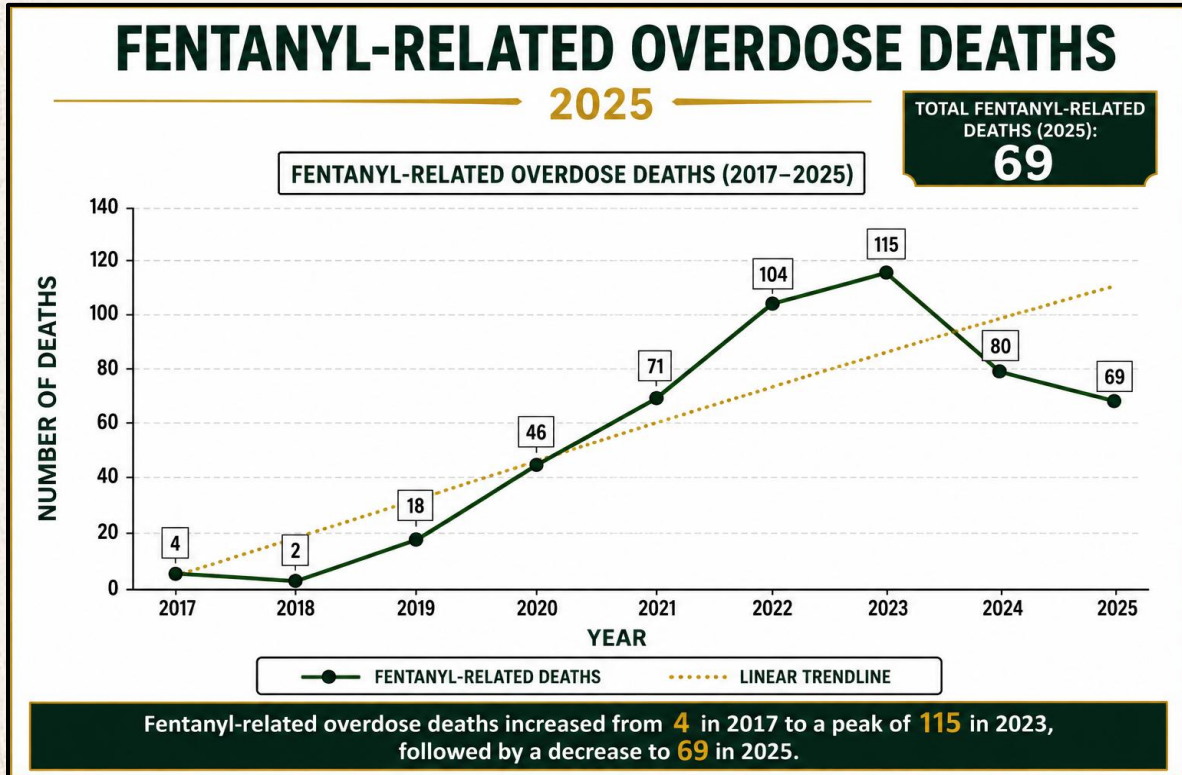
(20.8%)

of the 72 combined drug overdose deaths

At least one of methamphetamine, fentanyl, or cocaine was identified in **61** of the 72 **(84.7%)** combined drug overdose deaths.

CORONER UNIT

ACCIDENT - OVERDOSE



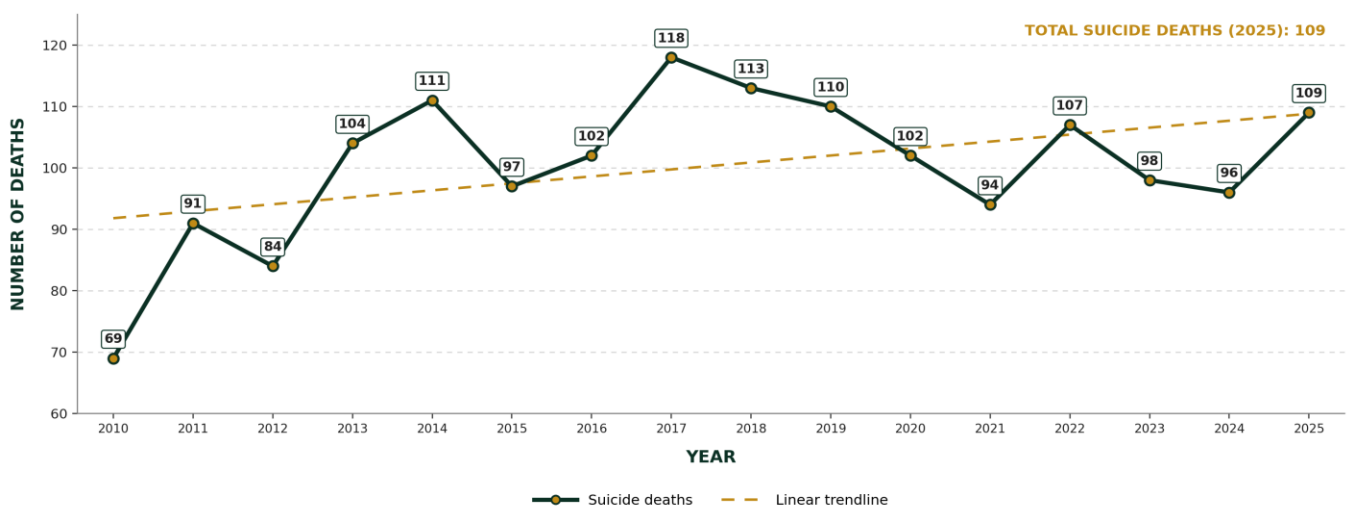
CORONER UNIT

SUICIDE

A suicide death is the intentional act of causing one's own death through a self-inflicted injury or poisoning with the intent to die.

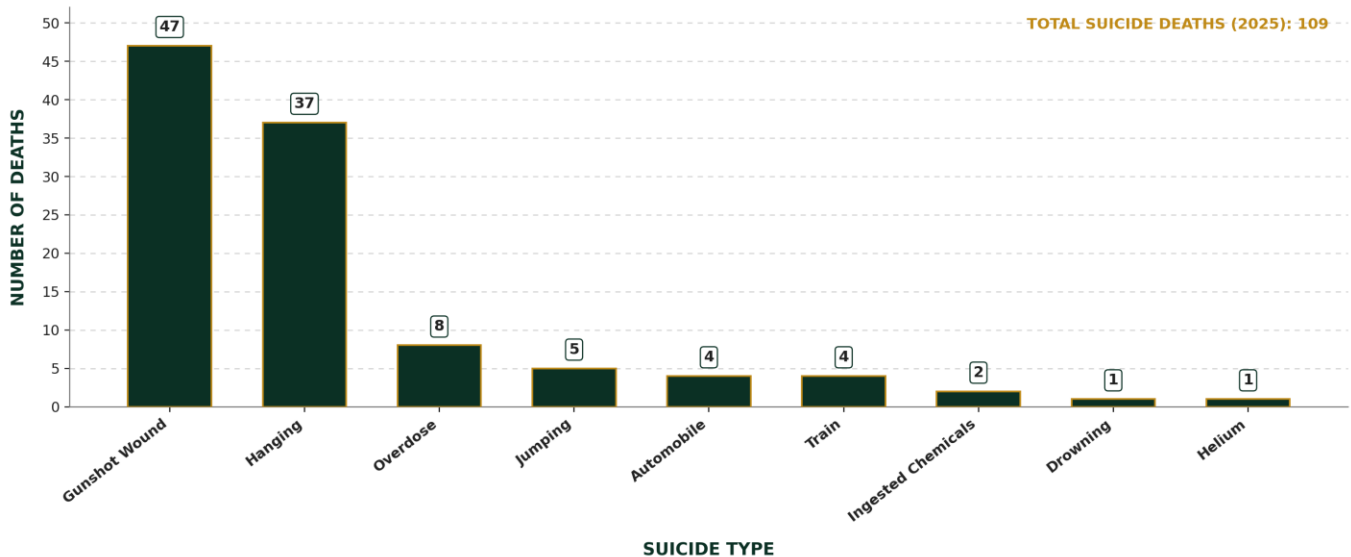
SUICIDE DEATHS BY YEAR

2010-2025



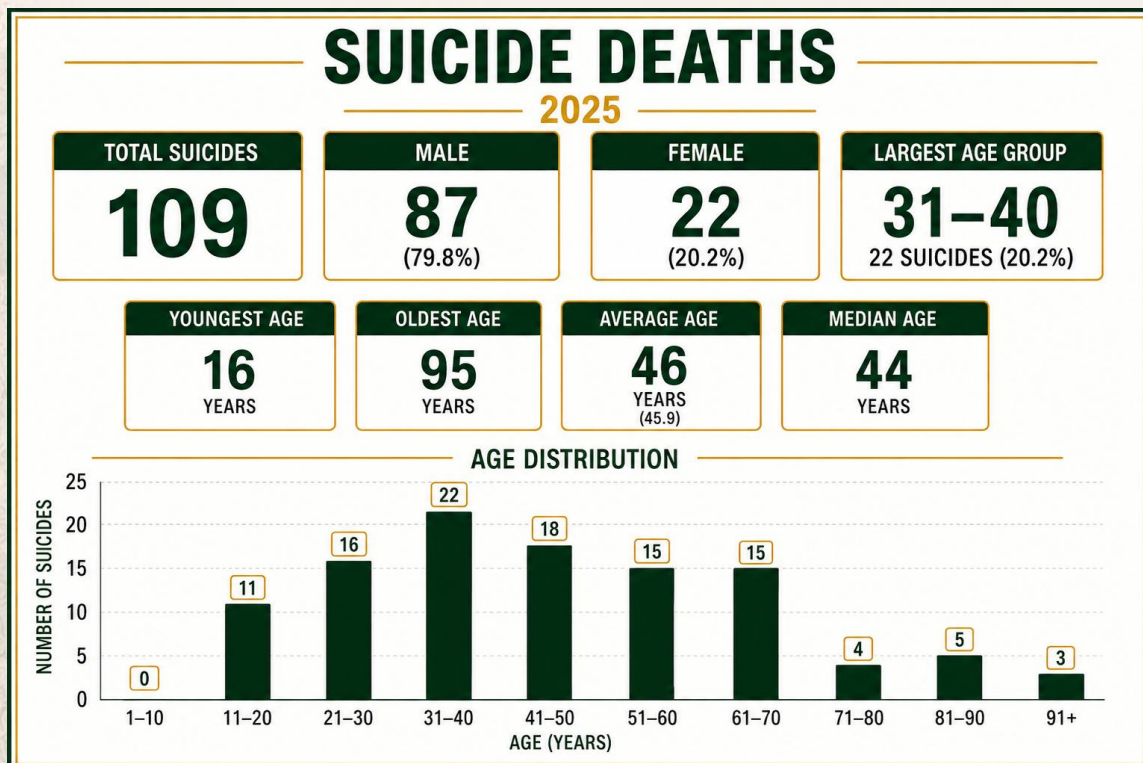
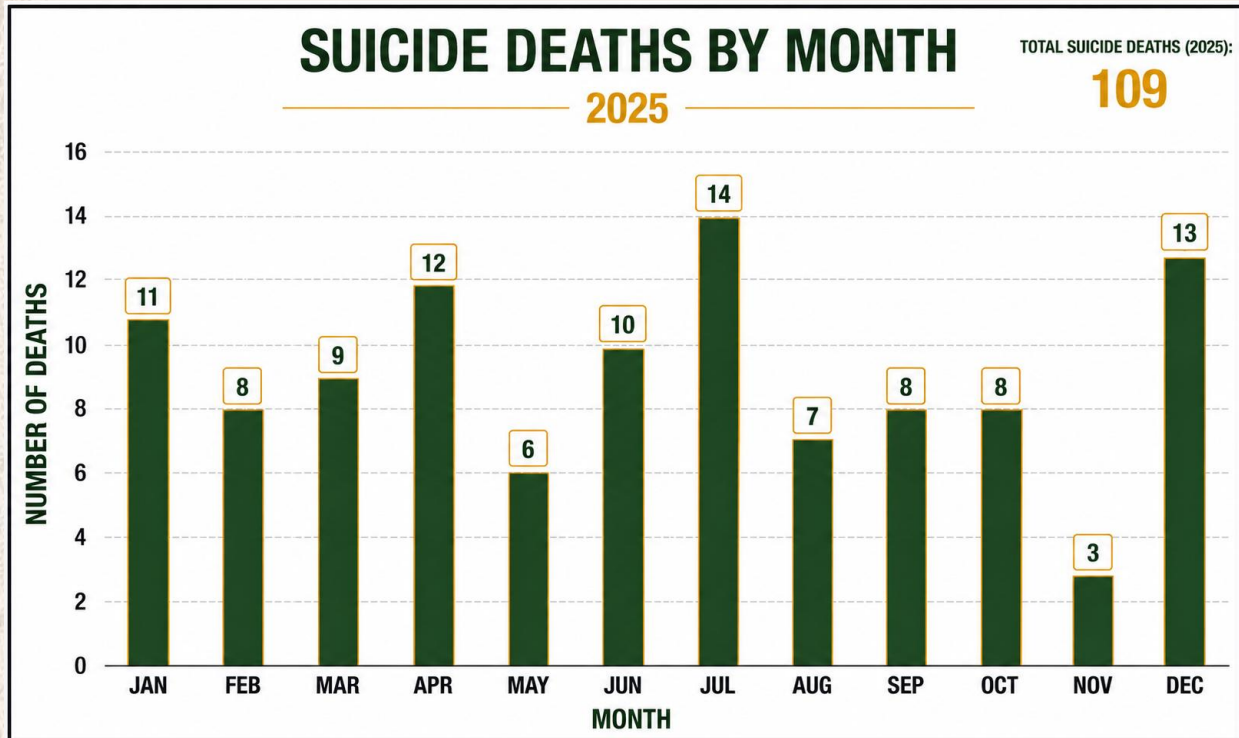
SUICIDE DEATHS BY TYPE

2025



CORONER UNIT

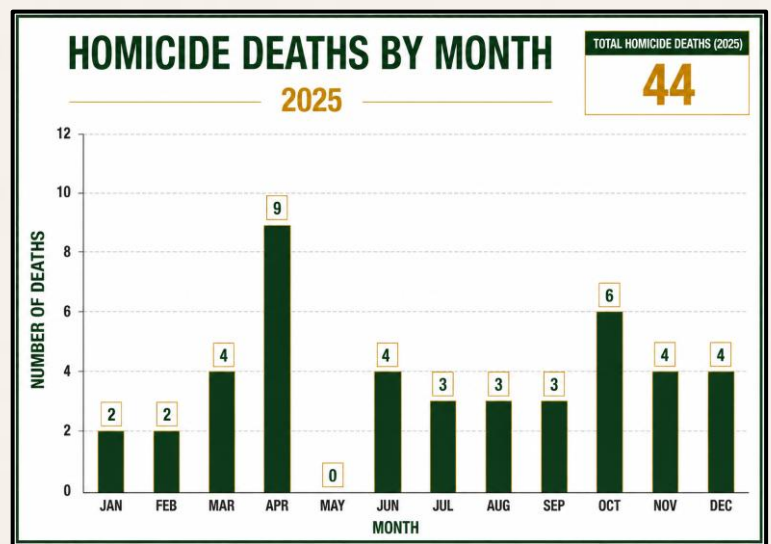
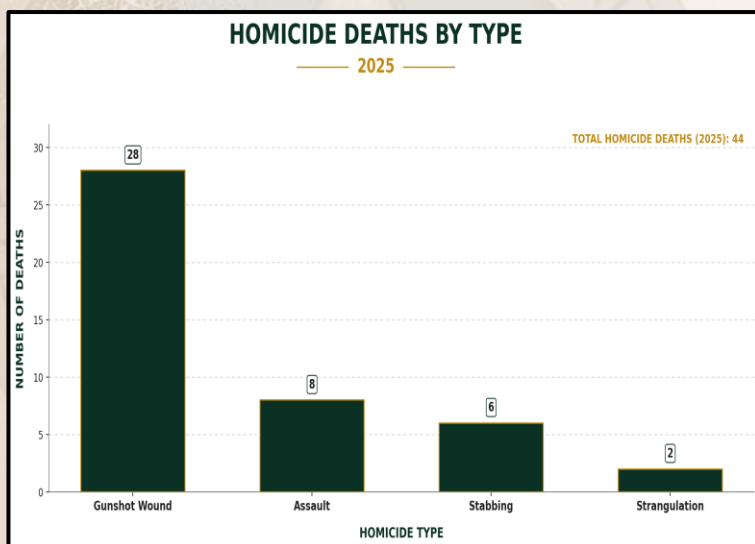
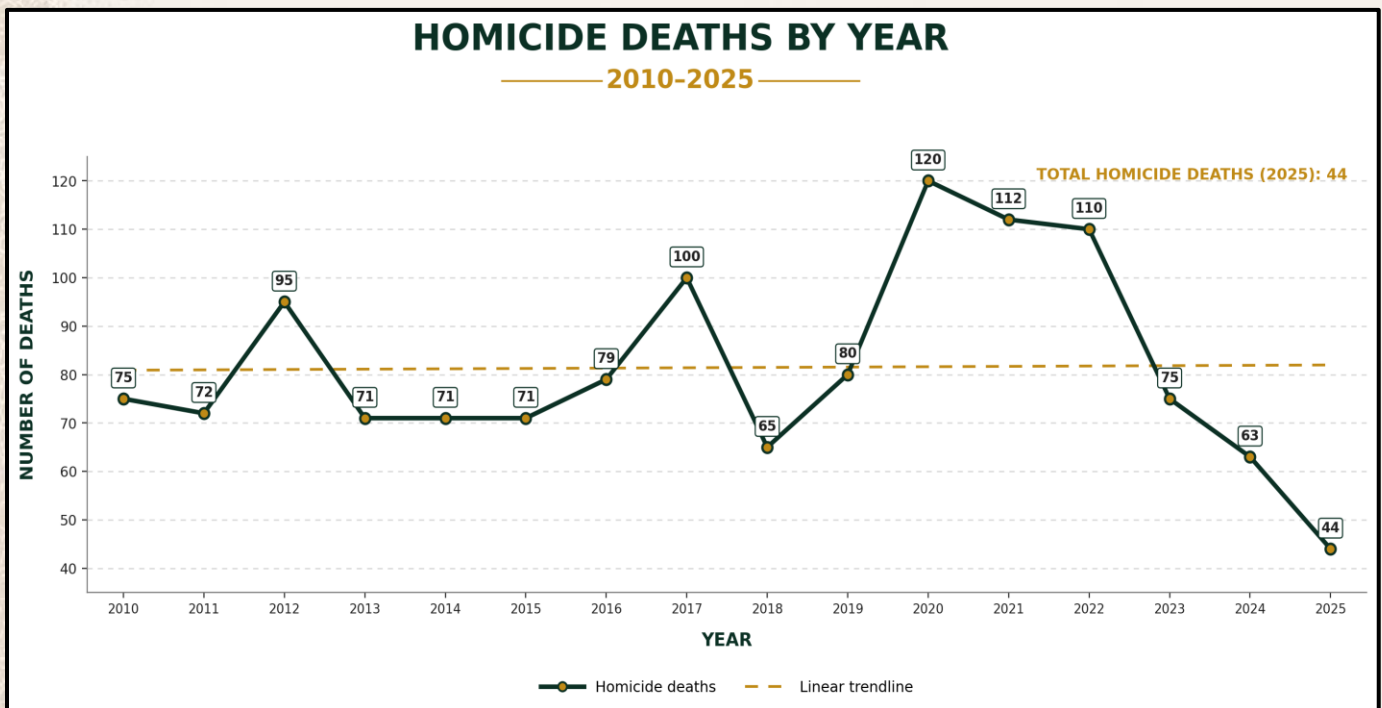
SUICIDE



CORONER UNIT

HOMICIDE

Homicide is a manner of death in which a person dies as the result of an intentional act committed by another person. The classification describes the circumstances of the death and does not, by itself, determine criminal responsibility or legal guilt.



CORONER UNIT

HOMICIDE

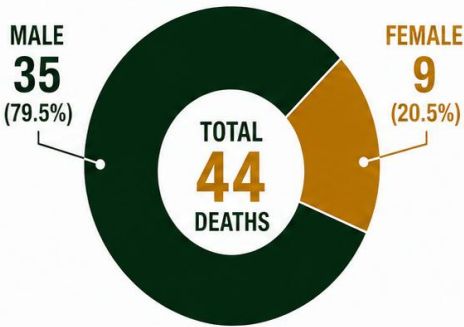
HOMICIDE DEATHS

2025 GENDER & AGE DISTRIBUTION

TOTAL HOMICIDE DEATHS (2025)

44

BY GENDER

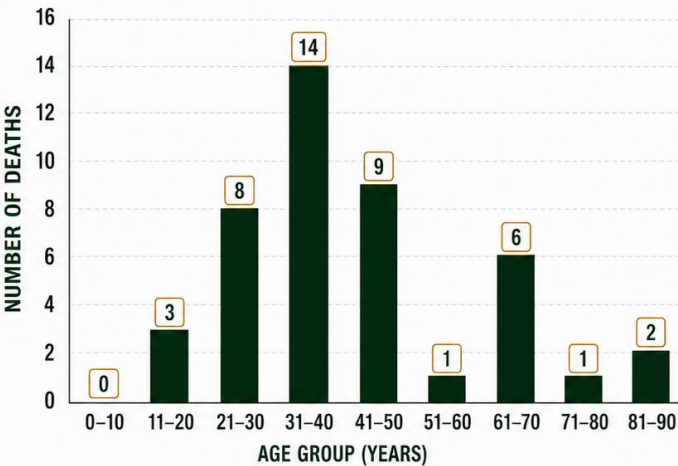


GENDER	# OF DEATHS	PERCENTAGE
MALE	35	79.5%
FEMALE	9	20.5%
TOTAL	44	100%

YOUNGEST AGE	OLDEST AGE	AVERAGE AGE	MEDIAN AGE
18 YEARS	90 YEARS	42 YEARS	38 YEARS

BY AGE GROUP

AGE RANGE: 18 – 90 YEARS

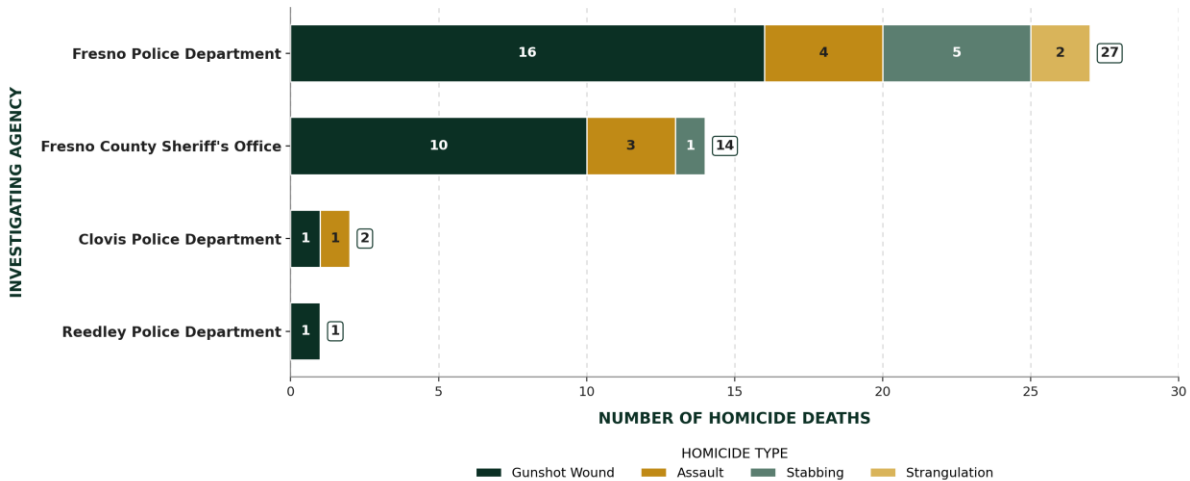


AGE GROUP (YEARS)	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	TOTAL
# OF DEATHS	0	3	8	14	9	1	6	1	2	44

HOMICIDE DEATHS BY INVESTIGATING AGENCY AND TYPE

2025

TOTAL HOMICIDE DEATHS (2025): 44



CORONER UNIT

NATURAL

A natural death is one caused solely by disease or the normal aging process, without an external injury or other non-natural event directly causing the death. Determining the specific cause of a natural death can be challenging, particularly when multiple medical conditions are present, requiring consideration of medical history, investigative findings, and postmortem examination results.

NATURAL DEATHS BY CLASSIFICATION

2025

TOTAL NATURAL DEATHS: 351

