TYPE IN PERMANENT BLACK INK

FLORIDA CERTIFICATE OF FETAL DEATH

LOCAL FILE NO.

To be completed by: FUNERAL DIRECTOR OR PERSON ACTING AS SUCH

1. NAME OF FETUS *(First, Middle, Last, Suffix)*
2. SEX (M/F/Unk)
3. DATE OF DELIVERY *(Month, Day, Year)*

4a. WEIGHT OF FETUS *(Enter lbs/ozs OR grams; grams preferred)* ________ lbs ________ ozs __________ grams

4b. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY _______________ *completed weeks*

5. TIME OF DELIVERY *(24 hr.)*

6. FACILITY NAME *(If not institution, give street and number)*

7. COUNTY OF DELIVERY

8. PLACE WHERE DELIVERY OCCURRED *(Check only one)*
____ Hospital ____ Clinic/Doctor's Office _______ Home Delivery *(Planned to deliver at home? ___ Yes ___ No)*
____ Freestanding Birthing Center _______ Other *(Specify)*

9. CITY, TOWN OR LOCATION OF DELIVERY

10a. MOTHER'S/PARENT'S NAME *(First, Middle, Last, Suffix)*

10b. MOTHER'S/PARENT'S NAME PRIOR TO FIRST MARRIAGE *(If applicable)*

11. MOTHER'S/PARENT'S DATE OF BIRTH *(Month, Day, Year)*

12. MOTHER'S/PARENT'S BIRTHPLACE *(State, Territory, or Foreign Country)*

13a. MOTHER'S/PARENT'S RESIDENCE - STATE

13b. COUNTY

13c. CITY, TOWN OR LOCATION

13d. STREET AND NUMBER

13e. APT. NO.

13f. ZIP CODE

13g. INSIDE CITY LIMITS? _______ Yes ____ No

14a. FATHER'S/PARENT'S NAME *(First, Middle, Last, Suffix)*

14b. FATHER'S/PARENT'S NAME PRIOR TO FIRST MARRIAGE *(If applicable)*

15. FATHER'S/PARENT'S DATE OF BIRTH *(Month, Day, Year)*

16. FATHER'S/PARENT'S BIRTHPLACE *(State, Territory, or Foreign Country)*

17a. LICENSE NUMBER *(of Licensee)*

17b. SIGNATURE OF FUNERAL SERVICE LICENSEE *(or person acting as such)* ►

18. NAME OF FUNERAL FACILITY

19a. FACILITY'S MAILING - STATE

19b. CITY OR TOWN

19c. STREET AND NUMBER

19d. ZIP CODE

20. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place)*

21a. LOCATION - STATE

21b. LOCATION - CITY OR TOWN

22a. METHOD OF DISPOSITION
____ Burial ____ Entombment ____ Cremation ____ Donation ____ Removal from State ___ Hospital Disposition
____ Other *(Specify)*

22b. IF CREMATION, DONATION, HOSPITAL DISPOSITION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? ___ Yes ____ No

State of Florida, Department of Health, Vital Statistics

MEDICAL CERTIFIER

If delivery attended by certified nurse midwife, death must be certified by supervising physician.
If delivery attended by licensed midwife or someone other than a licensed physician, death must be certified by medical examiner.

23. CERTIFIER: *(Check one)*
____ **Certifying Physician** - To the best of my knowledge, death occurred at the time, date and place stated, and the fetus was dead at delivery.
____ **Medical Examiner** - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place stated, and the fetus was dead at delivery.

24a. LICENSE NUMBER *(of Certifier)*

24b. CERTIFIER'S NAME

24c. CERTIFIER'S TITLE ____ M.D. ____ D.O.

25a. SIGNATURE OF CERTIFIER
► PHYSICIAN'S SIGNATURE

25b. DATE SIGNED *(Month, Day, Year)*

26a. CERTIFIER'S MAILING - STATE

26b. CITY OR TOWN

26c. STREET AND NUMBER

26d. ZIP CODE

27a. LICENSE NUMBER *(of Attendant)*

27b. ATTENDANT'S NAME *(If other than Certifier)*

27c. ATTENDANT'S TITLE *(If other than Certifier)*
Medical Examiner must certify if title is either L.M. or Other
____ C.N.M ____ L.M. ____ Other (Specify)

28. SUBREGISTRAR - *Signature and Date* ►

29a. LOCAL REGISTRAR - *Signature* ►

29b. DATE FILED BY REGISTRAR *(Month, Day, Year)*

To be completed by: MEDICAL CERTIFIER

30. REPORTED TO MEDICAL EXAMINER DUE TO CIRCUMSTANCES OF DEATH?
____ Yes ____ No

31. MEDICAL EXAMINER'S CASE NUMBER
___ ___ * ___ ___ * ___ ___ ___ ___ ___

32a. WAS AN AUTOPSY PERFORMED? *(check only one)*
____ Yes ____ No ____ Planned

32b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? *(check only one)*
____ Yes ____ No ____ Planned

32c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ____ Yes _____ No

33. ESTIMATED TIME OF FETAL DEATH
______ Dead at time of first assessment, no labor ongoing
______ Dead at time of first assessment, labor ongoing
______ Died during labor, after first assessment
______ Unknown time of fetal death

CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH

34a. INITIATING CAUSE(S) OR CONDITION(S)*: Among the choices below, please select the cause(s) or conditions(s) which most likely began the sequence of events resulting in the death of the fetus.*

____ PENDING AUTOPSY OR HISTOLOGICAL RESULTS

____ MATERNAL CONDITIONS/DISEASES *(Specify)*

____ COMPLICATIONS OF PLACENTA, CORD, MEMBRANES
____ Rupture of membranes prior to onset of labor ____ Abruptio Placenta
____ Placental Insufficiency ____ Prolapsed Cord ____ Chorioamnionitis
____ Other *(Specify)*

____ OTHER OBSTETRICAL OR PREGNANCY COMPLICATIONS *(Specify)*

____ FETAL ANOMALY *(Specify)*

____ FETAL INJURY *(Specify)*

____ FETAL INFECTION *(Specify)*

____ OTHER FETAL CONDITIONS/DISORDERS *(Specify)*

34b. OTHER SIGNIFICANT CAUSES OR CONDITIONS: *Select or specify all other causes or conditions contributing to death of the fetus as stated in 34a.*

___ MATERNAL CONDITIONS/DISEASES *(Specify)*

___ COMPLICATIONS OF PLACENTA, CORD, MEMBRANES
___ Rupture of membranes prior to onset of labor ___ Abruptio Placenta
___ Placental Insufficiency ____ Prolapsed Cord ___ Chorioamnionitis
___ Other *(Specify)*

___ OTHER OBSTETRICAL OR PREGNANCY COMPLICATIONS *(Specify)*

___ FETAL ANOMALY *(Specify)*

___ FETAL INJURY *(Specify)*

___ FETAL INFECTION *(Specify)*

___ OTHER FETAL CONDITIONS/DISORDERS *(Specify)*

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

35. MOTHER/PARENT OF HISPANIC OR HAITIAN ORIGIN? *(Specify if mother/parent is of Hispanic or Haitian Origin)*

____ Not of Hispanic/Haitian Origin ____ Unknown if Hispanic/Haitian Origin

Yes, of Hispanic/Haitian Origin *(Select one):* ____ Mexican ____ Puerto Rican ____ Cuban ____ Haitian

____ Other Hispanic *(Specify)*

36. MOTHER'S/PARENT'S RACE *(Specify the race/races to indicate what mother/parent considers themself to be. More than one race may be specified.)*

____ White ____ Black or African American ____ American Indian or Alaskan Native *(Specify tribe)*

____ Asian Indian ____ Chinese ____ Filipino ____ Japanese

____ Korean ____ Vietnamese ____ Other Asian *(Specify)*

____ Native Hawaiian ____ Guamanian or Chamorro ____ Samoan ____ Other Pacific Isl. *(Specify)*

____ Other *(Specify)*

37. MOTHER'S/PARENT'S EDUCATION *(Specify the mother's/parent's highest degree or level of school completed at time of delivery.)*

____ 8th or less ____ High school but no diploma ____ High school diploma or GED ____ College but no degree

College degree *(Specify):* ____ Associate ____ Bachelor's ____ Master's ____ Doctorate

38. DID MOTHER/PARENT GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

____ Yes ____ No ____ Unknown

39. MOTHER'S/PARENT'S SOCIAL SECURITY NUMBER

40a. PRENATAL CARE RECEIVED?

____ Yes ____ No *(If No, skip to #41)*

40b. DATE OF FIRST PRENATAL VISIT *(Month, Day, Year)*

40c. DATE OF LAST PRENATAL VISIT *(Month, Day, Year)*

40d. PRENATAL VISITS

Number ____________

41a-b. NUMBER OF PREVIOUS LIVE BIRTHS

41a. Number Now Living ________________

41b. Number Now Dead ________________

41c. DATE OF LAST LIVE BIRTH *(Month, Year)*

42. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY?
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If NONE, enter "0".

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months before Pregnancy	____________	OR	____________
First Three Months of Pregnancy	____________	OR	____________
Second Three Months of Pregnancy	____________	OR	____________
Third Trimester of Pregnancy	____________	OR	____________

43. MOTHER'S/PARENT'S HEIGHT

' " ________________ feet/inches

44. MOTHER'S/PARENT'S WEIGHT *(In pounds)*

________________ prepregnancy ____________ weight gained during pregnancy *(optional)*

45. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

46a. PLURALITY *(Single, twin, triplet, etc.)*

46b. IF NOT SINGLE BIRTH *(Born first, second, third, etc.)*

47. RISK FACTORS IN THIS PREGNANCY *(Check all that apply)*

____ Diabetes - Prepregnancy *(Diagnosis prior to this pregnancy)* ____ Diabetes - Gestational *(Diagnosis in this pregnancy)*

____ Hypertension - Prepregnancy *(Chronic)* ____ Hypertension - Gestational *(PIH, preeclampsia)* ____ Hypertension - Eclampsia

____ Mother/Parent had a previous cesarean delivery (If yes, how many? __________)

____ Pregnancy resulted from infertility treatment (If Yes, check all that apply)

____ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination

____ Assisted reproductive technology *(e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))*

____ Other *(Specify)* ____ None

48. METHOD OF DELIVERY *(Complete both items A and B)*

A. Fetal presentation at delivery: ____ Cephalic ____ Breech ____ Other *(Specify)*

B. Final route and method of delivery: *(Check one)* ____ Vaginal/Spontaneous ____ Vaginal/Forceps ____ Vaginal/Vacuum

____ Cesarean (If Cesarean, was a trial of labor attempted?) ____ Yes ____ No

49. MATERNAL MORBIDITY (Complications associated with labor and delivery) *(Check all that apply)*

____ Ruptured uterus ____ Admission to intensive care unit

____ Other *(Specify)* ____ None

50. MOTHER'S/PARENT'S MEDICAL RECORD NUMBER

State of Florida, Department of Health, Vital Statistics