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. DATE OF DELIVERY *(Month, Day, Year)*
3. SEX
4. WEIGHT OF FETUS *(Enter lbs/ozs OR grams: grams preferred)* _____ lbs _____ ozs _____ grams
5. TIME OF DELIVERY *(24 hr.)*
6. COUNTY OF DELIVERY
7. FACILITY NAME *(If not institution, give street address)*
8. CITY, TOWN OR LOCATION OF DELIVERY
9. PLACE WHERE DELIVERY OCCURRED *(Check one)*
___ Hospital ___ Freestanding Birthing Center ___ Clinic/Doctor's Office ___ Home *(Planned to deliver at home? ___ Yes ___ No)* ___ Other *(Specify)*
10a. MOTHER'S MAIDEN NAME *(First, Middle, Last)*
10b. MOTHER'S CURRENT SURNAME *(If different than 10a)*
11. IS MOTHER MARRIED? ___ Yes ___ No
12. MOTHER'S DATE OF BIRTH *(Month, Day, Year)*
13. MOTHER'S BIRTHPLACE *(State, Territory, or Foreign Country)*
14a. MOTHER'S RESIDENCE - STATE
14b. COUNTY
14c. CITY, TOWN OR LOCATION
14d. STREET ADDRESS
14e. APT. NO.
14f. ZIP CODE
14g. INSIDE CITY LIMITS? ___ Yes ___ No
15. FATHER'S NAME *(First, Middle, Last, Suffix)*
16. FATHER'S DATE OF BIRTH *(Month, Day, Year)*
17. FATHER'S BIRTHPLACE *(State, Territory, or Foreign Country)*
18a. LICENSE NUMBER *(of Licensee)*
18b. SIGNATURE OF FUNERAL SERVICE LICENSEE *(or person acting as such)* ▶
19. NAME OF FUNERAL FACILITY
20a. FACILITY'S MAILING - STATE
20b. CITY OR TOWN
20c. STREET ADDRESS
20d. ZIP CODE
21. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place)*
22a. LOCATION - STATE
22b. LOCATION - CITY OR TOWN
23a. METHOD OF DISPOSITION
___ Burial ___ Entombment ___ Cremation ___ Donation ___ Removal from State ___ Hospital Disposition
___ Other *(Specify)*
23b. IF CREMATION, DONATION, HOSPITAL DISPOSITION OR BURIAL AT SEA, WAS MEDICAL EXAMINER APPROVAL GRANTED? ___ Yes ___ No

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 reported to the medical examiner.

MEDICAL CERTIFIER

State of Florida, Department of Health, Vital Statistics

24. CERTIFIER: *(Check one)*
___ **Certifying Physician** - To the best of my knowledge, death occurred at the time, date and place stated, and the fetus was born dead.
___ **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 born dead.
25a. LICENSE NUMBER *(of Certifier)*
25b. CERTIFIER'S NAME
25c. CERTIFIER'S TITLE ___ M.D. ___ D.O.
26a. SIGNATURE OF CERTIFIER ▶
26b. DATE SIGNED (mm/dd/yyyy)
27. MEDICAL EXAMINER'S CASE NUMBER __ __ - __ __ - __ __ __ __
28a. CERTIFIER'S MAILING - STATE
28b. CITY OR TOWN
28c. STREET ADDRESS
28d. ZIP CODE
29a. LICENSE NUMBER *(of Attendant)*
29b. ATTENDANT'S NAME *(If other than Certifier)*
29c. ATTENDANT'S TITLE ___ C.N.M ___ L.M. ___ Other *(Specify)*
30. SUBREGISTRAR - *Signature and Date* ▶
31a. LOCAL REGISTRAR - *Signature* ▶
31b. DATE FILED BY REGISTRAR *(Mo., Day, Year)*

To be completed by: MEDICAL CERTIFIER

32. REPORTED TO MEDICAL EXAMINER DUE TO CIRCUMSTANCES OF DEATH? ___ Yes ___ No
33. ESTIMATED TIME OF FETAL DEATH ___ Before Labor ___ During Labor ___ During Delivery ___ Unknown time of fetal death
34a. WAS AN AUTOPSY PERFORMED? ___ Yes ___ No
34b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ___ Yes ___ No
34c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ___ Yes ___ No

CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH

35a. INITIATING CAUSE OR CONDITION: *Among the choices below, please select the one cause or condition 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)*

35b. OTHER SIGNIFICANT CAUSES OR CONDITIONS: *Select or specify all other causes or conditions contributing to death of the fetus as stated in 35a.*

___ 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)*

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INFORMATION FOR MEDICAL AND HEALTH USE ONLY

36. MOTHER'S RACE *(Specify the race/races to indicate what mother considers herself 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 OF HISPANIC OR HAITIAN ORIGIN? *(Specify if mother is of Hispanic or Haitian Origin)*

___ Yes ___ No *(If Yes, specify)* ___ Mexican ___ Puerto Rican ___ Cuban ___ Central/South American

___ Other Hispanic *(Specify)* ___ Haitian

38. MOTHER'S SOCIAL SECURITY NUMBER

39. MOTHER'S EDUCATION *(Specify the mother'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

40. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

___ Yes ___ No ___ Unknown

41. WAS MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?

___ Yes ___ No *(If Yes, specify name of facility transferred from)*

42a. PRENATAL CARE RECEIVED?

___ Yes ___ No *(If No, skip to # 43)*

42b. DATE OF FIRST PRENATAL VISIT *(Mo, Day, Yr)*

42c. DATE OF LAST PRENATAL VISIT *(Mo, Day, Yr)*

42d. PRENATAL VISITS

Number _____

43a-b. NUMBER OF PREVIOUS LIVE BIRTHS

43a. Now Living	43b. Now Dead
Number _____ ☐ None	Number _____ ☐ None

43c. DATE OF LAST LIVE BIRTH *(Month, Year)*

44a. NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous, induced losses or ectopic pregnancies)*

Number _____ *(Do not include this fetus)* ☐ None

44b. DATE OF LAST OTHER OUTCOME *(Month, Year)*

45. TOBACCO USE DURING PREGNANCY?

___ Yes ___ Yes, but quit ___ No *(If Yes, Avg. Number of Cigarettes/Day)* _____

46. MOTHER'S HEIGHT

_____ feet/inches

47. MOTHER'S WEIGHT *(In pounds)*

_____ prepregnancy _____ at delivery

48. OBSTETRIC ESTIMATE OF GESTATION

_____ *completed weeks*

49. DATE LAST NORMAL MENSES BEGAN *(Mo, Day, Yr)*

50a. PLURALITY *(Single, twin, etc.)*

50b. IF NOT SINGLE BIRTH *(Born first, second, etc.)*

51. HISTORY FACTORS FOR 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

___ Previous preterm birth

___ Other previous poor pregnancy outcome *(Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)*

___ Pregnancy resulted from infertility treatment

___ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination

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

___ Mother had a previous cesarean delivery (If yes, how many? _____)

___ Other *(Specify)*

___ None

52. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY *(Check all that apply)*

___ Gonorrhea ___ Syphilis ___ Chlamydia ___ Listeria ___ Group B Streptococcus

___ Cytomegalovirus ___ Parvovirus ___ Toxoplasmosis ___ Hepatitis B ___ Hepatitis C

___ Other *(Specify)*

___ None

53. METHOD OF DELIVERY *(Complete all items A through E)*

A. Was delivery with forceps attempted but unsuccessful? ___ Yes ___ No

B. Was delivery with vacuum extraction attempted but unsuccessful? ___ Yes ___ No

C. Fetal presentation at delivery: ___ Cephalic ___ Breech ___ Other *(Specify)*

D. Final route and method of delivery: *(Check one)* ___ Vaginal/Spontaneous ___ Vaginal/Forceps ___ Vaginal/Vacuum ___ Cesarean (Was a trial of labor attempted? ___ Yes ___ No)

E. Hysterotomy / Hysterectomy: ___ Yes ___ No

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

___ Maternal transfusion ___ Third or fourth degree perineal laceration ___ Ruptured uterus

___ Unplanned hysterectomy ___ Admission to intensive care unit ___ Unplanned operating room procedure following delivery

___ Other *(Specify)*

___ None

55. CONGENITAL ANOMALIES OF THE FETUS *(Check all that apply)*

___ Anencephaly ___ Meningomyelocele/Spina bifida ___ Cyanotic congenital heart disease

___ Congenital diaphragmatic hernia ___ Omphalocele ___ Gastroschisis

___ Limb reduction defect *(Excluding congenital amputation and dwarfing syndromes)* ___ Cleft Lip with or without Cleft Palate ___ Cleft Palate alone

___ Down Syndrome (Karotype: ____confirmed, ____ pending) Specify Karotype: _____

___ Chromosomal disorder (Karotype: ____confirmed, ____ pending) Specify Karotype: _____

___ Hypospadias

___ Other *(Specify)*

___ None