TYPE IN PERMANENT BLACK INK

	FILE NO.		0 ""							1	- 0		
1.	NAME OF FETUS (First,	, Middle, Last,	Suffix)							2. DAT	E OF DELIVER	RY (Month, E	Day, Year)
3. \$	SEX (M/F/Unk)	4. WEIGHT O	F FETUS <i>(Er</i>	nter lbs/oz	zs OR grams;	grams preferred)	5. TIM	IE OF DELI\	/ERY (24	hr.) 6. COU	NTY OF DELI\	/ERY	
	, , ,		lbs	ozs		grams	1			,			
7. 1	FACILITY NAME (If not i	institution, give		_						8. CITY	, TOWN OR LO	OCATION C	F DELIVERY
9. 1	PLACE WHERE DELIVE												
-	Hospital Other (Specify)	Freestan	ding Birthing	Center		_Clinic/Doctor's Offic	ce	Hor	ne Deliver	y (Planned to	deliver at home	e? Yes	: No)
10a	a. MOTHER'S/PARENT'S	S NAME (First	t Middle Las	t Suffix)					10h	MOTHER'S/P	ARENT'S NAM	IF PRIOR TO	O FIRST MARRI
.00		0 10 100	i, imaaro, zao	n, camby					1.00				(If appli
11.	MOTHER'S/PARENT'S	DATE OF BIR	RTH (Month,	Day, Year	r)	12. MOTHER'S/P	ARENT'	S BIRTHPL	ACE (State	e, Territory, or	Foreign Countr	y)	
13a	a. MOTHER'S/PARENT'S	S RESIDENCI	E - STATE	13b. C0	OUNTY					13c. CITY, T	OWN OR LOC	ATION	
10-	d. STREET AND NUMBE								42a ADT	. NO. 13f. ZIF	CODE	112=	INSIDE CITY LII
13a	J. STREET AND NOMBE	EK							ISE. AFT	. INO. 131. ZIF	CODE	13g.	Yes
14a	a. FATHER'S/PARENT'S	S NAME (First,	, Middle, Last	t, Suffix)					14b	FATHER'S/PA	ARENT'S NAMI	E PRIOR TO	FIRST MARRIA
													(If appli
15.	FATHER'S/PARENT'S	DATE OF BIR	TH (Month, D	Day, Year)		16. FATHER'S/PA	RENT'S	BIRTHPLA	CE (State,	Territory, or F	oreign Country,)	
17a	7a. LICENSE NUMBER (of Licensee)				17b. SIGNATURE OF FUNERAL SERVICE LICENSEE (or person acting as such)								
						>				T			
18.	NAME OF FUNERAL F	ACILITY	_ITY							19a. F	19a. FACILITY'S MAILING - STATE		
19b	o. CITY OR TOWN			T	19c. STREE	T ADDRESS						1	19d. ZIP CODE
20.	PLACE OF DISPOSITION	ON (Name of	cemetery, cre	ematory, o	or other place))		21a. LOC	ATION - S	TATE	21b. LOCA	TION - CITY	OR TOWN
22a	a. METHOD OF DISPOS Burial Entoi	SITION mbment	Cremation	Don	ation	Removal from State	,	Hospital Di	sposition				SPITAL DISPOS EDICAL EXAMIN
	Other (Specify)										OR BURIAL AT SEA, WAS MEDICAL EXAMINE APPROVAL GRANTED?Yes1		
lf d	elivery attended by cer	tified nurse n	nidwife, deat	th must b	e certified by	supervising physi	cian.						
• •		ancod midwif			-		·····						
If d					nan a license	d physician, death	must be						
If d	CERTIFIER: Certi	ifying Physici	ian - To the b	est of my	han a license knowledge, d	d physician, death	must be	ate and plac	e stated, a	nd the fetus wa			us was dand at
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23.	CERTIFIER:Certi (Check one)Medi	ifying Physici ical Examiner of Certifier)	ian - To the b r - On the bas	est of my sis of exan	han a license knowledge, d nination, and/	d physician, death	must be	ate and plac	e stated, a	nd the fetus wa		, and the fet	TIFIER'S TITLEM.D.
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___OTHER FETAL CONDITIONS/DISORDERS (Specify)

OTHER FETAL CONDITIONS/DISORDERS (Specify)

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

35.	MOTHER/PARENT OF HISPANIC OR H										
	Not of Hispanic/Haitian Origin	Unki	nown if Hispanic/F	Haitian Origin							
	Yes, of Hispanic/Haitian Origin (Select	one): Mex	can	Puerto Rican	Cuban	Haitian					
		Othe	er Hispanic <i>(Spec</i>	ify)							
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.)										
		Black or African Americ									
	_										
	Asian IndianChinese			Japar		liese					
	Native Hawaiian Guamanian or Ch			Other Asian (Specify) Samoan Other		r Pacific Isl. (Specify)					
	Other (Specify)		_ Samoan								
	<u> </u>										
37.	MOTHER'S/PARENT'S EDUCATION (S)	pecify the mother's/pa	rent's highest deg	ree or level of school co	mpleted at tim	e of delivery.)					
	8th or lessH	ligh school but no dipl	oma	_High school diploma o	or GED	College but no degree					
	College degree (Specify):	ssociate	Bachelor's		Master's	Doctorate					
38.	DID MOTHER/PARENT GET WIC FOOD	FOR HERSELF DUR	ING THIS PREG	NANCY?		39. MOTHER'S/PARENT'S SOCIAL SECURITY	NUMBER				
	YesNoUnkno	own									
408	a. PRENATAL CARE RECEIVED?	40b. DATE OF F	IRST PRENATAL	_ VISIT (Month, Day, Ye	ear) 40c. DAT	_ E OF LAST PRENATAL VISIT (Month, Day, Year,	40d. PRENATAL VISITS				
	YesNo (If No, skip to #4	41)					Number				
418	a-b. NUMBER OF PREVIOUS LIVE BIRTH	ls				41c. DATE OF LAST LIVE BIRTH (Month, Yea	r)				
	41a. Now Living	Number		None [
	41b. Now Dead	Number		None							
42.	CIGARETTE SMOKING BEFORE AND DI For each time period, enter either the nu	ımber of cigarettes or		Average number of ci	garettes or pac	eks of cigarettes smoked per day. # of cigarettes # of packs					
	the number of packs of cigarettes smoked. If NONE, enter "0". Three Months before Pregnancy OR										
				First Three Months of	Pregnancy	OR					
	Second Three Months of Pregnancy OR										
				Third Trimester of Pre	gnancy	OR	_				
43.	OBSTETRIC ESTIMATE OF GESTATION	N AT DELIVERY	44. MOTHER'S	/PARENT'S HEIGHT		45. MOTHER'S/PARENT'S WEIGHT (In pound	s)				
	completed weeks			feet/inches		prepregnancy	,				
10		(Martha Days Marth	47- DI UDALITI				thind of a				
46.	DATE LAST NORMAL MENSES BEGAN	(Month, Day, Year)	47a. PLURALIT	Y (Single, twin, triplet, e	rc.)	47b. IF NOT SINGLE BIRTH (Born first, second	, thira, etc.)				
48.	RISK FACTORS IN THIS PREGNANCY	(Check all that apply)									
	Diabetes - Prepregnancy (Diagnos	sis prior to this pregnar	ncy)	Diabetes - Gesta	tional (Diagnos	sis in this pregnancy)					
	Hypertension - Prepregnancy (Chronic)Hypertension - Gestational (PIH, preeclampsia)Hypertension - Eclampsia										
	Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))										
	Other (Specify)					_	None				
49.	METHOD OF DELIVERY (Complete both	items A and B)									
A.	. Fetal presentation at delivery:	Сері	nalic	Breech	Other	r (Specify)					
- Statis	B. Final route and method of delivery: (Check one)Vaginal/SpontaneousVaginal/ForcepsVaginal/Vacuum										
th, Vita											
of Florida, Department of Health, Vital Statistics	MATERNAL MORBIDITY (Complications	associated with labor	and delivery) (C	heck all that apply)							
rtment	Ruptured uterus	Admission to	o intensive care u	nit							
, Depai	Other (Specify)						None				
Florida											
State of The	MOTHER'S/PARENT'S MEDICAL RECORD Department of Health is required and auti		al Security Numb	ers for the reporting and	registration of	f birth and death records as provided in section 38	32.0135, F.S.				
రా											