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 (M/F/Unk)
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 and number)*
8. CITY, TOWN OR LOCATION OF DELIVERY
9. PLACE WHERE DELIVERY OCCURRED *(Check only one)*
____Hospital ____Freestanding Birthing Center ____Clinic/Doctor's Office _____Home Delivery *(Planned to deliver at home? ___ Yes ___ No)*
____ Other *(Specify)*
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 ADDRESS
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

MEDICAL CERTIFIER

State of Florida, Department of Health, Vital Statistics

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. LICENSE NUMBER *(of Attendant)*
26b. ATTENDANT'S NAME *(If other than Certifier)*
26c. ATTENDANT'S TITLE *(If other than Certifier)*
Medical Examiner must certifv if title is either L.M. or Other
____ C.N.M ____ L.M. ____ Other (Specify)
27a. CERTIFIER'S MAILING - STATE
27b. CITY OR TOWN
27c. STREET ADDRESS
27d. ZIP CODE
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.*	34b. OTHER SIGNIFICANT CAUSES OR CONDITIONS: *Select or specify all other causes or conditions contributing to death of the fetus as stated in 34a.*
____PENDING AUTOPSY OR HISTOLOGICAL RESULTS	
____MATERNAL CONDITIONS/DISEASES *(Specify)*	___MATERNAL CONDITIONS/DISEASES *(Specify)*
____COMPLICATIONS OF PLACENTA, CORD, MEMBRANES	___COMPLICATIONS OF PLACENTA, CORD, MEMBRANES
____Rupture of membranes prior to onset of labor ____Abruptio Placenta	___Rupture of membranes prior to onset of labor ____Abruptio Placenta
____Placental Insufficiency ____Prolapsed Cord ____Chorioamnionitis	___Placental Insufficiency ____Prolapsed Cord ____Chorioamnionitis
____Other *(Specify)*	___Other *(Specify)*
____OTHER OBSTETRICAL OR PREGNANCY COMPLICATIONS *(Specify)*	___OTHER OBSTETRICAL OR PREGNANCY COMPLICATIONS *(Specify)*
____FETAL ANOMALY *(Specify)*	___FETAL ANOMALY *(Specify)*
____FETAL INJURY *(Specify)*	___FETAL INJURY *(Specify)*
____FETAL INFECTION *(Specify)*	___FETAL INFECTION *(Specify)*
____OTHER FETAL CONDITIONS/DISORDERS *(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. Now Living Number _____ None ☐

41b. Now Dead Number _____ None ☐

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. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY

_____ *completed weeks*

44. MOTHER'S/PARENT'S HEIGHT

_____ feet/inches

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

_____ prepregnancy

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

47a. PLURALITY *(Single, twin, triplet, etc.)*

47b. IF NOT SINGLE BIRTH *(Born first, second, third, etc.)*

48. 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

49. 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

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

____ Ruptured uterus ____ Admission to intensive care unit

____ Other *(Specify)* ____ None

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

The Department of Health is required and authorized to collect Social Security Numbers for the reporting and registration of birth and death records as provided in section 382.0135, F.S.

State of Florida, Department of Health, Vital Statistics