IDAHO CERTIFICATE OF STILLBIRTH
-- How to Complete --

For each stillbirth (spontaneous fetal death) which occurs in this state and for each stillborn fetus that is found in this state, a stillbirth certificate is legally required to be filed with the Local Registrar of the district (county) within 5 days after the date of delivery or finding of the fetus.

"Stillbirth" means a spontaneous fetal death of twenty (20) completed weeks gestation or more, based on a clinical estimate of gestation, or a weight of three hundred fifty (350) grams (twelve and thirty-five hundredths (12.35) ounces) or more. [Idaho Code §39-241(20)]

The current version (at the time of delivery) of the Idaho Certificate of Stillbirth is to be completed and filed. *(An original Acknowledgment of Paternity Affidavit or certified copy of a court determination of paternity or non-paternity must accompany the stillbirth certificate if applicable.)*

When a stillbirth occurs in an institution (hospital or freestanding birthing center), the person in charge of the institution or a designated representative is to prepare a Certificate of Stillbirth. He or she must obtain the signature of the certifier (physician, physician assistant, advanced practice professional nurse or coroner as applicable), who will provide the medical data, and then forward the certificate to the mortician or person acting as such, who must provide the disposition information and file the certificate with the Local Registrar.

When a stillbirth occurs outside a hospital or freestanding birthing center, the mortician or person acting as such is to prepare a Certificate of Stillbirth; this person must obtain the medical data from and the signature of the attendant at the stillbirth and/or the county coroner as applicable.

Since the stillbirth certificate is a permanent legal document, it must be legibly completed using a typewriter with good black ribbon and clean keys, a computer printer with high resolution, or by printing legibly using permanent unfading black ink. Certificates completed in other colored ink or pencils are not acceptable.

Signatures appearing on the certificate must be **personally signed** in dark blue or black ink; other colored ink, pencil, rubber stamps, or facsimile signatures are not acceptable.

A certificate that is prepared on an improper form, is a photo or carbon copy, is defaced, contains lined-through information, excessive white-out, messy alterations or erasures, is incomplete, or contains improper or inconsistent data will not be accepted for filing.

All items must be completed or the reason for their omission explained. Entries such as "Unknown" "Not available", "Refused", or a dash "-" may be given when appropriate. Vital Statistics may question a high usage of "Unknown" entries.

Worksheets are useful in obtaining information for completing the stillbirth certificate. (Please be sure the wording on the worksheet matches the stillbirth certificate.) Review all information before and during completion of the stillbirth certificate to avoid errors, which can involve a great deal of time, inconvenience, and expense to correct.

If you encounter any unusual problems in completing a stillbirth certificate, contact your Local Registrar or **Vital Statistics**.

The following pages contain a description of every item on the stillbirth certificate and instructions for the completion of each.

Please note the following information before completing a stillbirth certificate.

(If the infant was born alive [see "live birth" definition following], but dies very soon after, a Certificate of Live Birth and a Certificate of Death must be filed - not a Certificate of Stillbirth.)

"Live Birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. [Idaho Code §39-241(10)]

(If the delivery is after 20 weeks, but gestation (fetal development) terminated prior to 20 weeks and the fetal weight is less than 350 grams or 12.35 ounces, a stillbirth certificate is not to be filed. *If, however, the fetal death was the result of an induced abortion, irrespective of gestation or weight, it must be reported on an Induced Termination of Pregnancy (abortion) Report, not a Certificate of Stillbirth*).

Two of the unnumbered items at the top of the stillbirth certificate, DATE FILED BY STATE REGISTRAR: (top left) and STATE FILE NO. (top right), will be completed by **Vital Statistics** staff when the certificate is accepted for permanent filing.

The third unnumbered item, Local Reg. No. (top right, just below STATE FILE NO.), will be completed by the Local Registrar at the time of completion of items #11a-b (refer to the Local Registrar section of these instruction).

S T I L L B O R N C H I L D

1. CHILD'S NAME (First, Middle, Last, Suffix)

Enter the child's first, middle, and last names exactly as given (including punctuation) by the parent(s) on the worksheet or on the paternity affidavit*. Be especially careful with names for which several different spellings are possible. Include any suffix to the child's name if applicable, such as Jr., Sr., II, III.

Note: Adequate spacing should be entered to distinguish between first, middle, and last names.

A last name (surname) must be entered for the child or stated to be "Unknown".

* Paternity affidavit	- If an Acknowledgment of Paternity Affidavit has been completed, the child's name on the stillbirth certificate must be the same as it is in the mother's section of the paternity affidavit (including spelling and punctuation).
No given names	- If the child has neither a first nor middle name, enter only the surname and leave the space for the first and middle names blank. DO NOT add entries such as "Baby girl", or "Infant boy".

No middle name - If the child does not have a middle name or initial, leave the middle name field blank. DO NOT enter "NMI" or "NMN".

Multiple given names - If multiple first or middle names are given, enter all in the appropriate places with a single space between, leaving adequate spacing between first, middle, and last names.

Multiple last names - If more than one last name is given, separate with a single space, hyphen "-", forward slash "/", or other symbol, as applicable.

No last name - If no last name is given for this child and the parents cannot be contacted, use the current legal last name of the mother.

Found stillborn - If the coroner cannot determine the name of a found stillborn child, enter "Unknown" in the name field. Do not enter names such as "John Doe" or "Jane Doe".

2. TIME OF DELIVERY (24 hr)

Enter the exact time (hour and minute) the child was delivered, based on a 24-hour clock, as four digits (0000 through 2359) with no colon and no a.m. or p.m. designation.

Midnight belongs to the beginning of the new day (enter as "0000").

The time/date sequence is:

2359 (11:59 p.m.) End of day
0000 (12:00 a.m.) Midnight Beginning of new day
0001 (12:01 a.m.)

Not known - If the exact time of delivery is not known, the time should be estimated as accurately as possible by the certifier; "Approx.", should be placed before the time.

Entries such as "A.M. hours", "Late P.M. hours", "Unknown A.M.", are acceptable.

If it is not possible to determine the time of delivery, an entry of "Unknown" is acceptable.

3. SEX

Enter the sex of the child as "Male" or "M" *or* "Female" or "F".

Unknown - If the sex of the child has not been determined, enter "Unknown" or "U".

4. DATE OF DELIVERY (Mo/Day/Yr)

Enter the complete date of delivery of the child - month, day, and four-digit year. Write out in full (January, February, March, etc.) or abbreviate (Jan., Feb., Mar., etc.) the name of the month. Do not use a number to designate the month.

Note: Midnight (0000) belongs to the beginning of the new day.

Not known - If the exact date of delivery is not known, the date is to be approximated as accurately as possible by the certifier, and "Approx." or other appropriate entry should be made to indicate that the date is approximated.

A date range, specified as "Between", may be accepted when a specific date cannot reasonably be determined or approximated.

An entry of "Found" or "Unknown" is not acceptable.

5. FACILITY NAME (If not a facility, give street and number)

Enter the full name of the facility (hospital or freestanding birthing center) where the delivery occurred. If delivery was not in a facility, enter the street and number, or physical location where the delivery occurred. (DO NOT enter a P.O. Box or Rural Route and Box Number.)

(A freestanding birthing center has no direct physical connection with an operative delivery center.)

The facility, street address, or location entered here must be located within or near the city, town, or location entered in item #6.

En route - If the delivery occurred on a moving conveyance en route to or on arrival at a facility, enter the full name of the facility.

Moving conveyance - If the delivery occurred on a moving conveyance not en route to a facility, enter as the place of delivery the street name and number of the location where the stillborn child was first removed from the conveyance, even if the conveyance crossed state or county lines.

At home or other place - If the delivery occurred at home or some other place, enter the street name and number of the house, building, or location where the delivery occurred.

No street address - If this location has no street name and number, enter a brief description that will identify the physical location.

6. CITY, TOWN, OR LOCATION OF DELIVERY

Enter the name of the city, town, or other location where the delivery occurred; this may be different from the city or town used in the mailing address of the delivery location.

This location must be within the county entered in item #7.

Moving conveyance - If the delivery occurred on a moving conveyance, enter the city, town, or location where the stillborn child was first removed from the conveyance.

7. COUNTY OF DELIVERY

Enter the name of the county where the delivery occurred.

Moving conveyance - If the delivery occurred on a moving conveyance, enter the county

where the stillborn child was first removed from the conveyance.

M O T H E R

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

Enter the mother's full legal name at the time of this delivery, including any suffix to her name if applicable.

(In all cases, the birth mother is to be listed and the father's information is to be completed according to the birth mother's marital status.)

8b. DATE OF BIRTH (Mo/Day/Yr) *[MOTHER'S]*

Enter the complete date of birth of the mother - month, day, and four-digit year. Write out in full (January, February, March, etc.) or abbreviate (Jan., Feb., Mar., etc.) the name of the month. Do not use a number to designate the month.

Not known - If any part of the mother's date of birth is not known, enter the known information and enter a "?" for the part(s) not known. Enter "Unknown" if all parts of the date are not known.

8c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)

Enter the full name of the mother as given at birth or by adoption, including any suffix to her name if applicable.

Not available - If the maiden last name is not given, refused, or not known, enter "Unknown". Do not leave blank.

Do not list a previous married name and do not enter "Same" or "Refused".

8d. BIRTHPLACE (State, Territory, or Foreign Country) *[MOTHER'S]*

Enter the place of birth of the mother.

United States - If the mother was born in the United States, enter the name of the state or territory. If the state or territory is not known, enter "U.S." only.

Canada - If the mother was born in Canada, enter the name of the province and "Canada". If the province is not known, enter "Canada" only.

Foreign - If the mother was born in any other foreign country, enter the name of the country. If the specific country is not known, enter "Foreign-unknown".

Not known - If no information is available regarding the place of birth, enter "Unknown".

9a. RESIDENCE OF MOTHER - STATE

Enter the name of the state in which the mother currently lives. This is where her household is located and where she is actually residing.

The mother's residence is not necessarily the same as her "home state", "voting residence", "mailing address", or "legal residence".

Temporary - Never enter a temporary residence such as one used during a visit, business trip, vacation, or short time stay at the home of a relative or friend, or home for unwed mothers for the purpose of awaiting the delivery of the child.

Note: Place of residence during a tour of military duty or during attendance at college is *not* considered temporary and should be entered as the mother's residence.

9b. COUNTY *[RESIDENCE OF MOTHER]*

Enter the name of the county in which the mother lives. The county entered here must be located within the state entered in item #9a.

9c. CITY, TOWN, OR LOCATION *[RESIDENCE OF MOTHER]*

Enter the name of the city, town, or location where the mother lives, which may not be the same as the city used for the mailing address. This location must be within the state and county entered in items #9a-b.

9d. STREET AND NUMBER *[RESIDENCE OF MOTHER*]

Enter the full street address of the place where the mother lives. (DO NOT enter a P.O. Box or Rural Route and Box Number.)

No street address - If this location has no street name and number, enter a brief description that will identify the physical location.

Unit or space - If there is a unit or space number (number, letter, or combination of the two) associated with this address that distinguishes between buildings (e.g., mobile homes), enter it as part of the street and number address.

Note: No entry for city or town should be made in this item.

9e. APT. NO. *[RESIDENCE OF MOTHER]*

Enter the apartment or room number of the place where the mother lives, if applicable.

Note: Complete this item only if there is a number (number, letter, or combination of the two) associated with this address that distinguishes between residences located within the same building.

9f. ZIP CODE *[RESIDENCE OF MOTHER]*

Enter the nine-digit Zip Code of the place where the mother lives.

Five-digit Zip Code - If only the five-digit Zip Code is known, enter those five digits only.

Foreign - Enter the appropriate postal code for the place where the mother lives, if

applicable.

9g. INSIDE CITY LIMITS? *[RESIDENCE OF MOTHER]*
□Yes □No

Check "Yes" or "No" to indicate if the mother's street address, entered in item #9d, is located inside the city limits of the city, town, or location entered in item #9c.

Unincorporated or outside city limits - If the city, town, or location entered in item #9c is unincorporated or if the street address entered in item #9d is outside the city limits, enter "No".

F A T H E R

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

Enter the father's full legal name at the time of this delivery, including, if applicable, any suffix to his name.

(Refer to the following information regarding who is or is not to be entered as the father, based on marital status of the mother.)

-------- *If mother was **MARRIED** (at delivery, conception, or any time between) refer to the* following:

Mother married - If the mother was married at conception, at any time during pregnancy, or at delivery, enter the full legal name of the husband. (The husband is the legal father.)

Married multiple times - If the mother was married at conception, at any time during pregnancy, or at delivery and there has been more than one husband during that time, the husband at the time of the delivery should be listed as the father. If the mother is not married at the time of the delivery, but was married at conception or during the interval between conception and delivery, the most recent husband during that time should be listed. (The husband is the legal father.)

Refusing husband info. - If the mother refuses to give the husband's information, leave the father's information blank and notify **Vital Statistics** that the mother refused to provide this information. Do not enter "Refused" or "Unknown".

Note: **The parent(s) will not be able to obtain a copy of the stillbirth certificate until the paternity issue is resolved with Vital Statistics.**

Husband not natural father - If the legal father (husband) is not the natural father, the natural father may be entered on the stillbirth certificate in place of the husband only if you have in your possession and submit with the stillbirth certificate either an Acknowledgment of Paternity Affidavit signed by the mother, the natural father, and the legal father

(husband) in the presence of a notary public (three-party affidavit -- all three must sign), or a certified copy of a court order that establishes paternity of this stillborn child; a divorce decree may suffice, depending on content. (Contact **Vital Statistics** if you are unsure if a divorce decree is adequate.)

Note: An Acknowledgment of Paternity Affidavit signed by the mother and the natural father may be used in conjunction with a certified copy of a court order of non-paternity establishing that the husband is not the natural father of this stillborn child yet not establishing who the natural father is; a divorce decree may suffice, depending on content. (Contact **Vital Statistics** if you are unsure if a divorce decree is adequate.)

No father to be listed - If the legal father (husband) is not the natural father, and neither the natural father nor the legal father (husband) will be entered on the stillbirth certificate, you must have in your possession and submit with the stillbirth certificate a certified copy of a court order of non-paternity establishing that the husband is not the natural father of this stillborn child yet not establishing who the natural father is; a divorce decree may suffice, depending on content. (Contact **Vital Statistics** if you are unsure if a divorce decree is adequate).

You must have the properly completed, notarized, original (three-party) paternity affidavit or certified copy of the court order in your possession and file it with the stillbirth certificate. If you have not received the affidavit or court order by the 5th day after delivery, the stillbirth certificate must be submitted with the legal father's (husband's) information listed; the parent(s) will then have to contact **Vital Statistics** to amend paternity.

If a person is biologically old enough to produce a child, he or she is old enough to sign an Acknowledgment of Paternity Affidavit.

(Idaho recognizes common-law marriages established prior to January 1, 1996; treat as married.)

-------- *If mother was **NOT MARRIED** (at delivery, conception, or any time between) refer to the following:*

Mother not married - If the mother was not married at conception, at any time during pregnancy, or at delivery, leave the father's information blank, except as provided below.

Note: If this item (father's name) is left blank, all other items pertaining to the father must also be left blank.

Establishing paternity - The name of the natural father may be entered only if you have in your possession either a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by both the mother and the natural father, or a certified copy of a court order establishing paternity. The paternity affidavit may be completed prior to delivery or after delivery.

You must have the properly completed, notarized, original paternity affidavit or certified copy of

the court order in your possession and file it with the stillbirth certificate. If you have not received the affidavit or court order by the 5th day after delivery, the certificate must be submitted without the father's information listed; the parents will then have to contact **Vital Statistics** to add the natural father.

If a person is biologically old enough to produce a child, he or she is old enough to sign an Acknowledgment of Paternity Affidavit.

-------- *If **NOT KNOWN** if mother married (at delivery, conception, or any time between)* refer to the following:

Not known if mother married -If the marital status of the mother is not known and cannot be determined, the father's name and other information are to be left blank. Notify **Vital Statistics** that the marital status is not known.

Note: The parent(s) will not be able to obtain a copy of the stillbirth certificate until the marital status and paternity issue are resolved with **Vital Statistics**.

10b. DATE OF BIRTH (Mo/Day/Yr) *[FATHER'S]*

.... *Complete only if the father's name is entered in item #10a.*

Enter the complete date of birth of the father - month, day, and four-digit year. Write out in full (January, February, March, etc.) or abbreviate (Jan., Feb., Mar., etc.) the name of the month. Do not use a number to designate the month.

Not known - If any part of the father's date of birth is not known, enter the known information and enter a "?" for the part(s) not known. If the complete date is not known, enter "Unknown".

10c. BIRTHPLACE (State, Territory, or Foreign Country) *[FATHER'S]*

.... *Complete only if the father's name is entered in item #10a.*

Enter the place of birth of the father.

United States - If the father was born in the United States, enter the name of the state or territory. If the state or territory is not known, enter "U.S." only.

Canada - If the father was born in Canada, enter the name of the province and "Canada". If the province is not known, enter "Canada" only.

Foreign - If the father was born in any other foreign country, enter the name of the country. If the specific country is not known, enter "Foreign-unknown".

Not known - If no information is available regarding the place of birth, enter "Unknown".

L O C A L R E G I S T R A R

11a. REGISTRAR'S SIGNATURE

The Local Registrar for the county where the delivery occurred or the stillborn infant was found

signs this item in permanent black or dark blue ink when the certificate is filed. *(The certificate must be complete and acceptable for permanent filing.)*

If an Assistant Local Registrar signs the stillbirth certificate, the Assistant Local Registrar must indicate that he or she is an assistant by including the title of "Assistant" after his or her signature. "Assistant" may be abbreviated as "Assist." or "Asst.".

11b. DATE SIGNED
MM / DD / YYYY

The Local Registrar is to enter the date that he or she signs the stillbirth certificate.

Local Reg. No. [(top right) - unnumbered item]

The Local Registrar is to enter the number he or she has assigned to this stillbirth certificate.

C E R T I F I E R

SIGNATURE(S): I certify that stated information concerning this child is true to the best of my knowledge and belief.

Note: The above statement applies to both signature items in the certifier area, item #12a. – Certifier's Signature and item #13a. – Coroner's Signature.

If there was no attendant at the delivery or if the circumstances suggest that the death of the fetus was due to other than natural causes, the certificate must be referred directly to the coroner who will investigate and sign the stillbirth certificate in item #13a.

Note: The coroner must also sign the stillbirth certificate in item #13a if the person in attendance is not a physician, physician assistant, or advanced practice professional nurse.

The definitions of physician, physician assistant, and advanced practice professional nurse for Vital Statistics purposes as stated in §39-241(12)(13) and (2), Idaho Code, (respectively) are as follows:

> "Physician" means a person legally authorized to practice medicine and surgery, osteopathic medicine, and surgery or osteopathic medicine in this state as defined in section §54-1803, Idaho Code.
>
> "Physician Assistant" means any person who is a graduate of an acceptable training program and who is otherwise qualified to render patient services as defined in section §54-1803, Idaho Code
>
> "Advanced Practice Professional Nurse" means a professional nurse licensed in this state who has gained additional specialized knowledge, skills and experience through a nationally accredited program of study and is authorized to perform advanced nursing practice as defined in section §54-1402, Idaho Code, and includes certified nurse midwives and nurse practitioners.

12a. Certifier's Signature Name (Type or print)

Obtain the signature of the certifier (physician, physician assistant or advanced practice professional nurse) on the line and check the box that applies to the certifier's title.

Note: **The certifier's typed or printed name in 12b must match the certifier's signature in 12a.**

The following applies only when a stillbirth occurs in an institution:

In the absence of the attending physician, physician assistant or advanced practice professional nurse or with his or her approval, the certificate may be completed and signed by:

1) The physician's associate physician,
2) The chief medical officer of the institution in which delivery occurred, or
3) The physician who performed an autopsy on the stillborn fetus, provided such individual has:
   - Access to the medical history of the case, **and**
   - Views the fetus at or after stillbirth.

Certifier's Signature

Obtain the personal signature in permanent black or dark blue ink, of the physician, physician assistant or advanced practice professional nurse. Rubber stamps or other facsimile signatures are not permitted.

The physician, physician assistant or advanced practice professional nurse who signs the stillbirth certificate must not state that he or she is signing "for" another physician, physician assistant or advanced practice professional nurse or the certificate will be rejected.

Note: **If no physician, physician assistant or advanced practice professional nurse was present at the delivery or the circumstances suggest that the stillbirth was due to an external event, the coroner must sign in item #13a.** (If the coroner must sign based on one of these provisions, the certifier information - items #12a-e may be completed but is not required.)

12b. CERTIFIER'S MAILING ADDRESS (Name, Street and Number, City, State, Zip Code)

Enter the complete name and mailing address of the certifier.

12c. CERTIFIER'S LICENSE NUMBER

Enter the state issued medical license number of the certifier.

If the certifier is not a state licensed physician (M.D., D.O., P.A., N.P., or C.N.M.), this item will be left blank.

(Many physicians who work at military hospitals are not state licensed.)

12d. DATE SIGNED
MM / DD / YYYY

The certifier is to enter the date that he or she signs the stillbirth certificate.

12e. DELIVERY ATTENDANT'S NAME AND TITLE

Check the appropriate box to identify the title of the certifier.

Other - If "Other (Specify)" is checked, type or print the title of the certifier.

Note: If the father is the certifier on the stillbirth certificate, list his title as "Father" only if his name is entered in item #10a on the stillbirth certificate. Otherwise, list his title as "Friend" or other appropriate title.

LIST / DEFINITIONS
LM - Licensed Midwife
CM - Certified Midwife
Other (Specify) - (e.g., grandmother, family friend, father, nurse, E.M.T.)

13a. TO BE COMPLETED BY CORONER ONLY: IF NOT ATTENDED BY PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE PROFESSIONAL NURSE OR IF FROM EXTERNAL CAUSES, CORONER'S SIGNATURE REQUIRED
Coroner's Signature -
Name (Type or print)

Cases in which the circumstances suggest that the stillbirth was not due to natural causes or when no physician, physician assistant or advanced practice professional nurse was in attendance at delivery must be referred to the coroner, who is to make an immediate investigation, supply the necessary medical data, and sign the stillbirth certificate.

Coroner's Signature

This item must be personally signed in permanent black or blue ink by the coroner of the county where the delivery occurred or the stillborn infant was found, when a *physician, physician assistant or advanced practice professional nurse was not* present at the delivery *or* when the circumstances suggest that the stillbirth was due to other than natural causes.

Name (Type or print)

Type or print the name of the coroner whose signature is in item #13a.

If this item is blank (not required), item #13b should also be blank.

13b. DATE SIGNED
MM / DD / YYYY

The coroner is to enter the date that he or she signs the stillbirth certificate.

D I S P O S I T I O N

14. METHOD OF DISPOSITION

Check the box corresponding to the method of disposition of the stillborn infant.

Cremation - If the stillborn's body in cremated in this state, "Cremation" should be checked. Cremation is considered to be final disposition on the stillbirth certificate. The method of disposition of the cremated remains should not be marked on the stillbirth certificate.

Donation - If the stillborn's body is donated to a hospital or school for scientific and educational purposes, "Donation" should be checked.

Hospital - If the hospital disposes of the stillborn's body, "Hospital" should be checked. The hospital may dispose of the body of a stillborn infant only if requested to do so by the parent(s).

Note: The hospital cannot dispose of the body of a live born infant, so care must be taken to be certain that the infant did not show any sign of life.

Removal - If the stillborn's body is removed from Idaho for disposition, such as burial or cremation, in another state, the box for "Removal from Idaho" should be checked. (If item #15, Place of Disposition, lists a state other than Idaho, this item must be checked as "Removal from Idaho.) *The box designating the actual disposition such as Burial or Cremation may also be checked.*

Other - If "Other (Specify)" is checked, enter the method of disposition on the line provided (e.g., dissolving, cryogenic storage).

LIST
Burial
Cremation
Hospital disposition
Donation
Removal from Idaho
Other (Specify) ___

15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)

Type or print the name of the cemetery, crematory, or other location of disposition. Also, enter the name of the city, town, or named area and the state where the place of disposition is located.

Cremation - If the stillborn's body is cremated, enter the name and address of the crematory where the cremation is done. Do not enter information about the disposition of the cremated remains, as the cremation is considered to be final disposition.

Donation - If the stillborn's body is donated to a hospital or school for scientific or educational purposes, enter the name and location (city or town and state) of that institution.

Hospital - If the hospital disposes of the stillborn's body, enter the name and address of the hospital. The hospital may dispose of a stillborn infant only if requested to do so by the parent(s).

Note: The hospital cannot dispose of the body of a live born infant, so care must be taken to be certain that the infant did not show any sign of life.

Removal - If the stillborn's body is removed from the state, specify the name and location of the cemetery, crematory, or other place of disposition to which the body is removed. Do not enter the name and location of the out-of-state funeral facility receiving the stillborn infant.

16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

Type or print the name and complete address (street and number, city, state, and zip code) of the funeral facility handling the disposition.

Hospital - If disposition is handled by the hospital, enter the name and address of the hospital. The hospital may dispose of a stillborn infant only if requested to do so by the parent(s).

Note: The hospital cannot dispose of the body of a live born infant, so care must be taken to be certain that the infant did not show any sign of life.

No facility - If the family is handling the disposition and no funeral facility or hospital facility is involved, enter the name and address of the person in charge of the stillborn's body and disposition and who signed the stillbirth certificate in item #17a.

17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH

The funeral service licensee or other person who assumes custody of the body and is responsible for completing the stillbirth certificate must personally sign the stillbirth certificate in permanent black or dark blue ink.

Funeral facility - If a funeral facility is handling the disposition, the mortician must sign the stillbirth certificate.

Hospital - If a hospital handles the disposition, the hospital authority (administrator, chief medical officer, or pathologist) must sign the stillbirth certificate.

No facility - If the family chooses to handle the disposition, the family member who assumes custody of and is responsible for the body must sign the stillbirth certificate.

Note: *Stamps or other types of facsimile signatures are not permitted.*

17b. LICENSE NUMBER (Of licensee)

Enter the license number of the funeral service licensee (i.e., mortician, funeral director) who signed the stillbirth certificate in item #17a.

No funeral facility - If the parent(s) has authorized the hospital to dispose of the stillborn, or the family has chosen to handle the disposition, enter a dash "-" or leave blank.

-- CAUSE/CONDITIONS CONTRIBUTING TO STILLBIRTH --

C A U S E O F S T I L L B I R T H

The items in this section (#18 - #24) are to be completed by the certifying physician, physician assistant, advanced practice professional nurse or coroner.

Physician / Coroner

A simple description of the conditions contributing to the stillborn's death should be entered, rather than a record describing all medical conditions present at death.

Causes of fetal death are diseases, abnormalities, injuries, or poisonings that contributed to the stillbirth. The cause of stillbirth information should be the certifier's best medical opinion.

A condition can be listed as "probable" even if it has not been definitively diagnosed.

Do not abbreviate conditions in this section. Abbreviations and parentheses should be avoided in reporting causes of stillbirth.

Take care to make the entry legible; the stillbirth certificate is a permanent legal record of the delivery of a stillborn child. Use a typewriter with good black ribbon and clean keys, or print legibly using permanent **black** ink. Do not use other colors of ink.

Causes of fetal death on the stillbirth certificate represent a medical opinion that might vary among individual physicians. In signing the stillbirth certificate, the physician, physician assistant, advanced practice professional nurse or coroner certifies that, in his or her opinion, the fetus died of the reported causes of death. The certifier's opinion and confidence in that opinion are based upon his or her training, knowledge of medicine, available medical records, symptoms, diagnostic tests, and available autopsy or histological placental results for the stillborn infant. Even if extensive information is available to the certifier, causes of fetal death may be difficult to determine, so the certifier may indicate uncertainty by qualifying the causes on the stillbirth certificate. The degree of uncertainty may be expressed using such terms as probable, possible, presumed, suspected, etc.

Cause of fetal death is used for medical and epidemiological research on disease etiology and evaluating the effectiveness of diagnostic and therapeutic techniques. It is a measure of health status at local, state, national, and international levels. Cause of stillbirth data is important for surveillance, research, design of public health and medical interventions, and funding decisions for research and development. The stillbirth certificate is a permanent record of an infant's death and is also a legal document.

External Cause or No Physician in Attendance

When a stillborn child is delivered without a physician, physician assistant or advanced practice professional nurse in attendance at the delivery, or when circumstances suggest the stillbirth was due to other than natural causes, the coroner must be notified and he or she must investigate the stillbirth and complete the cause of stillbirth section of the stillbirth certificate.

The definition of physician for Vital Statistics purposes as stated in §39-241(21), Idaho Code, is as follows: “Physician” means a person legally authorized to practice medicine and surgery in this state.

Certifier’s Responsibility

The certifier’s primary responsibility in completing the cause of stillbirth section is to report to the best of his or her knowledge, based upon available information, the initiating condition that most likely began the sequence of events resulting in the death of the fetus, and other contributing causes or conditions. Conditions in the fetus or mother, or of the placenta, cord, or membranes, should be reported if they are believed to have adversely affected the fetus.

Cause of stillbirth should include information provided to the certifier by the pathologist if tissue analysis, autopsy, or another type of postmortem exam was done. If microscopic exams for a stillbirth are still pending at the time the certificate is filed, the additional information should be reported to **Vital Statistics** by the certifier as soon as it is available.

Under Investigation

If the cause of the stillbirth is under investigation, awaiting autopsy or toxicology results, state “Pending Investigation” or “Pending Autopsy”. Upon completion of the investigation, a Supplemental Information for Cause of Stillbirth form, provided by Vital Statistics, should be completed and submitted by the certifier to Vital Statistics, providing the information necessary to complete the stillbirth certificate. (The coroner must be the certifier if no physician, physician assistant or advanced practice professional nurse was in attendance at the delivery or if the circumstances suggest that the stillborn’s death was due to other than natural causes.)

The cause of stillbirth section consists of two parts.

(Initiating cause/condition) - Item #18a
Item #18a is for reporting the single condition that most likely began/initiated the sequence of events resulting in the death of the fetus.

(Other significant causes or conditions) - Item #18b
Item #18b is to include all other diseases or conditions contributing to the death of the fetus that were not reported in item #18a and that did not result in the initiating cause of fetal death. These conditions may be conditions that are triggered by the initiating cause (#18a) or causes that are not among the sequence of events triggered by the initiating cause (#18a).

Report a specific condition in the space most appropriate to the given situation.

Report each disease, abnormality, injury, or poisoning that is believed to have adversely affected the fetus, including maternal conditions. If the medical opinion is that the use of alcohol, tobacco, or other substance by the mother, or a recent injury caused or contributed to the stillbirth, then this condition should be reported.

The initiating cause may result in an etiological or pathological sequence as well as a sequence in which an earlier condition is believed to have prepared the way for a subsequent cause by damage to tissues or impairment of function.

Note: Should additional medical information or autopsy or histological placental findings become available that would change the cause of stillbirth originally reported, the original stillbirth certificate should be amended by the certifying physician or coroner. The certifier should immediately report the revised cause of stillbirth to Vital Statistics.

18a. INITIATING CAUSE/CONDITION

(AMONG THE CHOICES BELOW, PLEASE CHECK OR SPECIFY THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)

Report the initiating cause of the terminal event that explains why the fetus died. This should be the certifier's best medical opinion. Do not report the terminal event.

A specific cause of the fetal death should be reported in this item so there is no ambiguity about the etiology of this case. List only one cause/condition in this item.

LIST

Maternal Conditions/Diseases (Specify) _____

Complications of Placenta, Cord, or 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) _____

- Unknown

18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS

(CHECK AND/OR SPECIFY IN ITEM 18b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)

Report all important diseases or conditions that contributed to the fetal death that were not reported as the initiating cause/condition in item #18a. *No entry is necessary in this item (#18b) if a single cause of fetal death reported in item #18a describes completely the stillborn's cause of death.*

LIST

Maternal Conditions/Diseases (Specify) _____

Complications of Placenta, Cord, or 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) _____

- Unknown

Other General Instructions for completing cause of stillbirth

Do not use abbreviations or parentheses in reporting causes of stillbirth.

In cases of uncertainty, wording such as probable, suspected, or presumed may be placed before the cause.

Always report, if applicable, the fetal injury (e.g., stab wound of mother's abdomen), the trauma, and impairment of function.

If two or more possible sequences resulted in the fetal death, or if two conditions seem to have added together, the certifier should report in item #18a the one that, in his or her opinion, most directly caused death; report in item #18b the other conditions or diseases.

Coroner Referrals

Any external agent or means as cause of stillbirth such as ***Accident*** or ***Trauma*** requires the signature of the coroner as the certifier (pursuant to §39-260, Idaho Code).

When there are questions concerning certain causes of stillbirth [e.g., **Hematoma** (usually indicates a trauma; if natural the terminology used is usually hemorrhage)], contact the Cause of Death Specialist (nosologist), at **Vital Statistics** at: **(208)-334-4991**.

Screen the cause of stillbirth section (especially item #18a); **check for any indication of other than natural cause of stillbirth.** If a stillbirth certificate must be returned to the coroner, it is not necessary, in most cases, to prepare a new certificate.

References

For additional information/instruction on how to complete the medical certification section of the stillbirth certificate, together with examples of properly completed causes of stillbirth, you may refer to:

X State resources.

X NCHS' Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting (available from NCHS, Vital Statistics, or at the following website http://cdc.gov/nchs/data/misc/hb_me.pdf).

***Note*:** Not all information provided from other sources is valid for Idaho.

Examples of properly completed causes of stillbirth statements

The following are examples of properly completed stillbirth certificates:

18a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE CHECK OR SPECIFY THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)	18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (CHECK AND/OR SPECIFY IN ITEM 18b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)
Maternal Conditions/Diseases (Specify) _____	Maternal Conditions/Diseases (Specify) _____
Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord } Chorioamnionitis ☐ Other (Specify) _____	Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis ☐ 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) **SEPSIS**
Other Fetal Conditions/Disorders (Specify) _____	Other Fetal Conditions/Disorders (Specify) _____
☐ Unknown	☐ Unknown

18a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE CHECK OR SPECIFY THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)	18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (CHECK AND/OR SPECIFY IN ITEM 18b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)
Maternal Conditions/Diseases (Specify)_____ ____**INCOMPETENT CERVIX**_____ ☐ Complications of Placenta, Cord, or 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) _____ _____ ☐ Unknown	Maternal Conditions/Diseases (Specify) _____ _____ Complications of Placenta, Cord, or 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)_____ ___**PREMATURITY**_____ ☐ Unknown

18a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE CHECK OR SPECIFY THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)	18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (CHECK AND/OR SPECIFY IN ITEM 18b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)
Maternal Conditions/Diseases (Specify)_____	Maternal Conditions/Diseases(Specify)_____
Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis } Other (Specify) **UMBILICAL CORD ANEURYSM**	Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis } Other (Specify) **CORD ACCIDENT**
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) _____
☐ Unknown _____	☐ Unknown _____

18a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE CHECK OR SPECIFY THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)	18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (CHECK AND/OR SPECIFY IN ITEM 18b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)
Maternal Conditions/Diseases (Specify) _____	Maternal Conditions/Diseases (Specify) _____
Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis ☐ Other (Specify) _____	Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor } Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis ☐ Other (Specify) _____
Other Obstetrical or Pregnancy Complications (Specify) __**OLIGOHYDRAMNIOS**_____	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) _____
☐ Unknown	☐ Unknown

18a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE CHECK OR SPECIFY THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)	18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (CHECK AND/OR SPECIFY IN ITEM 18b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)
Maternal Conditions/Diseases (Specify) _____ _____	Maternal Conditions/Diseases (Specify) _____ **FATAL MOTOR VEHICLE CRASH**
Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis Other (Specify) _____	Complications of Placenta, Cord, or Membranes: ☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis ☐ 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) _____ **ASPHYXIA**	
☐ Unknown	☐ Unknown

Note: The coroner's signature is required on the stillbirth certificate when the stillbirth was from external causes as shown in the example above.

Glossary of terms

Causes of fetal death: The causes of fetal death to be entered on the medical certificate of cause of stillbirth are all those diseases, morbid conditions or injuries which either initiated or contributed to fetal death and the circumstances of the accident or violence which produced any such injuries.

Initiating cause of fetal death: The disease or injury that most likely began the sequence of events resulting in the death of the fetus.

Possible solutions to common problems in stillbirth certification

Uncertainty:

Often several acceptable ways of writing a cause of stillbirth statement exist. Optimally, a certifier will be able to provide a simple description of the process leading to fetal death that is etiologically clear and to be confident that this is correct. Realistically, however, describing the process is sometimes difficult because the certifier is not certain.

In this case, the certifier should think through the causes about which he or she is confident and

what possible etiologies could have resulted in these conditions. The certifier should select the causes that are suspected to have been involved and use words such as “probable” or “presumed” to indicate that the description provided is not completely certain. Causes of death on the stillbirth certificate should not include terms such as prematurity without an explanation of the etiology, because they have little value for public health or medical research. Reporting a cause of stillbirth as unknown should be a last resort.

When a number of conditions or multiple organ/system failure resulted in stillbirth, the certifier should choose a single condition which most likely began the sequence of events resulting in the stillbirth and list the other conditions in #18b of the certification section. “Multiple system failure” could be included as an “other significant cause or condition” but with a specification of the systems involved to ensure that the detailed information is captured. Maternal conditions may have initiated or affected the sequence that resulted in a stillbirth. These maternal conditions should be reported in the cause of stillbirth statement in addition to the fetal causes.

Avoid ambiguity:

At some point, most certifiers will find themselves in the circumstance in which they are unable to provide a simple description of the process of fetal death. In this situation, the certifier should try to provide an initiating condition, qualify the causes about which he or she is uncertain, and be able to explain the certification chosen.

When conditions such as the following are reported, information about the etiology should be reported if possible:

Unknown	Low birth weight
Prematurity	Intrauterine hypoxia
Immaturity	

If the certifier is unable to determine the etiology of a process such as those shown above, the process must be qualified as being of an unknown, undetermined, probable, presumed, or unspecified etiology so it is clear that a distinct etiology was not inadvertently omitted.

19. <u>WEIGHT OF FETUS</u> (Check unit, grams preferred)

□ grams OR □ lb/oz

Enter the weight at time of delivery as recorded in the hospital or delivery attendant’s record, in either grams or pounds and ounces. Check the type of measure used. (The use of grams is preferred.)

Note: If the weight in grams is not available, enter the delivery weight in pounds and ounces. Do not convert from pounds and ounces to grams.

<u>Not known</u> - If the weight at time of delivery is not known (e.g., stillborn infant was found), enter “Unknown”.

However, if the obstetric estimate of gestation is also not known, the weight may be approximated and must be stated to be 350 grams or more in order to show that this fetus does meet the stillbirth definition.

The weight of the fetus is one of two factors used to determine whether this delivery

meets the definition of a stillbirth; the other is gestation.

If the weight is less than 350 grams (12.35 ounces), the gestation (Item #20) will then be the determining factor. If the weight of the fetus is 350 grams (12.35 ounces) or more, a stillbirth certificate must be filed, regardless of gestation.

> *(If the delivery is after 20 weeks, but gestation (fetal development) terminated prior to 20 weeks and the fetal weight is less than 350 grams or 12.35 ounces, a stillbirth certificate cannot be filed.)*

20. OBSTETRIC ESTIMATE OF GESTATION
(completed weeks)

Enter the obstetric estimate of the infant's gestation (fetal development) in completed weeks, based on the delivery attendant's final estimate of gestation. (The estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound.)

Do not complete this item based on the infant's date of delivery and the mother's date of last menstrual period.

The gestation of the fetus is one of two factors used to determine whether this delivery meets the definition of a stillbirth; the other is weight.

If the obstetric estimate of gestation is less than 20 completed weeks, the weight (Item #19) will then be the determining factor. If the obstetric estimate of gestation of the fetus is 20 completed weeks or more, a stillbirth certificate must be filed, regardless of weight.

Not known - If the obstetric estimate of gestation is not known, enter "Unknown". *However, if the weight of the fetus is less than 350 grams or 12.35 ounces, it must be stated that the gestation is 20 completed weeks or more to show that this fetus does meet the stillbirth definition.*

(If the delivery is after 20 weeks, but gestation (fetal development) terminated prior to 20 weeks and the fetal weight is less than 350 grams or 12.35 ounces, a stillbirth certificate cannot be filed.)

21. ESTIMATED TIME OF FETAL DEATH (Check one)

Check the one box that best describes the estimated time the fetus died.

LIST
Dead at first assessment, no labor ongoing
Dead at first assessment, labor ongoing
Died during labor, after first assessment
Unknown time of fetal death

22. WAS AN AUTOPSY PERFORMED?
□ Yes □ No □ Planned

Check the appropriate box to indicate if an autopsy (partial or complete) was performed or is planned to be performed.

Autopsy - Check “Yes” if a partial or complete autopsy was performed.

No Autopsy - Check “No” if an autopsy was not performed and is not planned to be performed.

Autopsy planned - Check “Planned” if an autopsy had not yet been performed but is planned to be performed

23. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?

□ Yes □ No □ Planned

Check the appropriate box to indicate if a histological placental examination was performed or is planned to be performed.

Examination - Check “Yes” if a histological placental examination was performed.

No examination - Check “No” if a histological placental examination was not performed and is not planned to be performed.

Examination planned - Check “Planned” if a histological placental examination had not yet been performed but is planned to be performed

24. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?

□ Yes □ No

Check “Yes” or “No” as to whether results from either an autopsy or histological placental examination were used to help determine the cause of fetal death.

The remaining items are located on the reverse side of the certificate.

DETACH AND COMPLETE REVERSE SIDE

(The following information located on the back of the certificate is for medical and health use only and does not appear on certified copies of the stillbirth certificate.)

Note: *Information on the father should be completed only if the name of the father is entered in items #10a-c.*

MEDICAL AND HEALTH SECTION *Complete Each Item*

25. MOTHER MARRIED? (at delivery, conception, or any time between)

□ Yes □ No

IF “NO”, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED?

□ Yes □ No

Check “Yes” or “No” to indicate if the mother was married at delivery, conception, or any time between.

(Idaho recognizes common-law marriages established prior to January 1, 1996; follow the procedures for Married*.)*

Married - Check "Yes" if the mother was married at the time of delivery, at the time of conception, or at any time during the pregnancy.

A person is legally married, even if separated, until the final divorce papers are signed and filed.

Note: If "Yes", the husband is the legal father and must be listed on the stillbirth certificate as the father unless you have in your possession either a properly completed, notarized, original Acknowledgment of Paternity Affidavit (three-party) signed by the mother, natural father, and legal father (husband), or a certified copy of a court determination of paternity or non-paternity. The affidavit or court order must be filed with the stillbirth certificate.

If a three-party paternity affidavit is completed, the question "If 'No', Has Paternity Acknowledgment Been Signed?", should be checked as "Yes", even though "Yes" is checked for the question "Is Mother Married".

Not married - Check "No" if the mother was not married at the time of delivery, at the time of conception, or at any time during the pregnancy. Also, check "Yes" or "No" to the question on signed paternity acknowledgment.

Note: If "No", the father's information must be left blank unless you have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by both the mother and natural father, or a certified copy of a court determination of paternity.

Not known - Enter a "?" if the marital status of the mother is not known and the information cannot be obtained. The father's information must be left blank. A paternity affidavit will not be accepted if the marital status for the mother is not known.

IF "NO", HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED?

□ Yes □ No

Check "Yes" or "No" to indicate if you have a signed paternity affidavit in hand to send in with the stillbirth certificate.

Paternity affidavits and court determinations of paternity must be filed with the stillbirth certificate.

If a person is biologically old enough to produce a child, he or she is old enough to sign an Acknowledgment of Paternity Affidavit.

Paternity affidavit - Check "Yes" only if you have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by both the mother and natural father. The paternity affidavit is to be filed with the stillbirth certificate. (The natural father will be entered on the stillbirth certificate as the father.)

Three-party affidavit - If the mother was married to someone other than the natural father, check "Yes" only if you have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by the mother, the natural father, and the husband. The three-party paternity affidavit is to be filed with the stillbirth certificate. (The natural father will be entered on the stillbirth certificate as the father.)

Note: In order to be acceptable, the Acknowledgment of Paternity Affidavit must be the current original form provided by **Vital Statistics** with the Rights and Responsibilities printed on the back. The information must be completed in ink or typed. The affidavit must include the full names and signatures of the mother and father (and husband when applicable); both the mother's and father's sections must include the child's date of delivery (or approximate date), the child's place of delivery, and a minimum of the **child's surname**. All required signatures must be individually notarized.

No paternity affidavit - Check "No" if you do not have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit.

Note: The parents may have signed a paternity affidavit at another location prior to the delivery of their child. However, unless you have in your possession and file with the stillbirth certificate the properly completed, notarized, original Acknowledgment of Paternity Affidavit or a certified copy of a court determination of paternity, you must mark "No" and the natural father's name cannot be entered on the stillbirth certificate.

26. PLACE WHERE DELIVERY OCCURRED (Check one)

Check the box that best describes the type of place where the delivery occurred.

Home delivery - If "Home delivery" is checked, also check "Yes" or "No" to indicate if the delivery was planned to be at home.

Planned -- Check "Yes" if the infant was delivered in a home and it was planned to be delivered at home.

Not planned -- Check "No" if the infant was delivered in a home and it was not planned to be delivered at home.

Not known -- If not known whether this was a planned home delivery, enter "?" after the "No" option.

En route - If the delivery occurred on a moving conveyance en route to a facility, check the box for "Other" and specify "En route".

Other - If "Other" is checked, and the delivery did not occur on a moving conveyance en route to a facility, specify the place where the delivery occurred (e.g., fire station, restaurant, store parking lot, pick-up truck, taxi cab).

LIST / DEFINITIONS
Hospital
Freestanding birthing center - No direct physical connection with an operative delivery center

Home delivery - The delivery occurred at a private residence
Planned to deliver at home?
Clinic / Doctor's office
Other (Specify)

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

□ Yes □ No

IF "YES", NAME OF FACILITY MOTHER TRANSFERRED FROM: ____

Check "Yes" or "No" to indicate if the mother was transferred before delivery, from another facility (hospital or freestanding birthing center) for medical indications.

Transfers include hospital to hospital, birth facility to hospital, etc. Transfers do not include home to hospital or home to freestanding birthing center.

Medical transfer - Check "Yes" if the mother was transferred from one facility to another facility for maternal medical or fetal indications before the stillborn child was delivered.

Enter the name of the facility the mother was transferred from, on the line following.

Only facility - Check "No" if this is the only facility the mother was admitted to for delivery.

Other transfer - Check "No" if the mother was transferred for circumstances other than for maternal medical or fetal indications or if she was transferred after delivery.

Home delivery - Check "No" if the mother was transferred from home.

-- IF "YES", NAME OF FACILITY MOTHER TRANSFERRED FROM:

If "Yes" is checked, enter on the line provided the name of the facility that the mother was transferred from for maternal medical or fetal indications before the stillborn child was delivered.

Not known - If the name of the facility is not known, enter "Unknown".

28. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

Check the category that best describes the highest degree or level of school completed by the mother at the time of delivery. An entry should be made in only one box.

Not known - If the education of the mother is not known, enter "Unknown" in the area above the first box.

LIST
8th grade or less (includes none)
9th-12th grade, but no diploma
High school graduate or GED completed
Some college credit, but no degree
Associate degree (e.g., A.A., A.S.)
Bachelor's degree (e.g., A.B., B.A., B.S.)
Master's degree (e.g., M.A., M.B.A., M.Ed, M.Eng, M.S., M.S.W.)

Doctorate or professional degree (e.g., D.D.S., D.O., D.V.M., Ed.D, J.D., LL.B, M.D., Ph.D)

29. MOTHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/ Latina)

Check "No" or the appropriate "Yes" box(es). The entry should reflect the response of the informant.

Not Hispanic	- If the mother is not of Hispanic origin, check the box which indicates *No, not Spanish/Hispanic/Latina*.
Of Hispanic origin	- If the mother is identified as Spanish/Hispanic/Latina, check the appropriate "Yes" box(es); if "other Spanish/Hispanic/Latina," specify the origin.
Multiple Hispanic origins	- Multiple origins can be checked, such as Mexican, Puerto Rican, and Cuban.
Hispanic origin not known	- If the mother is of Hispanic origin, but the specific origin is not known, check "Yes, other Spanish/Hispanic/Latina" and enter "Unknown" or "?" on the specify line.
Not known	- If it is not known if the mother is of Hispanic origin, enter "Unknown" in the area above the first box.

For the purposes of this item, "Hispanic" refers to people whose origins are from Spain, Mexico, or the Spanish-speaking countries of Central or South America.

LIST
No, not Spanish/Hispanic/Latina
Yes, Mexican, Mexican American, Chicana
Yes, Puerto Rican
Yes, Cuban
Yes, other Spanish/Hispanic/Latina (Specify)

30. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

Enter the race(s) of the mother as indicated by the informant.

Mixed race	- If the mother is of mixed race or national origin, enter all races indicated, such as Japanese, Hawaiian, and American Indian.
Tribe	- For American Indian or Alaska Native, enter the name of the enrolled or principal tribe on the line provided.
Specify	- If the checked box(es) indicates "(Specify)", enter the race(s) on the line provided.
Not known	- If the race of the mother is not known, enter "Unknown" in the area above the

first box.

LIST
White
Black or African American
American Indian or Alaska Native (Name of the enrolled or principal tribe)
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian (Specify)
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander (Specify)
Other (Specify)

31. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

.... *Complete only if the father's name is entered in item #10a.*

Check the category that best describes the highest degree or level of school completed. An entry should be made in only one box.

Not known - If the education of the father is not known, enter "Unknown" in the area above the first box.

LIST
8th grade or less (includes none)
9th-12th grade, but no diploma
High school graduate or GED completed
Some college credit, but no degree
Associate degree (e.g., A.A., A.S.)
Bachelor's degree (e.g., A.B., B.A., B.S.)
Master's degree (e.g., M.A., M.B.A., M.Ed, M.Eng, M.S., M.S.W.)
Doctorate or professional degree (e.g., D.D.S., D.O., D.V.M., Ed.D, J.D., L.LB, M.D., Ph.D)

32. FATHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)

.... *Complete only if the father is entered in item #10a.*

Check "No" or the appropriate "Yes" box(es). The entry should reflect the response of the informant.

Not Hispanic - If the father is not of Hispanic origin, check the first box, which indicates *No, not Spanish/Hispanic/Latino*.

Of Hispanic origin - If the father is identified as Spanish/Hispanic/Latino, check the

appropriate “Yes” box(es); if “other” Spanish/Hispanic/Latino, specify the origin.

Multiple Hispanic origins - Multiple origins can be checked, such as Mexican, Puerto Rican, and Cuban.

Hispanic origin not known - If the father is of Hispanic origin, but the specific origin is not known, check “Yes, other Spanish/Hispanic/Latino” and enter “Unknown” or “?” on the specify line.

Not known - If it is not known if the father is of Hispanic origin, enter “Unknown” in the area above the first box.

For the purposes of this item, “Hispanic” refers to people whose origins are from Spain, Mexico, or the Spanish-speaking countries of Central or South America.

LIST
No, not Spanish/Hispanic/Latino
Yes, Mexican, Mexican American, Chicano
Yes, Puerto Rican
Yes, Cuban
Yes, other Spanish/Hispanic/Latino (Specify)

33. FATHER’S RACE (Check one or more races to indicate what the father considers himself to be)

.... Complete only if the father’s name is entered in item #10a.

Enter the race(s) of the father as indicated by the informant.

Mixed race - If the father is of mixed race or national origin, enter all races indicated, such as Japanese, Hawaiian, and American Indian.

Tribe - For American Indian or Alaska Native, enter the name of the enrolled or principal tribe on the line provided.

Specify - If the checked box(es) indicates “(Specify)”, enter the race(s) on the line provided.

Not known - If the race of the father is not known, enter “Unknown” in the space above the first box.

LIST
White
Black or African American
American Indian or Alaska Native (Name of the enrolled or principal tribe) ____
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese

Other Asian (Specify) ____
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander (Specify) ____
Other (Specify) ____

34a. DATE OF FIRST PRENATAL CARE VISIT
MM / DD / YYYY □ No prenatal care

Enter the date (month, day, year) the mother first received an examination and/or counseling from a physician, other licensed health care provider, or midwife as part of an ongoing program of care for this pregnancy.

No prenatal care - If no prenatal care was received, check the box "No prenatal care".

Not known - If any part of the date is not known, enter the known information and enter a "?" for the part(s) not known.

34b. DATE OF LAST PRENATAL CARE VISIT
MM / DD / YYYY □ No prenatal care

Enter the date (month, day, year) of the mother's last recorded prenatal visit to a physician, other licensed health care provider, or midwife.

No prenatal care - If no prenatal care was received, check the box "No prenatal care".

Not known - If any part of the date is not known, enter the known information and enter a "?" for the part(s) not known.

35. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
(IF NONE, ENTER "0")

Enter the total number of recorded visits made by the mother for medical supervision of the pregnancy by a physician, other licensed health care provider, or midwife.

No prenatal visits - If no prenatal care was received, enter "0". The "No prenatal care" box should be checked in items #28a and #28b.

Not known - If the number of prenatal visits is unknown, enter "Unknown".

36. MOTHER'S HEIGHT
(feet/inches)

Enter the height of the mother in feet and inches. Enter whole inches only; drop fractions of inches - do not "round up".

37. MOTHER'S PREPREGNANCY WEIGHT
(pounds)

Enter the weight (in pounds) of the mother prior to this pregnancy. Enter whole pounds only; drop fractions or ounces - do not "round up".

Not known - If the mother's pre-pregnancy weight is not known, enter "Unknown".

38. MOTHER'S WEIGHT AT DELIVERY
(pounds)

Enter the weight (in pounds) of the mother at the time of delivery. Enter whole pounds only; drop fractions or ounces - do not "round up".

Not known - If the mother's weight at delivery is not known, enter "Unknown".

39. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?
□ Yes □ No

Enter "Yes" or "No" to indicate if the mother got WIC food for herself at any time during this pregnancy.

Not known - If it is not known if the mother got WIC food for herself at any time during this pregnancy, enter "Unknown" in the space after the "No" option.

MEDICAL AND HEALTH SECTION *Complete Each Item*

PREGNANCY HISTORY (Complete each section)

Include all *previous* pregnancies or deliveries to this mother. For multiple births/deliveries, include the information for the previous birth(s)/loss(es) of this same pregnancy. Do not include children by adoption. Do not include this stillborn child.

- - - - - - PREVIOUS LIVE BIRTHS
Complete items 40a-40c

40a. Now living
Number ___
□ None

Enter the number of children who were born alive to this mother *before* this stillborn child was delivered, who were still living at the time of this delivery.

None living - Check "None" if this is the first delivery to this mother or if all previous children were dead at the time this stillborn child was delivered.

Note: Include all live born infants in previous deliveries who are still living, and if this was a multiple delivery, include all live born infants who preceded this child in this delivery who were still alive when this stillborn child was delivered.

40b. Now Dead
Number ___
□ None

Enter the number of children who were born alive to this mother *before* this stillborn child was delivered, who were no longer living at the time of this stillborn child's delivery.

None dead - Check “None” if this is the first delivery to this mother or if all previous children were still living at the time this stillborn child was delivered.

Note: Include all live born infants in previous deliveries who were no longer living at the time of delivery of this stillborn child, and if this was a multiple delivery, include all live born infants who preceded this stillborn child in this delivery who were no longer living when this stillborn child was delivered.

40c. DATE OF LAST LIVE BIRTH
MM / YYYY

Enter the date of birth (month, year) of the *last (previous) child born alive* to this mother if applicable.

Not known - If any part of the date is not known, enter the known information and enter a “?” for the part(s) not known.

None - If this is the first delivery to this mother (item #40a and item #40b are checked “None”), this item will be blank.

- - - - - - OTHER PREGNANCY OUTCOMES
(spontaneous or induced losses or ectopic pregnancies)
Complete items 41a-41b

41a. Other Outcomes (Do not include this fetus)
Number ___
□None

Enter the total number of fetuses of any gestational age that were *not* delivered alive. Include all previous pregnancy losses that resulted in other than a live birth.

No other outcomes - Check “None” if this is the first pregnancy for this mother or if all previous pregnancies resulted in live born infants.

Note: Include all losses from previous pregnancies, and if this was a multiple delivery, include all losses that preceded this stillborn child in this delivery. Do not include this stillborn child.

41b. DATE OF LAST OTHER PREGNANCY OUTCOME
MM / YYYY

Enter the date of delivery (month, year) of the last spontaneous or induced loss or ectopic pregnancy, regardless of the length of gestation, if applicable.

Not known - If any part of the date is not known, enter the known information and enter a “?” for the part(s) not known.

None - If the mother had no previous pregnancy losses (item #41a is checked “None”), this item will be blank.

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:

Three months before pregnancy
First three months of pregnancy
Second three months of pregnancy
Last three months of pregnancy

Enter the average number of cigarettes or the average number of packs of cigarettes smoked for each of the four time periods listed.

Both given - If both the number of cigarettes and the number of packs are listed on the worksheet, enter only the number of cigarettes.

Range - If a range is given on the worksheet, enter only the highest number.

43. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY

Check the box that best describes the principal source of payment for this delivery.

Other - If "Other" is checked, specify the payer.
Not known - If the principal source of payment is not known, enter "Unknown" in the area above the first box.

LIST / DEFINITIONS

Private Insurance	- Blue Cross/Blue Shield, Aetna, etc.
Medicaid	- Medicaid program or comparable state program
Self-pay	- No third party identified
Indian Health Service	
CHAMPUS/TRICARE	
Other government (federal, state, local)	
Other	- Third party to pay - not listed above
None	- No delivery charges to pay

44. DATE LAST NORMAL MENSES BEGAN

MM / DD / YYYY

Enter the exact date (month, day, and year) that the last normal menstrual period began.

Part known - Enter the known part(s) of the date and enter a "?" for any part of the date not known.

Not known - If no parts of the date are known, enter "Unknown".

45. WAS SYPHILIS SEROLOGY PERFORMED FOR THIS PREGNANCY?

□ Yes □ No □ Refused

Check the appropriate box to indicate if a syphilis serology test was done for the infant's mother for this pregnancy.

Not done - Check "No" if it was not done, but not refused.

Refused - Check “Refused” if the test was not done because it was refused for any reason, including religious objection.

46. METHOD OF DELIVERY

(The physical process by which the complete delivery of the fetus was affected.)

Complete every section: A, B, C, D, and E.

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

(Obstetric forceps were applied to the fetal head in an unsuccessful attempt at vaginal delivery.)

Check “Yes” or “No” to indicate if delivery with forceps was attempted but was not successful.

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

(Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)

Check “Yes” or “No” to indicate if delivery with vacuum extraction was attempted but was not successful.

C. Fetal presentation at delivery (Check one)

Check the appropriate box that describes the fetal presentation at the time of delivery.

LIST / DEFINITIONS

Cephalic	- Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP) (face, brow, sinciput, mentum - chin)
Breech	- Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech (buttocks, sacrum)
Other	- Any other presentation not listed above, including shoulder, transverse lie, funis, compound

D. Final route and method of delivery (Check one)

Check the final route and method of delivery for this stillbirth.

Cesarean - If “Cesarean” is checked, also check “Yes” or “No” to indicate if a trial of labor was attempted.

Enter “Unknown” after the “No” option if not known whether a trial of labor was attempted.

LIST / DEFINITIONS

Vaginal / Spontaneous	- Delivery of the entire fetus through the vagina by the natural force of labor, with or without manual assistance from the delivery attendant
Vaginal / Forceps	- Delivery of the entire fetus through the vagina by application of obstetrical forceps to the fetal head
Vaginal / Vacuum	- Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head

Cesarean - Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls

If cesarean, was a trial of labor attempted? □ Yes □ No . . . .

Yes Labor was allowed, augmented, or induced with plans for a vaginal delivery

E. Hysterotomy/Hysterectomy

□ Yes □ No

Check "Yes" or "No" to indicate if a hysterotomy or hysterectomy was performed which affected the complete delivery of the fetus.

LIST / DEFINITIONS

Hysterotomy - Incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally

Hysterectomy - Surgical removal of the uterus. May be performed abdominally or vaginally

47. PLURALITY (single, twin, triplet, etc.)
(Specify)

Specify the delivery as single, twin, triplet, quadruplet, etc., based upon the number of fetuses (live or dead) delivered at any time in this pregnancy, regardless of gestational age.

Reabsorbed fetuses - "Reabsorbed" fetuses (those that are not delivered, expulsed, or extracted from the mother) should not be counted.

When a plural delivery occurs, prepare and file a separate certificate of live birth or stillbirth for each child or fetus as applicable. *(Make sure you have accounted for each one of the birth set with* ***Vital Statistics****.)*

48. IF NOT SINGLE BIRTH (born first, second, third, etc.)
(Specify)

Specify the order in which this stillborn child was delivered -- first, second, etc. (Include all live births and all fetal deaths from this pregnancy.)

Single delivery - If this is a single delivery, leave the item blank.

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

Check all boxes that apply to the risk factors of the mother during this pregnancy.

Diabetes - If diabetes is present, check either pre-pregnancy or gestational diabetes. Do not check both.

Hypertension - If hypertension is present, check either pre-pregnancy hypertension, gestational hypertension, or eclampsia. If eclampsia is present, one type of hypertension may also be checked (either pre-pregnancy or gestational).

Previous cesarean - If the mother has had a cesarean delivery in a previous pregnancy, indicate the number of previous cesarean deliveries she has had.

None / Not listed - If the mother has none of the risk factors identified in this list, check "None of the above".

LIST / DEFINITIONS

Diabetes: - Glucose intolerance requiring treatment
--Pre-pregnancy (diagnosis prior to this pregnancy)
--Gestational (diagnosis during this pregnancy)

Hypertension: - Elevation of blood pressure above normal for age, gender, and physiological condition
--Pre-pregnancy (chronic) - diagnosis prior to this pregnancy
--Gestational (PIH, preeclampsia) - Diagnosis during this pregnancy (PIH = Pregnancy-induced hypertension)
--Eclampsia - Hypertension with proteinuria with generalized seizures or coma. May include pathologic edema. If eclampsia is present, one type of hypertension (either gestational or chronic) may be checked.

Previous preterm birth - History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation

Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes:
-- Perinatal death (including fetal and neonatal deaths)
-- Small for gestational age
-- Intrauterine-growth-restricted birth

Pregnancy resulted from infertility treatment
- Any assisted reproduction treatment used to initiate the pregnancy.
--Fertility enhancing drugs, artificial insemination or intrauterine insemination - Any fertility enhancing drugs (e.g., Clomid, Pergonal), artificial insemination or intrauterine insemination used to initiate the pregnancy.
--Assisted reproductive technology -Any assisted reproductive technology (ART/technical procedures (e.g., IVF, GIFT, ZIFT)) used to initiate the pregnancy

Mother had a previous cesarean delivery
- Previous operative delivery by extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.

If yes, how many? ___

None of the above

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

Check all boxes that apply to infections that were present and/or were treated during this

pregnancy.

(Include infections present at the time of pregnancy diagnosis or confirmed diagnosis during the pregnancy, with or without documentation of treatment. Documentation of treatment is adequate if a definitive diagnosis is not present in the available record.)

Other infection - If an infection was present and/or treated during this pregnancy that is not identified in the list, check "Other" and specify the infection(s) on the line provided.

No infection - If no infections were present and/or treated during this pregnancy, check "None".

LIST / DEFINITIONS

Gonorrhea	- A positive test/culture for *Neisseria gonorrhoeae*.
Syphilis - (Also called lues)	- A positive test for *Treponema pallidum*
HIV Infection	- A positive test for human immunodeficiency virus (HIV)
Herpes Simplex Virus - (HSV)	- A positive test for the herpes simplex virus
Chlamydia	- A positive test for *Chlamydia trachomatis*
Listeria - (LM)	- A positive test for *Listeria monocytogenes*
Group B Streptococcus - (GBS)	- A positive test for *Streptococcus agalactiae* or group B streptococcus
Cytomegalovirus - (CMV)	- A positive test for *Cytomegalovirus*
Parvovirus - (B19)	- A positive test for Parvovirus B19
Toxoplasmosis - (Toxo)	- A positive test for *Toxoplasma gondii*
Hepatitis B - (HBV, serum hepatitis)	- A positive test for the hepatitis B virus
Hepatitis C - (Non A, non B hepatitis, HCV)	- A positive test for the hepatitis C virus
Other (Specify)	
None	

51. MATERNAL MORBIDITY (complications associated with labor and delivery)
(Check all that apply)

Check all serious medical complications experienced by the mother, associated with this labor and delivery.

None / Not listed - If none of the complications identified in this list pertain to this labor and delivery, check "None of the above".

LIST / DEFINITIONS

Maternal transfusion	- Includes infusion of whole blood or packed red blood cells associated with labor and delivery
Third or fourth degree perineal laceration	- 3º laceration extends completely through the perineal skin, vaginal mucosa, perineal body, and anal sphincter; 4º laceration is all of the above with extension through the rectal mucosa
Ruptured uterus	- Tearing of the uterine wall
Unplanned hysterectomy	- Surgical removal of the uterus that was not planned prior to the mother's admission; includes an anticipated, but not definitively planned, hysterectomy
Admission to intensive care unit	- Any admission, planned or unplanned, of the mother to a

	facility or unit designated as providing intensive care (ICU - Intensive Care Unit, MICU - Medical Intensive Care Unit, SICU - Surgical Intensive Care Unit)
Unplanned operating room procedure following delivery	- Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery; *excludes* postpartum tubal ligations
None of the above	

52. <u>CONGENITAL ANOMALIES OF FETUS</u> (Check all that apply)

Check all congenital anomalies of the stillborn child that apply. Include all malformations of the stillborn diagnosed prenatally or after delivery. Do not include birth injuries.

Down syndrome	- Check the appropriate box if a diagnosis of Down syndrome, Trisomy 21, is confirmed or pending.
Other chromosomal disorder	- Check the appropriate box if a diagnosis of a suspected chromosomal disorder is confirmed or pending, other than Down syndrome.
<u>None / Not listed</u>	- If the stillborn child has none of the anomalies identified in this list, check “None of the above”.

<u>LIST / DEFINITIONS</u>

Anencephaly	- Partial or complete absence of the brain and skull; also called anencephalus, acrania, or absent brain; includes craniorachischisis (anencephaly with a contiguous spine defect)
Meningomyelocele/Spina bifida	- Meningomyelocele - herniation of meninges and spinal cord tissue; also includes meningocele (herniation of meninges without spinal cord tissue) - Spina bifida - herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges) - Both open and closed (covered with skin) lesions should be included
Cyanotic congenital heart disease	- Congenital heart defects that cause cyanosis
Congenital diaphragmatic hernia	- Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity
Omphalocele	- A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis [see below]), although this sac may rupture. Also called exomphalos. Does not include umbilical hernia (completely covered by skin)

Gastroschisis	- An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. (Differentiated from omphalocele by the location of the defect and the absence of a protective membrane)
Limb reduction defect (excluding congenital amputation and dwarfing syndromes)	- Complete or partial absence of a portion of extremity, secondary to failure to develop; excludes congenital amputation and dwarfing syndromes
Cleft lip with or without cleft palate	- Incomplete closure of the lip; may be unilateral, bilateral, or median
Cleft palate alone	- Incomplete fusion of the palatal shelves; may be limited to the soft palate, or may extend into the hard palate. *(Cleft palate in the presence of cleft lip should be included in ˜Cleft lip with or without cleft palate˜)*
Down syndrome	- Trisomy 21, a chromosomal disorder --Karyotype Confirmed --Karyotype Pending
Suspected other chromosomal disorder	- Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure; this category excludes Down syndrome --Karyotype Confirmed --Karyotype Pending
Hypospadias	- Incomplete closure of the male urethra, resulting in the urethral meatus opening on the ventral surface of the penis. Includes: -- First degree (on the glans ventral to the tip) -- Second degree (in the coronal sulcus) -- Third degree (on the penile shaft)
Other (Specify)	- Any other congenital anomalies of the fetus not listed above
None of the above	

PATERNITY AFFIDAVIT

If the original completed paternity affidavit or a certified copy of the court determination of paternity or non-paternity is not in the possession of the person completing the stillbirth certificate, the certificate must be filed without the natural father's information. The parents will then need to work with **Vital Statistics**.

BLANK ITEMS

All items must be completed or accounted for; blank items not accounted for will be queried or the certificate may be returned to the mortician or certifier for completion as applicable.

MEDICAL AND HEALTH INFORMATION REFUSED

The medical and health use information is legally required. If the informant refuses to provide

information to complete the items in these sections of the stillbirth certificate please call, **Vital Statistics at (208) 334-5986, Dan Irwin, Field Coordinator or (208) 334-5984, Patricia Ross, Registration Supervisor.** However, certification is not possible without some of these items, such as mother's marital status and paternity acknowledgment.

AUTHORIZATION FOR FINAL DISPOSITION-TRANSIT PERMIT

An Authorization for Final Disposition (yellow; page 2) must accompany the stillborn fetus to the place of final disposition.

The mortician or person acting as such who first assumes possession of the stillborn fetus must obtain all authorizations for final disposition prior to final disposal or removal of the stillborn fetus from Idaho.

If the stillborn fetus is to transported out-of-state the Authorization for Final Disposition must be signed by the person responsible for certifying the cause of the stillbirth.

If the coroner is the person responsible for certifying the stillbirth certificate they must also sign the Authorization for Final Disposition.

If the stillborn fetus is to be cremated the Authorization for Final Disposition must be signed by the person responsible for certifying the cause of the stillbirth. An **ADDITIONAL** authorization to allow the procedure must also be obtained from the coroner prior to the cremation of the remains.

If the stillborn fetus is to be buried or donated within the state of Idaho and the cause of stillbirth was certified by a physician, physician assistant, or advanced practice professional nurse, only the mortician's signature is necessary for final disposition.

The hospital may dispose of the stillborn fetus at the request of the parents unless the coroner is responsible for signing the certificate of stillbirth.

When used as a transit permit for transportation by a common carrier, the permit must be attached to the shipping case.

When used as a permit for cremation, the crematory authority must retain the permit as a record of approved disposal of the remains. A photocopy may be made for a cemetery sexton who requires the authorization to bury cremated remains.

24 HOUR REPORT OF STILLBIRTH

A sample of the 24 Hour Report of Stillbirth is available online at www.vitalrecords.dhw.idaho.gov**.** It is the third copy of the multi-part Certificate of Stillbirth and should be sent to the Local Registrar within 24 hours.

Part three (pink paper)--Report of Death is to be sent by the mortician or person acting as such to the Local Registrar of the district in which the stillbirth occurred or the stillborn fetus was found within 24 hours after the mortician takes responsibility for the stillborn fetus. The mortician needs to complete the name of the deceased, date and place of delivery, and their signature and funeral facility address, then forward immediately to the Local Registrar.

The Local Registrar should use this form as a check on receiving a completed certificate of stillbirth. If a completed stillbirth certificate for a stillborn fetus named on a Report of Stillbirth is not received by the Local Registrar within five (5) days, the Local Registrar should contact the mortician. A 24 Hour Report of Stillbirth and a completed stillbirth certificate must be received by the Local Registrar for each stillbirth or stillborn fetus found within their registration district.

TRANSMITTAL

The Local Registrar should forward (as legally required) all properly completed original Certificates of Stillbirth to **Vital Statistics** immediately with a transmittal report form. *Local issuance sites may hold the certificate up to five (5) working days*. (A copy of the transmittal report form is available at Vital Records and Health Statistics.)

Each certificate should be screened, numbered, signed, and dated by the Local Registrar before being mailed to **Vital Statistics** in the preaddressed, postage-paid envelopes supplied for that purpose. It is extremely important that all stillbirth certificates reach **Vital Statistics** promptly in order that requests for copies for insurance and other benefits can be processed quickly. It is also important, however, that the certificates are complete and accurate when they are received by **Vital Statistics** so that further delay is avoided.

A completed transmittal report form indicating the number of birth, death, and stillbirth certificates being sent should accompany each batch of certificates sent to **Vital Statistics**.

Birth, death, and stillbirth certificates must be listed on separate transmittal forms.

When a new year begins, watch the dates of stillbirth carefully, the old year stillbirths must be listed on separate transmittal forms than the new year stillbirths.