DATE FILED BY STATE REGISTRAR: _____

State of Idaho

CERTIFICATE OF STILLBIRTH/MISCARRIAGE

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR WITH THE DEPARTMENT OF HEALTH AND WELFARE RAISED SEAL, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS STILLBIRTH/MISCARRIAGE UNDER §39-241(4) AND §39-274, IDAHO CODE

STATE FILE NO. _____

STILLBORN/ MISCARRIED

1. NAME OF STILLBORN/MISCARRIED (First, Middle, Last, Suffix)	2. TIME OF DELIVERY (24hr)	3. SEX	4. DATE OF DELIVERY (Mo/Day/Yr)

5. FACILITY NAME (If not facility, give street and number)	6. CITY, TOWN, OR LOCATION OF DELIVERY	7. COUNTY OF DELIVERY

MOTHER

TYPE/PRINT IN PERMANENT BLACK INK

FOR INSTRUCTIONS SEE HANDBOOK

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	8b. DATE OF BIRTH (Mo/Day/Yr)
8c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)	**8d. BIRTHPLACE** (State, Territory, or Foreign Country)

9a. RESIDENCE OF MOTHER - STATE	9b. COUNTY	9c. CITY, TOWN, OR LOCATION

9d. STREET AND NUMBER	9e. APT. NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS?
			☐ Yes ☐ No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	10b. DATE OF BIRTH (Mo/Day/Yr)	10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11a. CERTIFIER OF EVENT (Check only one, based on official capacity for this certificate)

☐ PHYSICIAN ☐ PHYSICIAN ASSISTANT ☐ ADVANCED PRACTICE REGISTERED NURSE

To the best of my knowledge, the event occurred at the time, date, and place, and due to the ***natural*** cause(s) / manner stated.

Certifier's Signature ► _____

11c. CERTIFIER'S LICENSE NUMBER

11d. DATE SIGNED ____/____/____ MM DD YYYY

11b. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print)	11e. DELIVERY ATTENDANT'S NAME AND TITLE
	NAME _____
	TITLE ☐ LM ☐ CM ☐ Other (Specify) _____

CORONER

12a. TO BE COMPLETED BY CORONER ONLY (STILLBIRTH ONLY): IF NOT ATTENDED BY PHYSICIAN, PHYSICIAN ASSISTANT, OR ADVANCED PRACTICE REGISTERED NURSE OR IF FROM EXTERNAL CAUSES, CORONER'S SIGNATURE REQUIRED

On the basis of examination and/or investigation, in my opinion, stillbirth occurred at the time, date, and place, and due to the cause(s) and manner stated.

Coroner's Signature ► _____

Name (Type or print) _____

12b. DATE SIGNED ____/____/____ MM DD YYYY

DISPOSITION

13. METHOD OF DISPOSITION	14. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)	15. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY
☐ Burial ☐ Cremation ☐ Hospital disposition ☐ Donation ☐ Removal from Idaho ☐ Other (Specify) _____		

16a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	16b. LICENSE NUMBER (of licensee)
►	

ADMINISTRATIVE USE ONLY

17. IS MOTHER MARRIED? (at delivery, conception, or any time between ☐ Yes ☐ No

IF "NO", HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? ☐ Yes ☐ No

18. PLACE WHERE DELIVERY OCCURRED (Check one)

☐ Hospital ☐ Home delivery
☐ Freestanding birthing center Planned to deliver at home? ☐ Yes ☐ No
☐ Clinic/Doctor's Office
☐ Other (Specify) _____

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

1 ☐ 8th grade or less (includes none)
2 ☐ 9th - 12th grade, but no diploma
3 ☐ High school graduate or GED completed
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (eg, AA, AS)
6 ☐ Bachelor's degree (eg, AB, BA, BS)
7 ☐ Master's degree (eg, MA, MBA, MEd, Meng, MS, MSW)
8 ☐ Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)

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

0 ☐ No, not Spanish/Hispanic/Latina
1 ☐ Yes, Mexican, Mexican American, Chicana
2 ☐ Yes, Puerto Rican
3 ☐ Yes, Cuban
4 ☐ Yes, other Spanish/Hispanic/Latina
(Specify)_____

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

01 ☐ White
02 ☐ Black or African American
03 ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
04 ☐ Asian Indian
05 ☐ Chinese
06 ☐ Filipino
07 ☐ Japanese
08 ☐ Korean
09 ☐ Vietnamese
10 ☐ Other Asian (Specify) _____
11 ☐ Native Hawaiian
12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (Specify) _____
15 ☐ Other (Specify) _____

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

1 ☐ 8th grade or less (includes none)
2 ☐ 9th - 12th grade, but no diploma
3 ☐ High school graduate or GED completed
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (eg, AA, AS)
6 ☐ Bachelor's degree (eg, AB, BA, BS)
7 ☐ Master's degree (eg, MA, MBA, MEd, Meng, MS, MSW)
8 ☐ Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)

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

0 ☐ No, not Spanish/Hispanic/Latino
1 ☐ Yes, Mexican, Mexican American, Chicano
2 ☐ Yes, Puerto Rican
3 ☐ Yes, Cuban
4 ☐ Yes, other Spanish/Hispanic/Latino
(Specify)_____

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

01 ☐ White
02 ☐ Black or African American
03 ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
04 ☐ Asian Indian
05 ☐ Chinese
06 ☐ Filipino
07 ☐ Japanese
08 ☐ Korean
09 ☐ Vietnamese
10 ☐ Other Asian (Specify) _____
11 ☐ Native Hawaiian
12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (Specify) _____
15 ☐ Other (Specify) _____

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COMPLETE REVERSE SIDE

MEDICAL AND HEALTH SECTION Complete Each Item

25. WEIGHT OF FETUS (Check unit, grams preferred)
☐ grams
OR _____
☐ lb/oz

26. OBSTETRIC ESTIMATE OF GESTATION
_____ (completed weeks)

27. ESTIMATED TIME OF FETAL DEATH (Check one)
☐ Dead at first assessment, no labor ongoing
☐ Dead at first assessment, labor ongoing
☐ Died during labor, after first assessment
☐ Unknown time of fetal death

28. WAS AN AUTOPSY PERFORMED?
☐ Yes ☐ No ☐ Planned

29. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?
☐ Yes ☐ No ☐ Planned

30. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?
☐ Yes ☐ No

31. WAS MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No

IF "YES" NAME OF FACILITY MOTHER TRANSFERRED FROM:

32a. INITIATING CAUSE/CONDITION
(AMONG THE CHOICES BELOW, PLEASE CHECK/SPECIFY THE ONE WITH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)

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

32b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
(CHECK AND/OR SPECIFY IN ITEM 25b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH OF THE FETUS)

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

33a. DATE OF FIRST PRENATAL CARE VISIT
____/____/_____ ☐ No prenatal care
MM DD YYYY

33b. DATE OF LAST PRENATAL CARE VISIT
____/____/_____ ☐ No prenatal care
MM DD YYYY

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

35. MOTHER'S HEIGHT
_____ (feet/inches)

36. MOTHER'S PREPREGNANCY WEIGHT
_____ (pounds)

37. MOTHER'S WEIGHT AT DELIVERY
_____ (pounds)

38. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?
☐ Yes ☐ No

MEDICAL AND HEALTH SECTION Complete Each Item

PREGNANCY HISTORY (Complete each section)

PREVIOUS LIVE BIRTHS (report live births and their current status by completing items 39a - 39c)

39a. Now Living
Number _____
☐ None

39b. Now Dead
Number _____
☐ None

OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)
Complete items 40a - 40b

40a. Other Outcomes (Do not include this fetus)
Number _____
☐ None

39c. DATE OF LAST LIVE BIRTH
____/_____
MM YYYY

40b. DATE OF LAST OTHER PREGNANCY OUTCOME
____/_____
MM YYYY

41. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. (IF NONE, ENTER "0")

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

	# OF CIGARETTES	# OF PACKS
Three months before pregnancy	_____ OR	_____
First three months of pregnancy	_____ OR	_____
Second three months of pregnancy	_____ OR	_____
Last three months of pregnancy	_____ OR	_____

42. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
1 ☐ Private Insurance
2 ☐ Medicaid
3 ☐ Self-pay
4 ☐ Indian Health Service
5 ☐ CHAMPUS/TRICARE
6 ☐ Other government (federal, state, local)
8 ☐ Other
0 ☐ None

43. DATE LAST NORMAL MENSES BEGAN
____/____/_____
MM DD YYYY

44. WAS SYPHILIS SEROLOGY PERFORMED FOR THIS PREGNANCY?
☐ Yes ☐ No ☐ Refused

MULTIPLE BIRTHS
Enter State File Number(s) of mate(s):

LIVE BIRTH(S)
_____
_____

STILLBIRTH(S)/ MISCARRIAGE(S)
_____
_____

45. METHOD OF DELIVERY
A. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No
C. Fetal presentation at delivery (Check one)
☐ Cephalic
☐ Breech
☐ Other
D. Final route and method of delivery (Check one)
☐ Vaginal/Spontaneous
☐ Vaginal/Forceps
☐ Vaginal/Vacuum
☐ Cesarean
If cesarean, was trial of labor attempted? ☐ Yes ☐ No
E. Hysterotomy/Hysterectomy ☐ Yes ☐ No

46. PLURALITY (Single, twin triplet, etc.)
(Specify) _____

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

51. CONGENITAL ANOMALIES OF THE FETUS (Check all that apply)
01 ☐ Anencephaly
02 ☐ Meningomyelocele/Spina bifida
03 ☐ Cyanotic congenital heart disease
04 ☐ Congenital diaphragmatic hernia
05 ☐ Omphalocele
06 ☐ Gatroschisis
07 ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
08 ☐ Cleft lip with or without cleft palate
09 ☐ Cleft palate alone
Down syndrome
10 ☐ Karyotype confirmed
11 ☐ Karyotype pending
Suspected other chromosomal disorder
12 ☐ Karyotype confirmed
13 ☐ Karyotype pending
14 ☐ Hypospadias
15 ☐ Other (Specify) _____
00 ☐ None

48. RISK FACTORS IN THIS PREGNANCY (Check all that apply)
Diabetes
01 ☐ Prepregnancy (diagnosis prior to the pregnancy)
02 ☐ Gestational (diagnosis in this pregnancy)
Hypertension
03 ☐ Prepregnancy (chronic)
04 ☐ Gestational (PIH, preeclampsia)
05 ☐ Eclampsia
06 ☐ Previous preterm birth
07 ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
Pregnancy resulted from infertility treatment
08 ☐ Fertility-enhancing drugs, Artificial insemination or intrauterine insemination
09 ☐ Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
10 ☐ Mother had a previous cesarean delivery
If yes, how many? _____
00 ☐ None of the above

49. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
01 ☐ Gonorrhea
02 ☐ Syphilis
03 ☐ HIV infection
04 ☐ Herpes Simplex Virus (HSV)
05 ☐ Chlamydia
06 ☐ Listeria
07 ☐ Group B Streptococcus
08 ☐ Cytomegalovirus
09 ☐ Parvovirus
10 ☐ Toxoplasmosis
11 ☐ Hepatitis B
12 ☐ Hepatitis C
13 ☐ Other (Specify) _____
00 ☐ None

50. MATERNAL MORBIDITY (complications associated with labor and delivery)
(Check all that apply)
1 ☐ Maternal transfusion
2 ☐ Third or fourth degree perineal laceration
3 ☐ Ruptured uterus
4 ☐ Unplanned hysterectomy
5 ☐ Admission to intensive care unit
6 ☐ Unplanned operating room procedure following delivery
0 ☐ None of the above

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REGISTRAR

52a. REGISTRAR'S SIGNATURE
▶

52b. DATE SIGNED
____/____/_____
MM DD YYYY