# Appendix D: Sample forms

**OREGON HEALTH AUTHORITY**  
**CENTER FOR HEALTH STATISTICS**

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## REPORT OF FETAL DEATH

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.D. Tag Number</td>
<td>(Print, Middle, Last, Suffix)</td>
</tr>
<tr>
<td>State File Number</td>
<td>(Print, Middle, Last, Suffix)</td>
</tr>
<tr>
<td>1. NAME OF FETUS — Optional</td>
<td>(Print, Middle, Last, Suffix)</td>
</tr>
<tr>
<td>2. TIME OF DELIVERY (Hr)</td>
<td>(Hr)</td>
</tr>
<tr>
<td>3. SEX</td>
<td></td>
</tr>
<tr>
<td>4. DATE OF DELIVERY (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>5a. FACILITY — NAME (if not an institution, give street and number)</td>
<td></td>
</tr>
<tr>
<td>5b. CITY, TOWN, OR LOCATION OF DELIVERY</td>
<td></td>
</tr>
<tr>
<td>5c. ZIP CODE</td>
<td></td>
</tr>
<tr>
<td>5d. COUNTY OF DELIVERY</td>
<td></td>
</tr>
<tr>
<td>6a. MOTHER’S CURRENT LEGAL NAME (First, Middle, Last, Suffix)</td>
<td></td>
</tr>
<tr>
<td>6b. DATE OF BIRTH (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>6c. MOTHER’S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)</td>
<td></td>
</tr>
<tr>
<td>6d. BIRTHPLACE (State, Territory, or Foreign Country)</td>
<td></td>
</tr>
<tr>
<td>6e. RESIDENCE OF MOTHER — STATE</td>
<td></td>
</tr>
<tr>
<td>6f. COUNTY</td>
<td></td>
</tr>
<tr>
<td>6g. CITY, TOWN, OR LOCATION</td>
<td></td>
</tr>
<tr>
<td>6h. STREET AND NUMBER</td>
<td></td>
</tr>
<tr>
<td>6i. ZIP CODE</td>
<td></td>
</tr>
<tr>
<td>6j. INSIDE CITY LIMITS</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
<tr>
<td>7a. FATHER’S CURRENT LEGAL NAME (First, Middle, Last, Suffix)</td>
<td></td>
</tr>
<tr>
<td>7b. DATE OF BIRTH (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>7c. BIRTHPLACE (State, Territory, or Foreign Country)</td>
<td></td>
</tr>
<tr>
<td>8a. DATE REPORT COMPLETED (Month, Day, Year)</td>
<td></td>
</tr>
<tr>
<td>8b. NAME AND TITLE OF PERSON COMPLETING REPORT (Type of print)</td>
<td></td>
</tr>
<tr>
<td>9. NAME AND TITLE OF ATTENDANT (Type or print)</td>
<td></td>
</tr>
<tr>
<td>10. IF SERVICES: FUNDING, HOME NAME AND ADDRESS</td>
<td></td>
</tr>
<tr>
<td>11a. DATE FILED BY REGISTRAR</td>
<td></td>
</tr>
<tr>
<td>11b. REGISTRAR — SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>12a. INITIATING CAUSE/CONDITION</td>
<td></td>
</tr>
<tr>
<td>(AMONG THE CHOICES BELOW, PLEASE SELECT THE ONE WHICH MOST LIKELY Began the sequence of events resulting in the death of the fetus)</td>
<td></td>
</tr>
<tr>
<td>Maternal Conditions/Diseases (Specify):</td>
<td></td>
</tr>
<tr>
<td>Complications of Placenta, Cord, or Membranes (Specify):</td>
<td></td>
</tr>
<tr>
<td>Rupture of membranes prior to onset of labor</td>
<td></td>
</tr>
<tr>
<td>Abruptio placenta</td>
<td></td>
</tr>
<tr>
<td>Placental insufficiency</td>
<td></td>
</tr>
<tr>
<td>Prolapsed cord</td>
<td></td>
</tr>
<tr>
<td>Chorioamnionitis</td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
</tr>
<tr>
<td>Other Obstetrical or Pregnancy Complications (Specify):</td>
<td></td>
</tr>
<tr>
<td>Fetal Anomaly (Specify):</td>
<td></td>
</tr>
<tr>
<td>Fetal Injury (Specify):</td>
<td></td>
</tr>
<tr>
<td>Fetal Infection (Specify):</td>
<td></td>
</tr>
<tr>
<td>Other Fetal Conditions/Disorders (Specify):</td>
<td></td>
</tr>
<tr>
<td>12b. OTHER SIGNIFICANT CAUSES OR CONDITIONS</td>
<td></td>
</tr>
<tr>
<td>(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)</td>
<td></td>
</tr>
<tr>
<td>Maternal Conditions/Diseases (Specify):</td>
<td></td>
</tr>
<tr>
<td>Complications of Placenta, Cord, or Membranes (Specify):</td>
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</tr>
<tr>
<td>Fetal Infection (Specify):</td>
<td></td>
</tr>
<tr>
<td>Other Fetal Conditions/Disorders (Specify):</td>
<td></td>
</tr>
<tr>
<td>13a. ESTIMATED TIME OF FETAL DEATH</td>
<td></td>
</tr>
<tr>
<td>Died at time of first assessment, no labor ongoing</td>
<td></td>
</tr>
<tr>
<td>Died at time of first assessment, labor ongoing</td>
<td></td>
</tr>
<tr>
<td>Died during labor, after first assessment</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>13b. WAS AN AUTOPSY PERFORMED?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Planned</td>
<td></td>
</tr>
<tr>
<td>13c. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Planned</td>
<td></td>
</tr>
<tr>
<td>13d. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>14. AMENDMENT</td>
<td></td>
</tr>
</tbody>
</table>

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**ORIGINAL - VITAL RECORD COPY**
<table>
<thead>
<tr>
<th>INFORMATION FOR MEDICAL AND HEALTH USE ONLY</th>
</tr>
</thead>
</table>
| 14. MOTHER MARRIED (all delivery, conception, or any time between)?
  - Yes
  - No
| 15. FACILITY'S NPI
| 16. MOTHER'S MEDICAL RECORD NUMBER
| 17. OF HISPANIC ORIGIN (check "Yes" or "No")
  - Yes
  - No
| 18. RACE (e.g., White, Black, American Indian, etc.)
  - Specify all that apply below
| 19. a. EDUCATION
  - Highest grade completed
| 19. b. No Education
| 20a. DATE OF FIRST PRENATAL CARE VISIT (Month, Day, Year)
  - No Prenatal Care
| 20b. DATE OF LAST PRENATAL CARE VISIT (Month, Day, Year)
| 20c. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
  - (Exclude, enter "0")
| 21. MOTHER'S HEIGHT??
  - (Inches)
| 22. MOTHER'S PRE-PREGNANCY WEIGHT??
  - (Pounds)
| 23. MOTHER'S WEIGHT AT DELIVERY??
  - (Pounds)
| 24. DID MOTHER GET WIC FOOD FOR HERSELF?
  - Yes
  - No
| 25. NUMBER OF LIVE BIRTHS
  - (Do not include birth)
| 25a. Number Now Living:
  - None
| 25b. Number Now Dead:
  - None
| 26. DATE OF LAST LIVE BIRTH
  - (Month, Year)
| 27. 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:
  - Number of cigarettes:
  - Number of packs:
| 27a. Three months before pregnancy
  - OR
  - First Trimester of Pregnancy
  - OR
  - Second Trimester of Pregnancy
  - OR
  - Third Trimester of Pregnancy
| 30. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?
  - Yes
  - No
| 31. ATTENDANTS NPI
| 32. RISK FACTORS IN THIS PREGNANCY
  - (Check all that apply)
| 32a. Diabetes
  - Pre-Pregnancy
  - Gestational (Diagnosis in this pregnancy)
| 32b. Hypertension
  - Pre-Pregnancy
  - Gestational (Pre-eclampsia, other)
| 32c. Other
  - Previous preterm birth
| 32d. Other prior pregnancy outcomes (including preterm birth, stillbirth, fetal death, congenital anomalies, etc.)
| 33. INJECTIONS RECEIVED BEFORE OR DURING THIS PREGNANCY
  - (Check all that apply)
| 33a. Gallamine
| 33b. Sympathomimetic
| 33c. Calcium Channel Blocker
| 33d. Other
| 34. METHOD OF DELIVERY
  - A. Fetal presentation at birth
  - B. Extraction method of delivery
  - C. C-Section
  - D. Vaginal Birth
| 35. MATERNAL MORTALITY
  - (Check all that apply)
| 35a. Maternal transfusion
| 35b. External cephalic version
| 35c. Jehovah's Witness
| 35d. Other
| 36. METHOD OF DISPOSAL
  - A. Burial
  - B. Crema
| 37. WEIGHT OF FETUS
  - (In grams)
  - (In lb and oz)
| 38. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY
  - (Completed weeks)
| 39. IF NOT SINGLE BIRTH - Delivered First, Second, Third, etc.
  - (Specify)
| 41. CONGENITAL ANOMALIES OF THE FETUS
  - (Check all that apply)
| 41a. Down Syndrome
| 41b. Cystic Hygroma
| 41c. Diaphragmatic hernia
| 41d. Omphalocele
| 41e. Conotruncal anomalies
| 41f. Other
  - (Specify)

STATE USE ONLY

a. 

b. 

c. 

d. 

(Specify)
### OREGON DEPARTMENT OF HUMAN SERVICES
#### CENTER FOR HEALTH STATISTICS

**CERTIFICATE OF DEATH**

<table>
<thead>
<tr>
<th>I.D. TAG NO.</th>
<th>STATE FILE NUMBER</th>
</tr>
</thead>
</table>

#### TO BE COMPLETED BY FUNERAL FACILITY

1. **Legal Name**
   - First
   - Middle
   - Last
   - Suffix
2. **Death Date** (MON DD YYYY)
3. **Sex (MF)**
4. **Age – Last Birthday**
5. **Under 1 Year**
6. **Under 1 Day**
7. **Social Security Number**
8. **County of Death**
9. **Date of Injury (MON DD YYYY)**
10. **Time of Injury**
11. **Place of Injury** (e.g., Decedent’s home, construction site, restaurant, wooded area)
12. **Injury at Work?**
13. **Was Decedent Ever in U.S. Armed Forces?**
14. **Residence County**
15. **State or Foreign Country**
16. **Zip Code + 4**
17. **Was Decedent Hispanic Origin?** (Yes or No, if yes, specify.)
18. **Race(s)**
19. **Under City Limits?**
20. **Spouse’s Name** (If married or widowed, give name prior to first marriage.)
21. **Usual Occupation** (Indicate type of work done during most of working life. DO NOT USE “RETIRED.”)
22. **Kind of Business/Industry** (DO NOT USE COMPANY NAME.)
23. **Father’s Name** (First, Middle, Last, Suffix)
24. **Mother’s Name Prior to First Marriage** (First, Middle, Last)
25. **Informant’s Name**
26. **Telephone Number**
27. **Relation to Decedent**
28. **Mailing Address** (Number & Street, City/Town, State, Zip + 4)
29. **Place of Death**
30. **Facility Name**
31. **Location of Death** (Give address.)
32. **City/Town or Location of Death**
33. **State**
34. **Zip Code + 4**
35. **Method of Disposition**
36. **Place of Disposition** (Name of cemetery, crematory, or other place)
37. **Location**
38. **Name and Complete Address of Funeral Facility** (Number & Street, City/Town, State, Zip + 4)
39. **Date of Disposition (MON DD YYYY)**
40. **Funeral Director’s Signature**
41. **OR License Number**
42. **Registrar’s Signature**
43. **Date Received (MON DD YYYY)**
44. **Local File Number**
45. **Record Amendment**
46. **Was case referred to Medical Examiner?**
47. **Autopsy?**
48. **Were autopsy findings available to complete the cause of death?**
49. **Time of Death**

#### CAUSE OF DEATH (See instructions and examples.)

**Final disease or condition resulting in death**

**IMMEDIATE CAUSE**

- a. Due to (or as a consequence of)
- b. Due to (or as a consequence of)
- c. Due to (or as a consequence of)
- d. Due to (or as a consequence of)

51. **Other significant conditions contributing to death, but not resulting in the underlying cause given above:**

52. **Manner of Death**
   - Natural
   - Homicide
   - Accident
   - Underdetermined
   - Suicide
   - Pending
53. **If Female**
   - Not pregnant within past year
   - Pregnant at time of death
   - Not pregnant but pregnant 43 days to 1 year before death
   - Unknown if pregnant within the past year
54. **Did tobacco use contribute to death?**
   - Yes
   - Probably
   - No
   - Unknown
55. **Date of Injury (MON DD YYYY)**
56. **Time of Injury**
57. **Place of Injury** (e.g., Decedent’s home, construction site, restaurant, wooded area)
58. **Injury at Work?**
   - Yes
   - No
   - Unknown
59. **Location of Injury** (Number & Street, City/Town, State, Zip + 4)
60. **Describe how injury occurred.**
   - Driver/Operator
   - Passenger
   - Pedestrian
   - Other (Specify)
61. **If transportation injury, specify**
62. **Name and Address of Certifier** (Number & Street, City/Town, State, Zip + 4)
63. **Name and Title of Attending Physician**
64. **Title of Certifier**
65. **License Number**
66. **Date Signed (MON DD YYYY)**
67. **Medical Certifier** - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
68. **Medical Examiner** - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
69. **Record Amendment**

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**Appendix D: Sample forms**

**PERMANENT BLACK INK.**

**TYPE OR PRINT IN**

**TO BE COMPLETED BY MEDICAL CERTIFIER**

**STATE FILE NUMBER**

**ORIGINAL - VITAL RECORDS COPY**

**D-3**