

# Commonwealth of Pennsylvania

## Fetal Death Certificate Registration

### Instruction Manual for Completing a Fetal Death Certificate

#### Introduction

##### **Purpose**

The fetal death report is a legal certificate. The certificate provides valuable health and research data. The information is used to study the causes of negative pregnancy outcome. These data are essential in planning and evaluating prenatal care services and obstetrical programs. They are also used to examine the consequences to the fetus of possible environmental and occupational exposures of parents.

A Certificate of Fetal Death is filed when a delivery results in a fetus of sixteen (16) weeks or more gestation, that shows **no** evidence of life after it is entirely outside the mother. This would be an infant that has no heartbeat, respiration, voluntary movement of muscles, or any other evidence of life. If the delivery results in a fetus that shows **any** sign of life, and then expires, a Certificate of Live Birth and Certificate of Death must be filed. The Department of Health does not require the filing of a fetal death certificate in any case where that fetal death is a result of an **induced termination of pregnancy**, including the death of a fetus 16 weeks or more gestation. **Spontaneous** fetal deaths of 16 weeks or more gestation must continue to be reported on the Department of Health's "Certificate of Fetal Death" (H105.024 – REV 5/04), according to existing procedures.

#### Specific Responsibilities

##### **Funeral Director or Person Acting as Such**

The funeral director or other person in charge of disposition is responsible for completing and filing the fetal death report. If the fetal death was the result of an accident, suicide, or homicide, the medical examiner or coroner must be notified and he or she must complete the cause of fetal death.

Pennsylvania Law requires that fetal deaths of 16 weeks gestation or more be reported. The Department of Health does not require the filing of a fetal death certificate in any case where that fetal death is a result of an **induced termination of pregnancy**, including the death of a fetus 16 weeks or more gestation. **Spontaneous** fetal deaths of 16 weeks or more gestation must continue to be reported on the Department of Health's "Certificate of Fetal Death" (H105.024 – REV 5/04), according to existing procedures.

The funeral director should be familiar with the Vital Statistics Law of 1953 and with the procedures involved.

The information necessary to complete the Certificate of Fetal Death should be obtained from the same persons and in the same manner as the death certificates. The hospital or the family should provide the required personal information; the attending physician should provide the required medical information; and information regarding the disposition of the fetus should be provided by the funeral director or person acting as such.

**The certificate is to be filed with any local registrar within 96 hours after the fetal death.**

### **Physician**

When a fetal death occurs in a hospital the physician is primarily responsible for providing the cause of fetal death and completing or verifying the remaining medical and health information. The physician's responsibilities are to:

- Enter or verify the date of delivery (month, day and year).
- Complete or verify the medical and health information section. (The person responsible for this may differ depending on institutional practice).
- Complete the cause of fetal death section.
- Return the fetal death certificate to the funeral director or person acting as such with the responsibility for filing the certificate.

When a fetal death occurs outside a hospital (for example, in a doctor's office or at home) and is attended by a physician, the physician must complete the entire certificate and send it directly to the local registrar.

### **Informant**

The informant, preferably the mother (or the father or another adult having knowledge of the personal facts concerning the delivery), is responsible for providing the legal facts, (for example, the parents names).

## **General Instructions**

The data necessary for preparing the fetal death certificate are obtained from the following persons or documents:

- Informant (in order of preference, one of the parents, a relative, or another person who has knowledge of the facts).
- Pronouncing physician and/or certifying physician, medical examiner or coroner
- Hospital or physician records.

**It is essential that the certificates be prepared as permanent legal records.**

- File the original certificate with the registrar. Reproductions or duplicates are **NOT** acceptable.
- Avoid abbreviations, except those recommended in the specific item instructions.
- Verify the spelling of names with the informant. Be especially careful with names that can have different spellings for the same sound, (for example: Smith or Smyth, Gail or Gayle, and Wolf or Wolfe).
- Use the current form designated by the Division of Vital Records.
- Type all entries whenever possible. If a typewriter cannot be used, print legibly in permanent black ink.
- Complete each item following the specific instructions for that item.
- Do not make alterations or erasures.
- Obtain all signatures. Rubber stamp or other facsimile signatures are **NOT** acceptable.
- Refer any questions or concerns not covered in this manual to either of the following:

**Division of Vital Records**  
101 South Mercer Street  
New Castle, PA 16101  
1-877-PA-HEALTH (724-3258)

**Division of Vital Statistics**  
555 Walnut Street, 6<sup>th</sup> Floor  
Harrisburg, PA 17102  
1-800-323-9613

# Certificate of Fetal Death

## Fetus Information

### 1. Name of Fetus (Optional-at the discretion of the parents)

**Name of fetus (Optional)**-Enter the name of the fetus-first name, middle name, last name, suffix as given by the parents.

### 2. Time of Delivery

Enter the exact **time of birth** using the 24-hour clock (military time).  
If the time is unknown, write unknown.

### 3. Sex (M/F/Unk)

Enter the sex of the fetus, "M" for male, "F" for female.  
If the sex is unknown, write unknown. Do not leave this item blank.

### 4. Date of Delivery (Mo/Day/Yr)

Enter the date of delivery (MM/DD/YY).

**Month**

01=January  
02=February  
03=March  
04=April  
05=May  
06=June  
07=July  
08=August  
09=September  
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## 5a & 5b. Place Delivery Occurred

If delivery occurred in a hospital enter the hospital name and NPI (National Provider Identifier). *The NPI is the facility id, but this will be blank for now because the facilities have not been assigned NPI Numbers.*

If delivery did **not** occur in a hospital, check the appropriate place of occurrence. (Freestanding birthing center, home delivery, clinic/doctor's office, or other).

**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 in 5a and in 5b check other and specify "En route". If the delivery occurred on a moving conveyance that was **not en route** to a facility, in 5b check other and enter the address where the fetus was first removed.

**Home delivery/Other place**-If the delivery occurred at home or some other place, in 5b check other and enter the number and street name of the location.

## 6. County of Delivery

Enter the name of the county where the delivery occurred. For deliveries occurring on a moving conveyance, enter the county where the fetus was first removed.

*Note:* If a fetus is abandoned and the place of delivery is unknown, the fetal death should be registered by the person most acquainted with the facts and the place of delivery would be considered Pennsylvania.

## 7. City, Boro or Township of Delivery

Enter the city, boro or township where the delivery occurred. For deliveries occurring on a moving conveyance, enter the city, boro or township where the fetus was first removed.

*This item only needs to be completed if delivery did not occur in a hospital.*

## 8. Zip Code of Delivery

Enter the zip code where the delivery occurred.

*This item only needs to be completed if delivery did not occur in a hospital.*

## **Mother's Information**

### **9a. Mother's Current Legal Name (First, Middle, Last, Suffix)**

Enter mother's first name, middle name, last name, and suffix as given.

### **9b. Date of Birth (Mo/Day/Yr)**

#### **Date of birth**

Enter the mother's date of birth (MM/DD/YY).

#### **Month**

01=January  
02=February  
03=March  
04=April  
05=May  
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### **9c. Mother's Name Prior to First Marriage (First, Middle, Last, Suffix)**

Enter mother's first name, middle name, last name, and suffix prior to her first marriage (maiden name) as given.

### **9d. Birthplace (State, Territory or Foreign Country)**

Enter the mother's birthplace. If born in the US enter the state, if born outside of the US enter the country. If unknown, write unknown.

## **10. Where Does Mother Actually Live?**

### **10a. State**

Enter the name of the state where the mother lives.

### **10b. County**

Enter the county where the mother lives.

### **10c. & 10d. Does mother live in a township?**

Check 'yes' or 'no'.

If you check 'yes' enter the name of the township.

If you check 'no' enter the name of the city/boro limits.

### **10e. Complete Number and Street**

Enter the street number and street name as given.

#### **Apartment #**

Enter the apartment number as stated. You may use letters for the apartment number as well as numbers.

### **10f. City/Boro**

Enter the city/boro as stated.

### **10g. Zip code**

Enter the zip code as stated.

### **10h. If not United States, *country***

Enter the country where the mother lives, if not in the United States.

## Father's Information

### 11a. Father's Current Legal Name (First, Middle, Last, Suffix)

Enter father's first name, middle name, last name, and suffix as given.  
If the mother chooses **not** to name a father enter "refused".

### 11b. Date of Birth (Mo/Day/Yr)

#### Date of birth

Enter the father's date of birth (MM/DD/YY).

#### Month

01=January  
02=February  
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04=April  
05=May  
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### 11c. Birthplace ( State, U.S. territory, or Foreign Country)

Enter the father's birthplace. If born in the US enter the state, if born outside of the US enter the country. If unknown, write unknown.

## Disposition

### **12a. Method of Disposition**

Check the appropriate method of disposition. If “other” is checked, specify the method on the line provided. If the remains are to be used by a hospital, medical or mortuary school for scientific or educational purposes check “donation”.

### **12b. Place of Disposition** (*cemetery, crematory, or other place*)

Enter the name of the cemetery, crematory, hospital, medical school, or other place of disposition.

### **12c. Location –City/Town, State, Zip Code**

Enter the name of the city or town, state and zip code where the place of disposition is located.

### **13a. Signature of Funeral Service Licensee or Person acting as such**

The funeral service licensee or other person assuming custody of the remains and charged with the responsibility for completing the fetal death certificate, should sign in **permanent black ink**. Rubber stamps or facsimile signatures are **not** permitted.

### **13b. License Number** (of Licensee)

Enter the personal state license number of the funeral service licensee. If some other person who is not a licensed funeral director signed in item 13a, identify the category of license and corresponding license number; if the person possesses no license at all enter “None”.

### **14. Name and Address of Facility**

Enter the name and address of the funeral home, hospital, etc., that handled the remains prior to disposition.

## Attendant and Registration Information

### 15. Attendant's Name, Title, and NPI (National Provider Identifier)

Enter the name, title and NPI for the attendant. The attendant is the individual who is physically present and responsible for the delivery of the fetus.

**NOTE:** Ignore NPI for now, since no numbers have been assigned to providers.

### 16. Registrar's Signature and Number

Leave this item blank.

### 17. Date Filed

Leave this item blank.

## Cause of Fetal Death

### 18. Cause/Conditions contributing to Fetal Death

#### 18a. Initiating Cause/Condition

Among the choices listed, please select the **one** that most likely began the sequence of events resulting in the death of the fetus. If it is not clear to you where to report a condition, write it on the "specify" line that seems most appropriate.

#### 18b. Other Significant Causes or Conditions

Select or specify all **other** conditions contributing to death in item 18a.

#### 18c. Weight of the Fetus (grams preferred, specify unit)

Enter the weight of the fetus in grams. If the weight in grams is not available enter the birth weight in pounds and ounces. **Do not convert pounds and ounces to grams.**

### **18d. Obstetric Estimate of Gestation at Delivery**

Enter the obstetric estimate of gestation in completed weeks as estimated by the attendant. Do **not** complete this item based on the date of delivery and the date last normal menses began. If the obstetric estimate of gestation is unknown, enter unknown.

### **18e. Estimated Time of Fetal Death**

Check the appropriate box for estimated time of fetal death with respect to labor and assessment.

### **18f. Was an Autopsy Performed?**

Check the appropriate box to whether or not an autopsy was performed.

### **18g. Was a Histological Placental Examination Performed?**

Check the appropriate box to whether or not a histological placental examination was performed.

### **18h. Were Autopsy or Histological Placental Examination Results used in determining the cause of Fetal Death?**

Check the appropriate box to whether or not the autopsy or histological placental examination findings were used in determining the cause of the fetal death.

### **18i. Certification**

Obtain the signature of the physician, coroner, or medical examiner that can certify the fetus was delivered dead on the date stated in question 4. Enter the certifier's mailing address and the exact month, day, and year the certifier signed the certificate. Rubber stamps or other facsimile signatures are **not** permitted.

## Mother's Information

### 19. Mother's Social Security Number

Enter the mother's social security number as stated. If the social security number is unknown, enter unknown.

### 20. Mother's Medical Record Number (Optional)

Enter the mother's medical record number. This number is assigned by the hospital.

### 21. Principal Source of Payment

Check the principal source of payment from the choices listed.  
If you select other, you must specify the source of payment.  
If unknown, check other and write unknown on the line provided.

### 22. Mother's Education (Check the box that best describes the highest degree or level of school completed at the time of delivery)

Check the most appropriate education level completed by the mother. Report only those years of school that were completed. Only count formal schooling; do not include beauty, barber, trade, business, technical or other special schools when determining the highest grade completed.

### 23. Mother of Hispanic Origin? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)

Check the appropriate box that best describes the mother's Hispanic origin.

If **not** Spanish/Hispanic/Latina, select "**No, not Spanish/Hispanic/Latina**".  
If the mother is Spanish/Hispanic/Latina, select the appropriate option from the list. If you are **other** Spanish/Hispanic/Latina, select other and specify.

**NOTE:** "Hispanic" refers to those people whose origins are from Spain, Mexico or the Spanish-speaking countries of Central or South America. A person may report Hispanic origin based on the country of origin or a parent, grandparent, or

some far-removed ancestor. The response should reflect what the person considers himself or herself to be and not based on percentages of ancestry. In addition to the major groups of Hispanic, Cuban, Mexican, and Puerto Rican, other groups should also be identified in the space provided.

If a mother indicates that she is of multiple Hispanic origins, enter the origin as ‘Yes, other Spanish/Hispanic/Latina’ and specify. If a mother indicates that she is Mexican-American or Cuban-American, enter the Hispanic origin as ‘Yes, Mexican or Yes, Cuban’. If unknown, check other and write unknown on the line provided.

**24. Mother’s Race (Check ONE OR MORE races to indicate what the mother considers herself to be)**

Check **ALL THAT APPLY** by putting a checkmark in the appropriate boxes. If the mother indicates she is bi-racial, check “other” and write bi-racial on the line provided. If the mother’s race is unknown, check “don’t know/not sure”. If the mother refuses, check “refused”.

Race information should be obtained from the mother or informant.

**25. Mother’s Single Race Self-Designation (Check ONLY ONE to indicate which best represents the mother’s race)**

Check the race that best represents the mother. Check **ONLY ONE** by putting a checkmark in the appropriate box. If the mother checks “other”, write the race she considers herself to be on the line provided.

**NOTE:** If more than one race is provided for this question, select “don’t know/not sure”.

Race information should be obtained from the mother or informant.

**26. Mother Married**

Check “Yes” if the mother, at the time of delivery, was married to the father listed in question 11a. Otherwise, check “No”.

**NOTE:** A woman is legally married even if she is separated; a woman is no longer married after divorce papers are signed.

### 27a. Date of First Prenatal Care Visit

Enter the date of the first prenatal care visit (MM/DD/YYYY).

**Month**

- 01=January
- 02=February
- 03=March
- 04=April
- 05=May
- 06=June
- 07=July
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If there were no prenatal care visits, just check the box “No prenatal care” and leave item 27b blank.

### 27b. Date of Last Prenatal Care Visit

Enter the date of the last prenatal care visit (MM/DD/YYYY).

**Month**

- 01=January
- 02=February
- 03=March
- 04=April
- 05=May
- 06=June
- 07=July
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If there is no date for last prenatal care visit, leave this item blank.

**28. Total Number of Prenatal Visits for this Pregnancy**

Enter the total number of prenatal care visits during this pregnancy.  
If there are no prenatal care visits, write "0".  
If unknown, write unknown on the line provided.

**29. Mother's Height**

Enter the mother's height in feet and inches.  
If unknown, write unknown on the line provided.

**30. Mother's Pre-pregnancy Weight**

Enter the mother's pre-pregnancy weight in pounds.  
If unknown, write unknown on the line provided.

**31. Mother's Weight at Delivery**

Enter the mother's weight at delivery in pounds.  
If unknown, write unknown on the line provided.

**32. Did Mother get WIC Food for Herself during this Pregnancy?**

Select 'Yes' or 'No' by putting a checkmark in the appropriate box.

**33. Number of previous Live Births**

**33a. Number of Previous Live Births Now Living (Do not include this child)**

Enter the number of children born alive to this mother who are still living at the time of this delivery. Do **not** include this child or children by adoption. Check "None" if this is the first delivery to this mother or if all previous children are dead. If unknown, write unknown on the line provided.

**33b. Number of Previous Live Births Now Dead (Do not include this child)**

Enter the number of prior children born alive to this mother who are no longer living. Do **not** include this child or any children by adoption. Check “None” if this is the first delivery to this mother or if all previous children are still living. If unknown, write unknown on the line provided.

**33c. Date of Last Live Birth**

Enter the date of last live birth (MM/YYYY).

**Month**

- 01=January
- 02=February
- 03=March
- 04=April
- 05=May
- 06=June
- 07=July
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**34. Number of Other Pregnancy Outcomes (Spontaneous, Induced Losses or Ectopic Pregnancies)**

**34a. Other Outcomes**

Enter the number of prior fetuses that were delivered dead regardless of the length of gestation. Do **not** include this fetus. Include each recognized loss of a product of conception, such as ectopic pregnancy, miscarriage, still birth, and spontaneous or induced abortion. Check “None” if this is the first pregnancy for this mother or if all previous pregnancies resulted in a live-born fetus.

**34b. Date of Last Other Pregnancy Outcome:**

Enter the date of last other pregnancy outcome (MM/YYYY).

**Month**

- 01=January
- 02=February
- 03=March
- 04=April
- 05=May
- 06=June
- 07=July
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**35. Cigarette Smoking Before and During Pregnancy.**

For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked.

**Average Number of cigarettes smoked per day.**

**Three months before pregnancy:**

Enter the number of cigarettes smoked.

**First three months of pregnancy:**

Enter the number of cigarettes smoked.

**Second three months of pregnancy:**

Enter the number of cigarettes smoked.

**Last three months of pregnancy:**

Enter the number of cigarettes smoked.

**NOTE:** You may enter either the number of cigarettes smoked or the number of packs smoked. If mother did not smoke enter "0" for each 3 month period. If unknown, write unknown on the line provided in each 3 month period.

The number of cigarettes in a pack is 20.

**36. Date Last Normal Menses Began:**

Enter the date of last normal menses (MM/DD/YYYY).

**Month**

- 01=January
- 02=February
- 03=March
- 04=April
- 05=May
- 06=June
- 07=July
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**NOTE:** If the exact day is unknown but the month and year are known, enter a partial date. Write unknown on the line provided if the full date cannot be determined.

**37. Plurality – Single, Twin, Triplet, ect.**

Enter the plurality of the fetus. Specify the delivery as single, twin, triplet, quadruplet, ect.

**38. If not a Single Birth – Born First, Second, Third, ect.**

Enter the birth order of the fetus - Born first, second, third, etc.

**NOTE:** If you choose single for the plurality, birth order can be left blank.

**39. Mother Transferred for Maternal, Medical or Fetal Indications for Delivery**

Check “Yes” or “No”. If mother was transferred, check “Yes” and write the name of the facility the mother was transferred from on the line provided. If mother was **not** transferred check “No”.

## **Medical and Health Information**

### **40. Risk Factors in this Pregnancy (Check all that apply)**

Check each of the medical risk factors that the mother experienced during this pregnancy. You may select more than one.

**NOTE:** If “Mother had a previous cesarean delivery” is checked, you must enter a number. If “None of the above” is selected, there should be **no** other risk factors checked.

### **41. Infections Present and/or Treated during this Pregnancy (Check all that apply)**

Check each of the infections that were present and/or treated during this pregnancy. You may select more than one.

**NOTE:** If “None of the above” is selected, there should be **no** other infections selected.

### **42. Method of Delivery**

**NOTE:** All 5 questions (A, B, C, D, & E) must be completed.

**A. Was delivery with forceps attempted but unsuccessful? (Obstetric forceps were applied to the fetal head in an unsuccessful attempt at vaginal delivery.)**

Check “Yes” or “No”.

**B. Was delivery with vacuum extraction attempted but unsuccessful? (Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)**

Check “Yes” or “No”.

**C. Fetal presentation at birth**

Check whether the presentation at birth was Cephalic, Breech, or Other. You may only select one.

**D. Final route and method of delivery**

Check the final route and method of delivery. You may only select one. If “Cesarean” is selected, you must answer “Was trial of labor was attempted” by selecting “Yes” or “No”.

## E. Hysterotomy/Hysterectomy

Check “Yes” or “No”.

### 43. Maternal Morbidity: (Check all that apply)

Check any complications that were associated with labor and delivery. You may select more than one.

**NOTE:** If “None of the above” is selected, there should be **no** other morbidities selected.

### 44. Congenital Anomalies of the Newborn (Check all that apply)

Check each congenital anomaly of the fetus. You may select more than one.

**NOTE:** If “None of the above” is selected, there should be **no** other anomalies selected. Only congenital anomalies listed here should be reported. Other congenital anomalies that may be present, but not listed, should not be reported.