



INDIANA STATE - CERTIFICATE OF FETAL DEATH

State Form 11410 (R4/01-08)

Local No: 500004

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

State File No: 500004

1. NAME OF FETUS (optional at the discretion of the parents) TIM WALTON		2. TIME OF DELIVERY 11:11 (24hr)		3. SEX (M/F/Unk) MALE		4. DATE OF DELIVERY (Mo/Day/Yr) 04/02/10	
5a. CITY, TOWN, OR LOCATION OF DELIVERY DECATUR		7. PLACE WHERE DELIVERY OCCURRED (Check one) Hospital <input checked="" type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home Delivery. Planned to deliver at home? Yes <input type="checkbox"/> No <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Other <input type="checkbox"/> (Specify)				8. FACILITY NAME (if not institution, give street and number) ADAMS COUNTY MEMORIAL HOSPITAL111	
5b. ZIP CODE OF DELIVERY						9. FACILITY I.D. (NPI)	
6. COUNTY OF DELIVERY ADAMS							
10a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) TINA WALTON				10b. DATE OF BIRTH (Mo/Day/Yr) 01/01/1975			
10c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix) TINA JOHNSON				10d. BIRTHPLACE (State, Territory, or Foreign Country) INDIANA			
11a. RESIDENCE OF MOTHER - STATE INDIANA		11b. COUNTY MARION		11c. CITY, TOWN, OR LOCATION INDIANAPOLIS			
11d. STREET AND NUMBER WEST STREET			11e. APT #		11f. ZIP CODE 46204		11g. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
12a. FATHER'S CURRENT LEGAL NAME JOHN WALTON			12b. DATE OF BIRTH (Mo/Day/Yr) 01/02/1965		12c. BIRTHPLACE (State, Territory, or Foreign Country) INDIANA		
13. METHOD OF DISPOSITION: Donation <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Hospital Disposition <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) <input type="checkbox"/>			14. ATTENDANT'S NAME AND NPI IBRS STATE TEST CERTIFIER			14a. TITLE: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/OM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify)	
15. NAME OF FUNERAL HOME INDIANA FUNERAL HOME				15a. PLACE OF DISPOSITION INDIANA			
15b. SIGNATURE OF INDIANA FUNERAL SERVICE LICENSEE JACKSON						15c. LICENSE NUMBER (OF LICENSEE) 234567	
16. SIGNATURE OF LOCAL HEALTH OFFICER BRIAN ZURCHER						16a. FILE DATE	
17. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH							
17a. INITIATING CAUSE/CONDITION Among the choices below, please select the one that most likely began the sequence of events resulting in the death of the fetus, and check one box for the Manner of Death in Item 17c. Maternal Conditions/Diseases <u>NO BREATING</u> (Specify) Complications of Placenta, Cord, or Membranes <input checked="" type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio Placenta <input type="checkbox"/> Placental Insufficiency <input type="checkbox"/> Prolapsed Cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) Other Obstetrical or Pregnancy Complications (Specify) Fetal Anomaly (Specify) <u>UNKNOWN</u> Fetal Injury (Specify) Fetal Infection (Specify) Other Fetal Conditions/Disorders (Specify) <input type="checkbox"/> Unknown				17b. OTHER SIGNIFICANT CAUSES OR CONDITIONS Select Or Specify All Other Conditions Contributing To Death in Item 17a. Maternal Conditions/Diseases <u>NEED TO BE IDENTIFIED</u> (Specify) Complications of Placenta, Cord, or Membranes <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio Placenta <input type="checkbox"/> Placental Insufficiency <input type="checkbox"/> Prolapsed Cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) Other Obstetrical or Pregnancy Complications (Specify) Fetal Anomaly (Specify) Fetal Injury (Specify) Fetal Infection (Specify) Other Fetal Conditions/Disorders (Specify) <input type="checkbox"/> Unknown			
17c. MOTHER'S MANNER OF DEATH (IF APPLICABLE) CHECK ONE BOX <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		17d. DATE OF INJURY (Mo/Day/Yr)		17e. TIME OF INJURY		17f. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		17h. PLACE OF INJURY -at home, farm, street, factory, etc. Specify:		17i. LOCATION (Street & Number or Rural Route Number, City or Town, State)			
17j. DATE PRONOUNCED DEAD (Month/Day/Year) APR/02/2010		17k. MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		17l. IF YES, SPECIFY DRIVER, PASSENGER, PEDESTRIAN, ETC.			
17m. WEIGHT OF FETUS (grams preferred, specify unit) 02 lbs.03 oz. <input type="checkbox"/> grams <input checked="" type="checkbox"/> lb/oz		17n. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY 30 (completed weeks)		17o. ESTIMATED TIME OF FETAL DEATH <input checked="" type="checkbox"/> Dead at time of first assessment, no labor ongoing <input type="checkbox"/> Dead at time of first assessment, labor ongoing <input type="checkbox"/> Died during labor, after first assessment <input type="checkbox"/> Unknown time of fetal death		17p. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Planned	
				17q. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Planned			
17r. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
18. SIGNATURE, OF PERSON CERTIFYING CAUSE OF DEATH CERTIFIER, IBRS STATE TEST						18a. LICENSE NUMBER 55555555	
18b. NAME, ADDRESS AND ZIP CODE OF PERSON CERTIFYING CAUSE OF DEATH CERTIFIER, IBRS STATE TEST , 2566 , 46742						18c. DATE CERTIFIED 4/2/2010	

19. MOTHER'S EDUCATION <i>(Check the box that best describes the highest degree or level of school completed at the time of delivery)</i> <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th-12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input checked="" type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		20. MOTHER OF HISPANIC ORIGIN? <i>(Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)</i> <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____		21. MOTHER'S RACE <i>(Check one or more races to indicate what the mother considers herself to be)</i> <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or Principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____	
22. MOTHER MARRIED? <i>(At delivery, conception, or anytime between)</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		23a. DATE OF FIRST PRENATAL CARE VISIT <i>(MM/DD/YYYY)</i> <input checked="" type="checkbox"/> Prenatal Care <input type="checkbox"/> No Prenatal Care	23b. DATE OF LAST PRENATAL CARE VISIT <i>(MM/DD/YYYY)</i>	23c. TOTAL NUMBER OF VISITS FOR THIS PREGNANCY 0 (if none, enter "0")	
24. MOTHER'S HEIGHT 05/01 (feet/inches)	25. MOTHER'S PREPREGNANCY WEIGHT 120 (pounds)	26. MOTHER'S WEIGHT AT DELIVERY 145 (pounds)	27. DID MOTHER GET WIC FOOD FOR HERSELF DURING PREGNANCY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28. NUMBER OF PREVIOUS LIVE BIRTHS		29. NUMBER OF OTHER PREGNANCY <i>(spontaneous or induced losses or ectopic pregnancies)</i>		30. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY <i>(For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If NONE enter "0")</i> Avg. # of cigarettes, or packs, smoked/day # cigarettes # packs	
28a. NOW LIVING 0 <i>number</i> <input checked="" type="checkbox"/> None	28b. NOW DEAD 0 <i>number</i> <input checked="" type="checkbox"/> None	29a. OTHER OUTCOMES 0 <i>number (Do not include this fetus)</i> <input checked="" type="checkbox"/> None	Three Months Before Pregnancy 0 OR	First Three Months of Pregnancy 0 OR	Second Three Months of Pregnancy 0 OR
28c. DATE OF LAST LIVE BIRTH MM/YYYY	29b. DATE OF LAST OTHER PREGNANCY OUTCOME MM/YYYY	31. DATE LAST NORMAL MENSES BEGAN 09/01/2009 MM/DD/YYYY	32. PLURALITY - Single, Twin, Triplet, etc. (Specify) SINGLE	32a. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) SINGLE	
33. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED _____					
34. RISK FACTORS IN THIS PREGNANCY <i>(check all that apply)</i> Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Pregnancy resulted from infertility treatment-if yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a previous cesarean delivery. If checked, how many previous cesarean deliveries? <input checked="" type="checkbox"/> None of the above			35. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY <i>(check all that apply)</i> <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Listeria <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> Parvovirus <input type="checkbox"/> Toxoplasmosis <input checked="" type="checkbox"/> None of the above <input type="checkbox"/> Other (Specify) _____ Was A Standard Licensed Diagnostic Test For Syphilis Performed For The Mother: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown Date the blood specimen was taken _____ Was the test made During Pregnancy <input type="checkbox"/> Time of Delivery <input type="checkbox"/> If Test Not Given Specify Reason <input type="checkbox"/> Mother Refusal <input checked="" type="checkbox"/> Syphilis Status Known <input type="checkbox"/> Insurance Would Not Pay <input type="checkbox"/> Unknown <input type="checkbox"/> Other Specify: _____ Was A Standard Licensed Diagnostic Test For HIV Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown Was the test made During Pregnancy <input type="checkbox"/> Time of Delivery <input type="checkbox"/> If Test Given Specify Date _____ If Test Not Given Specify Reason <input checked="" type="checkbox"/> Mother Refusal <input type="checkbox"/> HIV Status Known <input type="checkbox"/> Insurance Would Not Pay <input type="checkbox"/> Unknown <input type="checkbox"/> Other Specify: _____		
36. METHOD OF DELIVERY A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No C. Fetal presentation at delivery <input type="checkbox"/> Cephalic <input checked="" type="checkbox"/> Breech <input type="checkbox"/> Other D. Final route and method of delivery <i>(Check one)</i> <input type="checkbox"/> Vaginal/Spontaneous <input checked="" type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No E. Hysterotomy/Hysterectomy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		37. MATERNAL MORBIDITY <i>(Check all that apply)</i> Complications associated with labor and delivery <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedure following delivery <input checked="" type="checkbox"/> None of the above		38. CONGENITAL ANOMALIES OF THE FETUS (Check all that apply) <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb induction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input checked="" type="checkbox"/> None of the anomalies listed above	