

Ohio Department of Health  
**VITAL STATISTICS**  
**CERTIFICATE OF FETAL DEATH** State File No. \_\_\_\_\_

DO NOT WRITE IN MARGIN RESERVED FOR ODH DATA CODING

Reg. Dist. No. \_\_\_\_\_  
Primary Reg. Dist. No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

a. \_\_\_\_\_ 1. FETUS - NAME \_\_\_\_\_ 2a. DATE OF DELIVERY (Month, Day, Year) \_\_\_\_\_ 2b. TIME OF DELIVERY \_\_\_\_\_ M

b. \_\_\_\_\_

c. **FETUS** 3. SEX OF FETUS \_\_\_\_\_ 4. FACILITY NAME (If not institution, give street and number) \_\_\_\_\_

d. \_\_\_\_\_ 5a. CITY, VILLAGE OR LOCATION OF DELIVERY \_\_\_\_\_ 5b. COUNTY OF DELIVERY \_\_\_\_\_

e. \_\_\_\_\_

f. \_\_\_\_\_ 6a. MOTHER'S NAME (First, Middle, Last) \_\_\_\_\_ 6b. MAIDEN SURNAME \_\_\_\_\_ 7a. DATE OF BIRTH (Month, Day, Year) \_\_\_\_\_ 7b. AGE \_\_\_\_\_

**PARENTS** 8a. RESIDENCE - STATE \_\_\_\_\_ 8b. COUNTY \_\_\_\_\_ 8c. CITY, TOWN, OR LOCATION \_\_\_\_\_ 8d. STREET AND NUMBER \_\_\_\_\_

g. \_\_\_\_\_ 8e. INSIDE CITY LIMITS? (Yes or No) \_\_\_\_\_ 8f. ZIP CODE \_\_\_\_\_ 9. FATHER'S NAME (First, Middle, Last) \_\_\_\_\_ 10a. DATE OF BIRTH (Month, Day, Year) \_\_\_\_\_ 10b. AGE \_\_\_\_\_

**DISPOSITION** 11a. BURIAL, CREMATION, OTHER (Specify) \_\_\_\_\_ 11b. DATE \_\_\_\_\_ 11c. NAME OF GEMETERY OR CREMATORY \_\_\_\_\_ 11d. LOCATION (City, village, or county) - (State) \_\_\_\_\_

12a. INFORMANT - NAME - ADDRESS \_\_\_\_\_ 12b. SIGNATURE OF FUNERAL DIRECTOR OR OTHER PERSON (LIC. NO.) \_\_\_\_\_

12c. FUNERAL FIRM AND ADDRESS (CITY) (STATE) (ZIP) \_\_\_\_\_

**PHYSICIAN CERTIFIER** 13a. DATE FILED BY LOCAL REG. \_\_\_\_\_ 13b. REGISTRAR'S SIGNATURE \_\_\_\_\_ 13c. DATE PERMIT ISSUED \_\_\_\_\_ 13d. SIGNATURE OF PERSON ISSUING PERMIT (Dist. No.) \_\_\_\_\_

14a. I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD \_\_\_\_\_ 14b. DATE SIGNED \_\_\_\_\_ 14c. ATTENDANT - M.D., D.O., or CORONER (Specify) \_\_\_\_\_

14d. ATTENDANT - NAME AND MAILING ADDRESS (Type or Print) (Street or R.F.D. No., city or village, state, zip) \_\_\_\_\_ 15. AUTHORIZED OFFICIAL (If delivery not attended by physician) SIGNATURE \_\_\_\_\_

h. \_\_\_\_\_

i. \_\_\_\_\_

j. \_\_\_\_\_

k. \_\_\_\_\_

l. \_\_\_\_\_

**CAUSE** 16. PART I. FETAL DEATH WAS CAUSED BY: [ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)] SPECIFY FETAL OR MATERNAL

IMMEDIATE CAUSE

Fetal or maternal condition directly causing fetal death (a) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF:

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF:

(c) \_\_\_\_\_

m. \_\_\_\_\_

n. \_\_\_\_\_

PART II. Other significant conditions of fetus or mother contributing to fetal death but not resulting in the underlying cause given in Part I. \_\_\_\_\_ 17. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNK. (Specify) \_\_\_\_\_ 18. AUTOPSY PERFORMED?  Yes  No

- Indicate Mandatory Fields
- Indicate Optional Fields