

CERTIFICATE OF FETAL DEATH

Province _____	Registry No. _____
City/Municipality _____	

F E T U S	1. NAME (First) _____ (Middle) _____ (Last) _____		
	2. SEX (Male/Female/Undetermined)		3. DATE OF DELIVERY (Day) _____ (Month) _____ (Year) _____
	4. PLACE OF DELIVERY (Name of Hospital/Clinic/Institution/ House No., St., Barangay) _____ (City/Municipality) _____ (Province) _____		
	5a. TYPE OF DELIVERY (Single, Twin, Triplet, etc.) _____		5b. IF MULTIPLE DELIVERY, FETUS WAS (First, Second, Third, etc.) _____
	5c. METHOD OF DELIVERY (Normal spontaneous vertex, if others, specify) _____		5d. BIRTH ORDER (live births and fetal deaths including this delivery) (First, Second, Third, etc.) _____
5e. WEIGHT OF FETUS _____ grams			

M O T H E R	6. MAIDEN NAME (First) _____ (Middle) _____ (Last) _____		
	7. CITIZENSHIP _____	8. RELIGION/RELIGIOUS SECT _____	9. OCCUPATION _____
	10. AGE at the time of this delivery (completed years) _____		11c. No. of children born alive but are now dead _____
	11a. Total number of children born alive _____	11b. No. of children still living _____	
12. RESIDENCE (House No., St., Barangay) _____ (City/Municipality) _____ (Province) _____ (Country) _____			

F A T H E R	13. NAME (First) _____ (Middle) _____ (Last) _____		
	14. CITIZENSHIP _____	15. RELIGION/RELIGIOUS SECT _____	16. OCCUPATION _____
17. AGE at the time of this delivery (completed years) _____			

MARRIAGE OF PARENTS

18a. DATE (Month) _____ (Day) _____ (Year) _____	18b. PLACE (City/Municipality) _____ (Province) _____ (Country) _____
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MEDICAL CERTIFICATE

19. CAUSES OF FETAL DEATH

a. Main disease/condition of fetus _____

b. Other diseases/conditions of the fetus _____

c. Main maternal disease/condition affecting fetus _____

d. Other maternal disease/condition affecting fetus _____

e. Other relevant circumstances _____

20. FETUS DIED: _____ 1 Before Labor _____ 2 During labor/delivery _____ 3 Unknown

21. LENGTH OF PREGNANCY (in completed weeks) _____

22a. ATTENDANT (Physician, Nurse, Midwife, Hilot or Traditional Birth Attendant, none, others (specify)) _____

22b. CERTIFICATION OF FETAL DEATH

I hereby certify that the foregoing particulars are correct as near as same can be ascertained and I further certify that I have attended/ have not attended the death of the fetus at _____ am/pm on the date of delivery specified above.

Signature _____

Name in Print _____

Title or Position _____

Address _____

_____ Date _____

REVIEWED BY:

Signature Over Printed Name of Health Officer

Date

23. CORPSE DISPOSAL (Burial, Cremation, if others, specify) _____	24. BURIAL/CREMATION PERMIT Number _____ Date Issued _____	25. AUTOPSY (Yes /No) _____
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26. NAME AND ADDRESS OF CEMETERY OR CREMATORY _____

<p>27. CERTIFICATION OF INFORMANT</p> <p>I hereby certify that all information supplied are true and correct to my own knowledge and belief.</p> <p>Signature _____</p> <p>Name in Print _____</p> <p>Relationship to the Deceased _____</p> <p>Address _____</p> <p>Date _____</p>	<p>28. PREPARED BY</p> <p>Signature _____</p> <p>Name in Print _____</p> <p>Title or Position _____</p> <p>Date _____</p>
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<p>29. RECEIVED BY</p> <p>Signature _____</p> <p>Name in Print _____</p> <p>Title or Position _____</p> <p>Date _____</p>	<p>30. REGISTERED BY THE CIVIL REGISTRAR</p> <p>Signature _____</p> <p>Name in Print _____</p> <p>Title or Position _____</p> <p>Date _____</p>
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REMARKS/ANNOTATIONS (For LCRO/OCRG Use Only)

TO BE FILLED-UP AT THE OFFICE OF THE CIVIL REGISTRAR

7	8	9	12	14	15
16	19a	19c			

