State of Colorado
Certificate of Fetal Death

Local File No. | State File No.

Fetus

1. FETUS NAME (First, Middle, Last)	2. DATE OF DELIVERY (Month, Day, Year)	3. TIME OF DELIVERY	4. SEX (M/F/UNK)

5a. PLACE WHERE DELIVERY OCCURRED (check one)	5b. FACILITY NAME (If not institution, give street and number)	5c. FACILITY ID. (NPI)
❑ Hospital ❑ Clinic/Doctors office ❑ Freestanding birthing center ❑ Home delivery: Planned to deliver at home? ❑ Yes ❑ No ❑ Other (Specify) ____		

5d. CITY, TOWN, OR LOCATION OF DELIVERY	5e. ZIP CODE	5f. COUNTY OF DELIVERY

Parents

6a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last)	6b. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)	6c. MOTHER'S DATE OF BIRTH

6d. MOTHER'S BIRTHPLACE (State, Territory, or Foreign Country)	7a. MOTHER'S RESIDENCE - STATE	7b. MOTHER'S RESIDENCE - COUNTY	7c. MOTHER'S RESIDENCE - CITY, TOWN, OR LOCATION

7d. MOTHER'S RESIDENCE STREET AND NUMBER	7e. MOTHER'S RESIDENCE - APT. NO.	7f. RESIDENCE - ZIP CODE	7g. INSIDE CITY LIMITS?
			❑ Yes ❑ No

8a. FATHER'S/CO-PARENT CURRENT LEGAL NAME	8b. FATHER'S/CO-PARENT DATE OF BIRTH	8c. FATHER'S/CO-PARENT BIRTHPLACE (State, Territory, or Foreign Country)

Registration and Attendant

9a. *REGISTRAR'S SIGNATURE*	9b. *DATE FILED BY REGISTRAR (Month, Day, Year)*

10a. METHOD OF DISPOSITION

❑ Burial-Cemetery/Burial-Private Land/Entombment ❑ Hospital Disposition ❑ Cremation ❑ Removal From State ❑ Donation ❑ Other (Specify) ____

10b. NAME AND ADDRESS OF FUNERAL ESTABLISHMENT OR PERSON ACTING AS SUCH	10c. PLACE OF DISPOSTION (Name of cemetery, crematory, or other place - CITY, STATE)

11a. ATTENDANT'S NAME AND NPI	11b. ATTENDANT'S MAILING ADDRESS (Street or R.F.D. No. City, State, Zip)
NAME: ____ NPI: ____ TITLE: ❑ MD ❑ DO ❑ CNM/CM ❑ OTHER MIDWIFE ❑ OTHER (Specify): ____	

12a. REPORT COMPLETED BY:	12b. DATE REPORT COMPLETED	13a. WAS AN AUTOPSY PERFORMED?
NAME: ____ TITLE: ____		❑ Yes ❑ No ❑ Planned If yes, name of facility used for autopsy: ____

13b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?	13c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?	14. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY	15. ESTIMATED TIME OF FETAL DEATH
❑ Yes ❑ No ❑ Planned	❑ Yes ❑ No	____ Completed weeks	❑ Dead at time of first assessment, no labor ongoing ❑ Dead at time of first assessment, labor ongoing ❑ Died during labor, after first assessment ❑ Unknown time of fetal death

CAUSE/CONDITION(S) CONTRIBUTING TO FETAL DEATH

Cause Contributing to Death

16a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE SELECT THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)

Maternal Conditions/Diseases (Specify) ____

Complications of Placenta, Cord, or Membranes
- ❑ Rupture of membranes prior to onset of labor
- ❑ Abruptio placenta
- ❑ Placental insufficiency
- ❑ Prolapsed cord
- ❑ Chorioamnionitis
- ❑ Other (Specify) ____

Other Obstetrical or Pregnancy Complications (Specify) ____

Fetal Anomaly (Specify) ____

Fetal Injury (Specify) ____

Fetal Infection (Specify) ____

Other Fetal Conditions/Disorders (Specify) ____

❑ Unknown

16b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 16b)

Maternal Conditions/Diseases (Specify) ____

Complications of Placenta, Cord, or Membranes
- ❑ Rupture of membranes prior to onset of labor
- ❑ Abruptio placenta
- ❑ Placental insufficiency
- ❑ Prolapsed cord
- ❑ Chorioamnionitis
- ❑ Other (Specify) ____

Other Obstetrical or Pregnancy Complications (Specify) ____

Fetal Anomaly (Specify) ____

Fetal Injury (Specify) ____

Fetal Infection (Specify) ____

Other Fetal Conditions/Disorders (Specify) ____

❑ Unknown

❑ PARENT(S) MAY BE INTERESTED IN A STILLBIRTH CERTIFICATE.

(rev. 10/20)

17a. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at time time of delivery)

- ❑ 8th grade or less
- ❑ 9th-12th grade, no diploma
- ❑ High school graduate or GED completed
- ❑ Some college credit but no degree
- ❑ Associate degree (e.g., AA, AS)
- ❑ Bachelor's degree (e.g., BA, AB, BS)
- ❑ Master's degree (e.g.,MA, MS, MSW,MBA)
- ❑ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
- ❑ Unknown

17b. 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.)

- ❑ No, not Spanish/Hispanic/Latina
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina (Specify) ____________
- ❑ Unknown

17c. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native (Name of the enrolled or principal tribe) ____________
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian (Specify) ____________
- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander (Specify) ____________
- ❑ Other (Specify) ____________
- ❑ Unknown

18. PREGNANCY HISTORY (Complete each section)

NUMBER OF PREVIOUS LIVE BIRTHS

18a. Now living	18b. Now dead
Number ______	Number ______
❑ NONE	❑ NONE
❑ Unknown	❑ Unknown

19. MOTHER MARRIED/UNION STATUS? (At time of delivery, conception, or any time in between)

❑ Yes ❑ No ❑ Civil Union ❑ Unknown

20. DATE OF FIRST PRENATAL CARE VISIT

_____/_____/_____ ❑ No care ❑ Unknown

21. MONTH OF PREGNANCY PRENATAL CARE BEGAN - First, Second, Third, etc. (Please check one)

❑ 1st	❑ 5th	❑ 9th
❑ 2nd	❑ 6th	❑ No care
❑ 3rd	❑ 7th	❑ Unknown
❑ 4th	❑ 8th	

22. DATE LAST NORMAL MENSES BEGAN

____

❑ Unknown

18c. DATE OF LAST LIVE BIRTH

____

23. PLURALITY - Single, Twin, Triplet, etc. (Specify)

24. IF NOT SINGLE DELIVERY - Delivered First, Second, Third, etc.

25. WEIGHT OF FETUS (Grams Preferred, Specify Unit)

________ Grams

________ Lbs/Oz

❑ Unknown

26. MOTHER'S HEIGHT

____________ (feet/inches)

❑ Unknown

27. MOTHER'S PREPREGNANCY WEIGHT

__________ (pounds)

❑ Unknown

28. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

❑ Yes ❑ No ❑ Unknown

29. 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:	# of cigarettes		# of packs	
Three months before pregnancy	____________	OR	____________	❑ Unknown
First three months of pregnancy	____________	OR	____________	
Second three months of pregnancy	____________	OR	____________	
Third trimester of pregnancy	____________	OR	____________	

30. RISK FACTORS IN THIS PREGNANCY (Check all that apply):

DIABETES

- ❑ Prepregnancy (Diagnosis prior to this pregnancy)
- ❑ Gestational (Diagnosis in this pregnancy)

HYPERTENSION

- ❑ Prepregnancy (Chronic)
- ❑ Gestational (PIH, preeclampsia)
- ❑ Eclampsia

- ❑ Pregnancy resulted from infertility treatment (if yes, check all that apply:)
  - ❑ Fertility-enhancing drugs, Artifical insemination or intrauterine insemination
  - ❑ Assisted reproductive technology (e.g., in vitro gamete intrafallopian transfer (GIFT)
- ❑ Mother had a previous cesarean delivery
  If yes, how many: ____________
- ❑ Unknown
- ❑ None of the above

31. METHOD OF DELIVERY

A. Fetal presentation at delivery

- ❑ Cephalic
- ❑ Breech
- ❑ Other

B. Final route and method of delivery (Check one)

- ❑ Vaginal/Spontaneous
- ❑ Vaginal/Forceps
- ❑ Vaginal/Vacuum
- ❑ Cesarean
  If cesarean, was a trial or labor attempted?
  ❑ Yes ❑ No

C.❑ Unknown

32. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)

- ❑ Ruptured uterus
- ❑ Admission to intensive care unit
- ❑ None of the above
- ❑ Unknown

FETUS NAME (First, Middle, Last) ____________ DATE OF DELIVERY (Month, Day, Year) ____________

COUNTY OF DELIVERY ____________