MISSISSIPPI STATE BOARD OF HEALTH

HANDBOOK

ON

REGISTRATION AND REPORTING OF VITAL EVENTS:

LIVE BIRTHS
DEATHS
SPONTANEOUS FETAL DEATHS
INDUCED TERMINATIONS OF PREGNANCY

EFFECTIVE JANUARY 01, 2012

Additional free copies of this handbook may be obtained from

Vital Records Registration Unit
P. O. Box 1700
Jackson, MS 39215-1700

Telephone number: 601-576-7960

Location: Felix J. Underwood Building
Room 110
571 Stadium Drive
Jackson, MS 39216

CONTENTS

GENERAL INFORMATION

INTRODUCTION

The registration and reporting of live births, deaths, spontaneous fetal deaths, induced terminations of pregnancy, adverse outcome of induced terminations, marriages, divorces and annulments is a state and local function in this country with state laws prescribing the means through which this is accomplished. In Mississippi, as in most other states, the legislature placed the responsibility for obtaining and filing such records within the State Department of Health, and collection began November 1, 1912.

Thousands of physicians, hospital staff members, county medical examiners, funeral directors, midwives, local registrars for marriages (circuit clerks) and divorces (chancery clerks) and staff of the bureau of vital statistics perform designated functions within the statewide system through which the needed records are obtained. Each of these groups contributes to the successful operation of the collection process, and upon them depend the completeness and accuracy, and thus the usefulness, of the certificates and reports submitted.

Uses made of these records are many and include legal as well as medical and statistical. Some of the data items have only legal uses, some are for statistical use only, and many serve both purposes. Although each state decides upon the content and format of its own records in accordance with its own laws, the items of information, for the most part conform to the contents of model "standard" certificates. These models are developed cooperatively by the states and the National Center for Health Statistics, a branch of the Centers for Disease Control and Prevention, US Department of Health and Human Services, in order to promote consistency in the facts available for legal and statistical uses. The Standard forms are revised approximately once every ten years to meet changing needs, and the revisions incorporate the main recommendations received from every state from the various persons who prepare and work with these records.

The record forms effective in Mississippi and most other states on January 1, 1989, are based on such revisions. Contents of the Mississippi records are almost exactly the same as contents of the standard forms. Since the 1989 revision there has been another revision in 2003; however, due to insufficient funds to pay for the changes required, these forms have not been adopted by most states, including Mississippi.

The following sections provide instructions for the successful completion of Certificate of Live Birth, Certificate of Death, Report of Spontaneous Fetal Death, Report of Induced Termination of Pregnancy, and Report of Adverse Reaction to Induced Termination of Pregnancy.

REGISTRATION OF LIVE BIRTHS

LIVE BIRTH DEFINED

"Live Birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

CERTIFIED COPIES OF CERTIFICATES OF LIVE BIRTH

A certified copy may be obtained by anyone with a legitimate and tangible interest in the birth record, generally the immediate family. Blank applications should be secured from the Vital Records office in Jackson. Completed applications and the fee, ($15.00 for the first copy and $5.00 for each additional copy of the same record ordered at the same time), should be sent to:

Mississippi Vital Records
P O Box 1700
Jackson, MS 39215-1700

QUESTIONS

If clarification, additional information, or assistance is needed regarding the registration of a live birth, contact your Vital Records Field Representative, the supervisor for Vital Records Registration, or the State Registrar.

Rules and Regulations pertaining to the registration of Births can be obtained from the Mississippi State Department of Health.

CERTIFICATE OF LIVE BIRTH, FORM NO. 500, REVISED 01/10/2008

TYPE OR PRINT WITH BLACK INK

FILING DATE

CERTIFICATE OF LIVE BIRTH
STATE OF MISSISSIPPI

STATE FILE NUMBER 123-

CHILD

1. CHILD–NAME — First / Middle / Last
2a. DATE OF BIRTH (Month, Day, Year)
2b. HOUR OF BIRTH — m.
3. SEX
4a. THIS BIRTH SINGLE, TWIN, TRIPLET, ETC. (Specify)
4b. IF NOT SINGLE BIRTH, BORN FIRST, SECOND, ETC. (Specify)
5. BIRTH WEIGHT (Enter only in the type of measure on the scales used) — lbs. / ozs. / OR / grams
6a. HOSPITAL OR CLINIC–NAME (If not in either, give street address or route number)
6b. CITY OR TOWN OF BIRTH
6c. COUNTY OF BIRTH

FATHER

7a. FATHER–NAME — First / Middle / Last
7b. RACE (Specify White, Black, American Indian, etc.)
7c. DATE OF BIRTH (Month, Day, Year)
7d. STATE OF BIRTH

MOTHER
For RESIDENCE items, enter actual location of home rather than mailing address.

8a. MOTHER–NAME — First / Middle / Maiden
8b. RACE (Specify White, Black, American Indian, etc.)
8c. DATE OF BIRTH (Month, Day, Year)
8d. STATE OF BIRTH
9a. RESIDENCE–STATE
9b. COUNTY
9c. CITY OR TOWN
9d. INSIDE CITY LIMITS (Specify Yes or No)
9e. STREET AND NUMBER OR RURAL LOCATION
10a. MAILING ADDRESS–STREET AND NUMBER OR ROUTE AND BOX NUMBER
10b. CITY OR TOWN
10c. STATE AND ZIP CODE

INFORMANT

11a. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THIS CERTIFICATE IS CORRECT
SIGNATURE OF EITHER PARENT ➤
11b. SOCIAL SECURITY CARD REQUESTED FOR NEWBORN ☐ Yes ☐ No
11c. DATE SIGNED (Month, Day, Year)
12a. I CERTIFY THAT THE STATED INFORMATION CONCERNING THIS CHILD IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF
SIGNATURE ➤
12b. DATE SIGNED (Month, Day, Year)
12c. NAME AND TITLE OF PERSON WHO DELIVERED CHILD IF OTHER THAN CERTIFIER (Type or Print)
12d. CERTIFIER–NAME AND TITLE (Type or print)
12e. MAILING ADDRESS (Street and number or box number, City or town, State, ZIP code)

INFORMATION FOR MEDICAL AND HEALTH USE ONLY (This information will not be issued on certified copies)

FATHER

13. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.)
14. SOCIAL SECURITY NUMBER
15. EDUCATION (Check ONLY the HIGHEST level COMPLETED) — Elementary or High School 0 1 2 3 4 5 6 7 8 9 10 11 12 — College Years 1 2 3 4 5+

MOTHER
If the answer to item 23 is No, items 7a-7d, 13, 14, and 15 should be blank. (Unless a paternity affidavit is attached)

16. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.)
17. SOCIAL SECURITY NUMBER
18. EDUCATION (Check ONLY the HIGHEST level COMPLETED) — Elementary or High School 0 1 2 3 4 5 6 7 8 9 10 11 12 — College Years 1 2 3 4 5+
19. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
PRENATAL CARE BY DOCTOR OR CLINIC
21a. MONTH (STAGE) OF PREGNANCY FIRST VISIT MADE — No Care ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐
21b. NUMBER OF VISITS ☐ None or Total
20. CLINICAL ESTIMATE OF GESTATION (Weeks)
CHECK ALL THAT APPLY
21c. PROVIDER OF PRENATAL CARE — No Care ☐ 0 / M.D. ☐ 1 / CHC/PCC ☐ 2 / H.D. ☐ 3 / Other, Specify ☐ 4

PREGNANCY HISTORY OF MOTHER

PREVIOUS LIVE BIRTHS (Do NOT include this child or children adopted by mother)
OTHER TERMINATIONS (Spontaneous and induced Abortions, Miscarriages, Stillbirths, Fetal Deaths)
23. MOTHER MARRIED AT BIRTH, CONCEPTION, OR AT ANY TIME BETWEEN? ☐ No ☐ Yes
22a. NOW LIVING ☐ None or Number
22b. NOW DEAD ☐ None or Number
22d. OTHER TERMINATIONS ☐ None or Number
24. IF MOTHER NOW WIDOWED OR DIVORCED, GIVE DATE (Month, Day, Year)
22c. DATE OF LAST PREVIOUS LIVE BIRTH (Month, Day, Year)
22e. DATE OF LAST OTHER TERMINATION (Month, Day, Year)
NOTE: If Mother was married at any time between the conception and birth of this child, a paternity affidavit cannot be used.

CHILD

APGAR SCORE
25a. 1 MINUTE
25b. 5 MINUTES
26. DID BABY DIE? (If so, specify Month, Day, Year) ☐ No ☐ Yes
27. IS BABY TO BE ADOPTED? ☐ No ☐ Yes

Mississippi State Department of Health — Revised 1-10-08 — Form No. 500

MOTHER

28a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

☐ 01 Anemia (Hct. < 30/Hgb. < 10)
☐ 02 Cardiac disease
☐ 03 Acute or chronic lung disease
☐ 04 Diabetes
☐ 05 Genital herpes
☐ 06 Hydramnios/Oligohydramnios
☐ 07 Hemoglobinopathy
☐ 08 Hypertension, chronic
☐ 09 Hypertension, pregnancy-associated
☐ 10 Eclampsia
☐ 11 Incompetent cervix
☐ 12 Previous infant 4000 + grams
☐ 13 Previous preterm or small-for-gestational-age infant
☐ 14 Renal disease
☐ 15 Rh sensitization
☐ 16 Uterine bleeding
☐ 00 None
☐ 17 Other _____ (Specify)

28b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items)

Tobacco use during pregnancy Yes ☐ No ☐
Average number cigarettes per day _____
Alcohol use during pregnancy Yes ☐ No ☐
Average number drinks per week _____
Weight gained during pregnancy _____ lbs.

29. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)

☐ 01 Febrile (> 100° F, or 38° C.)
☐ 02 Meconium, moderate/heavy
☐ 03 Premature rupture of membrane (> 12 hours)
☐ 04 Abruptio placenta
☐ 05 Placenta previa
☐ 06 Other excessive bleeding
☐ 07 Seizures during labor
☐ 08 Precipitous labor (< 3 hours)
☐ 09 Prolonged labor (> 20 hours)
☐ 10 Dysfunctional labor
☐ 11 Breech/Malpresentation
☐ 12 Cephalopelvic disproportion
☐ 13 Cord prolapse
☐ 14 Anesthetic complications
☐ 15 Fetal distress
☐ 00 None
☐ 16 Other _____ (Specify)

30. METHOD OF DELIVERY (Check all that apply)

☐ 01 Vaginal
☐ 02 Vaginal birth after previous C-section
☐ 03 Primary C-section
☐ 04 Repeat C-section
☐ 05 Forceps
☐ 06 Vacuum

31. OBSTETRIC PROCEDURES (Check all that apply)

☐ 01 Amniocentesis
☐ 02 Electronic fetal monitoring
☐ 03 Induction of labor
☐ 04 Stimulation of labor
☐ 05 Tocolysis
☐ 06 Ultrasound
☐ 00 None
☐ 07 Other _____ (Specify)

32. MOTHER TRANSFERRED PRIOR TO DELIVERY?

☐ No ☐ Yes

If Yes, enter name and city of facility transferred from:

CHILD

33. CONGENITAL ANOMALIES OF CHILD (Check all that apply)

☐ 01 Anencephalus
☐ 02 Spina bifida/Meningocele
☐ 03 Hydrocephalus
☐ 04 Microcephalus
☐ 05 Other central nervous system anomalies (Specify) _____
☐ 06 Heart malformations
☐ 07 Other circulatory/respiratory anomalies (Specify) _____
☐ 08 Rectal atresia/stenosis
☐ 09 Tracheo-esophageal fistula/Esophageal atresia
☐ 10 Omphalocele/Gastroschisis
☐ 11 Other gastrointestinal anomalies (Specify) _____
☐ 12 Malformed genitalia
☐ 13 Renal agenesis
☐ 14 Other urogenital anomalies (Specify) _____
☐ 15 Cleft lip/palate
☐ 16 Polydactyly/Syndactyly/Adactyly
☐ 17 Club foot
☐ 18 Diaphragmatic hernia
☐ 19 Other musculoskeletal/integumental anomalies (Specify) _____
☐ 20 Down's syndrome
☐ 21 Other chromosomal anomalies (Specify) _____
☐ 00 None
☐ 22 Other _____ (Specify)

34. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

☐ 01 Anemia (Hct. < 39/Hgb. < 13)
☐ 02 Birth injury
☐ 03 Fetal alcohol syndrome
☐ 04 Hyaline membrane disease/RDS
☐ 05 Meconium aspiration syndrome
☐ 06 Assisted ventilation < 30 min.
☐ 07 Assisted ventilation ≥ 30 min.
☐ 08 Seizures
☐ 00 None
☐ 09 Other _____ (Specify)

35. INFANT TRANSFERRED? ☐ No ☐ Yes
If Yes, enter name and city of facility transferred to:

INSTRUCTIONS FOR COMPLETING LIVE BIRTH CERTIFICATE

Complete each item on the certificate, starting with Item 1. CHILD-NAME. Do not write or type in the File Date or State File Number space above Item 1, these will be completed by Vital Records Registration Unit when the record is received for filing.

Under the following circumstances the items specified below should be left blank:

1. Item 4b should be blank if single birth.

2. Items 7a-d, and 13-15 should be blank if mother is not married (Item 23 answered "No") and there is no acknowledged father.

3. Item 12c should be blank if certifier and person who delivered child are the same.

If information is not available for any of the other items, enter "Unknown", do not enter "N.A." or "?".

The top part of the certificate (Items 1 through 12e) is referred to as the "legal" portion. It is the part that will be reproduced for a certified copy of the certificate. Please take special care to complete this section as neatly and as completely as possible.

Item 1. CHILD NAME (FIRST, MIDDLE, LAST)

First and Middle names (Given names):

Enter the name as provided by the parents. Do not assume the spelling, if the name is provided verbally, ask for the spelling of each name. Accent marks (e.g. Renee´) may be used; however, numbers cannot be used. If the parents have not selected given names for the child, enter "Unnamed" for the first name and the last name only. Never enter such terms as "Baby girl" or "Infant boy."

Last name (Surname):

Entries of Jr., II, etc. following the last name are acceptable.

Review **Rule 18–Surname of child** under **RULES PERTAINING TO LIVE BIRTH** in Rules Governing the Registration and Certification of Vital Events. The rule is paraphrased here for convenience of use.

1. For a child born to a mother who was married at the time of birth (Item 23 answered "Yes"), enter the last name of the mother's husband unless both parents have signed a Verification of Name of Child form. Parents have the right to name their child any name they choose, however, we require that non traditional last names be verified and signed off on by both parents and witnessed by a hospital representative. Note that a woman who is separated but not divorced is considered to be still married.

2. For a child born to a mother who was married at or after the time of conception but was widowed or divorced at the time the child was born (Item 23 answered "Yes"), enter the last name of the deceased or divorced husband.

3. For a child born to a mother who was not married at the time of conception or birth or at any time in between BUT there is an acknowledged father (item 23 answered "No"), enter the last name of the acknowledged father unless both parents have signed a Verification of Name of Child form to name the child otherwise.

4. For a child born to a mother who was not married at the time of conception or birth or at any time in between and there is no acknowledged father (Item 23 answered "No"), enter the legal last name of the mother unless the mother has signed a Verification of Name of Child form to name the child otherwise.

Refer problems not covered in these instructions to your Vital Records Field Representative, the supervisor of the Vital Records Registration Unit, or the State Registrar.

Item 2a. DATE OF BIRTH (MONTH, DAY, YEAR)

Enter the exact month, day, and year the child was born.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-08 for June 4, 2008.

Pay particular attention to the entry of month, day, and year when the birth occurs around midnight or on December 31. Consider a birth exactly at midnight to have occurred at the end of one day rather than at the beginning of the next day.

Item 2b. HOUR OF BIRTH

Enter the exact time (hour and minute) the child was born according to local time. This can be entered with a 12 hour clock with a.m. or p.m. designated, or with a 24 hour clock.

Enter 12 noon as "12 Noon." If the time was one minute after 12 noon, enter "12:01 p.m."

Enter 12 midnight as "12 Mid." If the time was one minute after 12 midnight, enter "12:01 a.m."

Item 3. SEX

Enter "Male" or "Female". Do not abbreviate or use other symbols.

If the sex could not be determined, enter "Unknown".

PLURALITY and BIRTH ORDER Items 4a. and 4b.

When a plural birth occurs, prepare a separate record for each child or fetus even if they are Siamese twins. File certificates relating to the same plural set at the same time. However, do not hold completed certificates while waiting for uncompleted ones if this will result in late filing. If any members of a plural set were born dead, write a note on the back of the certificates for live-born members specifying which members of the set were born dead. Similarly, if any members of a plural set were born in another county or state, write a note on the back of the certificates being filed in your county stating where the other members of the set were born.

Item 4a. THIS BIRTH SINGLE, TWIN, TRIPLET, ETC.

Specify whether this was a single birth, twin, triplet, quadruplet, etc.

Item 4b. IF NOT SINGLE BIRTH, BORN FIRST, SECOND, ETC.

If this was a plural birth, specify the order in which this child was born - first, second, etc. Make no entry if this was a single birth.

Item 5. BIRTH WEIGHT

Enter the birth weight of the child as it is recorded in the hospital or clinic record or as measured by the attendant at a birth not in a hospital or clinic. Enter only in the type measure on the scales used.

Enter the weight either in the section for pounds and ounces or in the section for grams, depending on the scales used. Do not enter in both types of measurement and do not convert from one measure to the other.

If weight is in pounds and ounces be sure to make an entry in both pounds and ounces even if one of the entries is “0.”

PLACE OF BIRTH Items 6a. - 6c.

For births occurring on a moving conveyance within the United States, enter the information for place of birth as if the birth had occurred at the place where the child was first removed from the conveyance since that is where the birth must be registered. However, if the birth occurred in international waters or airspace or in a foreign country and the child was first removed from the conveyance in this state, contact the State Registrar for instructions.

Item 6a. HOSPITAL OR CLINIC NAME (IF NOT IN EITHER, GIVE STREET ADDRESS OR ROUTE NUMBER)

If the birth occurred in a hospital or clinic, enter the full name of the hospital or clinic and the hospital or clinic code.

If the birth occurred enroute to a hospital or clinic, enter the name of the hospital or clinic, add the word "Enroute," and enter the hospital or clinic code.

If the birth did not occur in or enroute to a hospital or clinic, enter the street address or other specific location of the place where the birth occurred. The word "Home" is not a satisfactory entry.

If the birth occurred at home but cord was not cut until mother reached the hospital, the hospital name should be entered as place of birth.

Item 6b. CITY OR TOWN OF BIRTH

Enter the name of the city or town where the birth occurred. This should be the city or town where the hospital, clinic, or other place named in 6a is located.

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Item 6c. COUNTY OF BIRTH

Enter the name of the county where the birth occurred. This should be the county in which the hospital, clinic, or other place named in 6a is located.

Item 7a. FATHER NAME (FIRST, MIDDLE, LAST)

Review **Rule 17–Paternity** under **RULES PERTAINING TO LIVE BIRTHS** in Rules Governing the Registration and Certification of Vital Events. The rule is paraphrased here for convenience of use.

If the child was:

1. Born to a mother who was married at the time of birth (Item 23 answered "Yes"), enter the name of her husband. Note that a woman who is separated but not divorced is considered to be still married.

2. Born to a mother who was married at or after the time of conception but was widowed or divorced at the time the child was born (Item 23 answered "Yes"), enter the name of the deceased or divorced husband.

3. Born to a mother who was not married at the time of conception or birth or at any time in between BUT there is an acknowledged father (Item 23 answered "No"), and both have signed and had notarized an "Acknowledgement of Paternity" affidavit, enter the name of the acknowledged father.

4. Born to a mother who was not married at the time of conception or birth or at any time in between and no acknowledged father (Item 23 answered “No”), make no entry regarding the father's name. DO NOT enter “Unknown.”

If a father’s name is provided entries of Jr., Sr., II, etc. following the last name are acceptable

Refer problems regarding the entry of the father's name to your Vital Records Field Representative, the supervisor of Vital Records Registration, or the State Registrar.

Item 7b. FATHER RACE

Enter the race of the father as it is obtained from the father, mother, or other informant.

For groups other than white, black, or American Indian, enter the national origin of the father such as Chinese, Japanese, Korean, Filipino, Hawaiian, etc.

If it is necessary to abbreviate the race because of lack of space, do not use a single-letter abbreviation such as “C” because it would not be enough to identify the race.

If the informant indicates that the father is of mixed race, enter both races or national origins.

If the father is an American Indian, it is desirable to enter the specific name of the Indian tribe.

Make no entry if the father's name is not entered in 7a (Item 23 answered “No”).

Item 7c. FATHER DATE OF BIRTH (MONTH, DAY, YEAR)

Enter the exact month, day, and year the father was born.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-88 for June 4, 1988.

Make no entry if the father's name is not entered in 7a (Item 23 answered “No”).

Item 7d. FATHER STATE OF BIRTH

If the father was born in the United States, enter the name of the state. If the father is known to have been born in the United States but the state is unknown, enter “Unknown.”

If the father was not born in the United States, enter the name of the country. If the father is known to have been born in a foreign country but the country is unknown, enter “Unknown.”

If no information is available as to whether the father was born in the United States or a foreign country, enter “Unknown.”

Make no entry if the father's name is not entered in 7a (Item 23 answered “No”).

Item 8a. MOTHER NAME (FIRST, MIDDLE, MAIDEN, LEGAL)

Enter the full maiden name of the mother. If mother's maiden name is the same as her married name, please make a notation on the back of the certificate.

Do not enter a last name acquired by marriage for maiden name.

Do not enter an assumed name for an unwed mother.

Item 8b. MOTHER RACE

Enter the race of the mother as it is obtained from the father, mother, or other informant.

For groups other than white, black, or American Indian, enter the national origin of the mother such as Chinese, Japanese, Korean, Filipino, Hawaiian, etc.

If it is necessary to abbreviate the race because of lack of space, do not use a single-letter abbreviation such as “C” because it would not be enough to identify the race.

If the informant indicates that the mother is of mixed race, enter both races or national origins.

If the mother is an American Indian, it is desirable to enter the specific name of the Indian tribe.

Item 8c. MOTHER DATE OF BIRTH (MONTH, DAY, YEAR)

Enter the exact month, day, and year the mother was born.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-88 for June 4, 1988

Item 8d. MOTHER STATE OF BIRTH

If the mother was born in the United States, enter the name of the state. If the mother is known to have been born in the United States but the state is unknown, enter “Unknown.”

If the mother was not born in the United States, enter the name of the country. If the mother is known to have been born in a foreign country but the country is unknown, enter "Unknown."

If no information is available as to whether the mother was born in the United States or a foreign country, enter "Unknown."

MOTHER'S RESIDENCE Items 9a. - 9e.

Mother's residence is the place where she has set up house keeping and where she usually sleeps. This is not necessarily the same as her "Home State," "Voting Residence," or "Legal Residence." Never enter a temporary residence such as one used during a visit, business trip, or vacation.

Residence for a short time at the home of a relative, friend, or home for unwed mothers for the purpose of awaiting the birth of a child is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should, therefore, be shown as place of residence of mother on the certificate.

The place of residence shown should be the actual location of the mother's home regardless of the mailing address. For example, if a mother lives in Rankin County and her mailing address is a rural route out of Jackson, the county listed should be Rankin even though the city of Jackson is in Hinds County. The same rule applies if an out-of-state address is involved. For example, if a mother whose home is in Marshall County, Mississippi has a Collierville, Tennessee mailing address, Mississippi and Marshall County should be listed as state and county of residence, but can be listed as Collierville, Tennessee.

Item 9a. MOTHER'S RESIDENCE STATE

Enter the name of the state in which the mother's place of residence is actually located. This may differ from the state used in her mailing address.

If the mother is not a U.S. resident, enter the country of residence.

Item 9b. MOTHER'S RESIDENCE COUNTY

Enter the name of the county in which the mother's place of residence is actually located.

Item 9c. MOTHER'S RESIDENCE CITY OR TOWN

Enter the name of the city or town in or near which the mother's place of residence is actually located. This may differ from the city or town used in her mailing address.

Item 9d. MOTHER'S RESIDENCE INSIDE CITY LIMITS

Enter “Yes” if the place where the mother lives is located inside the city limits of an incorporated place named in 9c.

Enter “No” if the place where the mother lives is located outside the city limits of an incorporated place named in 9c or is in an unincorporated place.

Item 9e. MOTHER'S RESIDENCE STREET AND NUMBER OR RURAL LOCATION

Enter the number and street name of the place where the mother lives. Do not use punctuation in this item.

If the place where the mother lives has no number and street name, enter the R.F.D. or route number and box number, showing which of these kinds of numbers was used.

Do not enter “General Delivery” or “P.O. Box” in this item. If the street the mother lives on has no name or route number or highway number, enter “No named street.”

Item 10a. MOTHER'S MAILING ADDRESS STREET AND NUMBER OR ROUTE AND BOX NUMBER

Do not use punctuation in this item.

Enter the street and number or other specific information needed for addressing mail to the mother. If the mother lives in an apartment complex or other location that requires an apartment or suite number be sure to include it in the mailing address. This may be different from the location information entered in 9e.

Item 10b. MOTHER'S MAILING ADDRESS CITY OR TOWN

Enter the city or town used in addressing mail to the mother. This may be different from the city or town of location entered in 9c.

Item 10c. MOTHER'S MAILING ADDRESS STATE AND ZIP CODE

Enter the state and ZIP code used in addressing mail to the mother. This may be different from the state of location entered in 9a.

Item 11a. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THIS CERTIFICATE IS CORRECT, SIGNATURE OF EITHER PARENT

After the personal facts about the family have been entered on the certificate and reviewed by one of the parents, obtain the signature of that parent.

NEVER have a parent sign a certificate which does not have the personal information entered.

Item 11b. SOCIAL SECURITY CARD REQUESTED FOR NEWBORN

If "Yes" is checked, there must be a signature in 11a. If "Yes" is checked, and a parent signed the certificate the State Department of Health will release such identifying information to Social Security Office as is needed to issue a Social Security card for the child. If there is no parent signature the response will be changed to "No" and the parent will have to contact their local Social Security Office for a Social Security card for the child. Also, be aware that if the postal service can not deliver mail due to a missing apartment or suite number in the mailing address, the Social Security mail will be returned to Social Security Administration office for voiding and destruction, and the parent(s) will have to apply directly to SSA.

If "No" is checked, a card can be obtained by the parent(s) directly from the Social Security Office.

Item 11c. INFORMANT, DATE SIGNED (MONTH, DAY, YEAR)

Enter the date the parent reviewed and signed the certificate on which the personal information was entered.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-08 for June 4, 2008.

Item 12a. I CERTIFY THAT THE STATED INFORMATION CONCERNING THIS CHILD IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, SIGNATURE (OF CERTIFIER)

If the birth occurred in a hospital or clinic, obtain the signature of the physician or other person in attendance at birth, or the designated hospital representative (usually Medical Records staff).

If the birth occurred in a hospital or clinic and the attendant at birth does not certify to the facts of birth within 72 hours after the birth, obtain the signature of the hospital administrator or a person on the medical records staff.

If the birth did not occur in a hospital or clinic, obtain the signature of the attendant at or immediately after birth, or of the father or mother if there was no attendant, or of the person in charge of the premises where the birth occurred if the father is absent and the mother is not able to certify to the facts of birth.

Item 12b. CERTIFIER, DATE SIGNED (MONTH, DAY, YEAR)

Enter the date the certifier, attendant or designated representative signed the certificate.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-08 for June 4, 2008.

Item 12c. NAME AND TITLE OF PERSON WHO DELIVERED CHILD IF OTHER THAN CERTIFIER

Type or print the name and title of the person who delivered the child if different from the person whose signature appears in 12a.

Make no entry if the person who delivered the child is the same as the person whose signature appears in 12a.

Item 12d. CERTIFIER NAME AND TITLE

Type or print the name and title of the person whose signature appears in 12a.

Item 12e. CERTIFIER MAILING ADDRESS (STREET AND NUMBER OR BOX NUMBER, CITY OR TOWN, STATE, ZIP CODE)

Enter the mailing address of the person whose signature appears in 12a. Do not use punctuation in this item.

LOWER PART OF LIVE BIRTH CERTIFICATE

The information provided in this part of the record (13 through 35) is of great importance for health and statistical purposes but will not appear on a certified copy of the certificate.

Item 13. FATHER ORIGIN OR DESCENT

Enter the origin or descent of the father as it is obtained from the father, mother, or other informant. Origin or descent refers to the nationality group of the person or his ancestors before their arrival in the United States (except for American Indians and Alaska natives). The entry is to reflect what the person considers himself to be, and is not based on percentages of ancestry, use terms such as Mexican, Afro American, Cuban, etc.

Do not enter a religious group such as Jewish, Moslem, Protestant, etc. Obtain the country of origin or nationality group.

Do not enter “White” or “Caucasian” or “European.”

If the father is of mixed origin or descent, enter all groups named.

If, after explanation of the meaning of this item, the person does not identify with any foreign nationality and considers himself to be “American,” enter “American.”

This item should be asked independently of the race item. Even though the entries for the two items could be the same for Alaska natives, American Indians, Chinese, Hawaiians, Japanese, etc., both items must be completed.

Make no entry if the father's name is not entered in Item 7a (Item23 answered “No”).

Item 14. FATHER SOCIAL SECURITY NUMBER

Enter the complete Social Security account number of the father.

Enter “000-00-0000, without hyphens” if the father does not have a Social Security account.

Enter “999-99-9999, without hyphens” if social security account is Unknown.

Make no entry if the father's name is not entered in Item 7a (Item 23 answered “No”).

Item 15. FATHER EDUCATION

Check the highest grade or college year completed in “regular” schooling. Do not check any levels below the highest one completed.

Do not enter any other kind of schooling such as barber and beauty schools, business or trade schools, and the like. Although these are important, they are not considered “regular” schools for the purposes of this item.

Make no entry if the father's name is not entered in Item 7a (Item 23 answered “No”).

Item 16. MOTHER ORIGIN OR DESCENT (SPECIFY CUBAN, AFRO AMERICAN, MEXICAN, ETC.)

Enter the origin or descent of the mother as it is obtained from the father, mother, or other informant. Origin refers to the nationality group of the person or her ancestors before their arrival in the United States (except for American Indians and Alaska natives). The entry is to reflect what the person considers herself to be, and is not based on percentages of ancestry.

Do not enter a religious group such as Jewish, Muslem, Protestant, etc. Obtain the country of origin or nationality group.

Do not enter “White” or “Caucasian” or “European.”

If the mother is of mixed origin or descent, enter all groups named.

If, after explanation of the meaning of this item, the person does not identify with any foreign nationality and considers herself to be “American,” enter “American.”

This item should be asked independently of the race item. Even though the entries for the two items could be the same for Alaska natives, American Indians, Chinese, Hawaiians, Japanese, etc., both items must be completed.

Item 17. MOTHER SOCIAL SECURITY NUMBER

Enter the complete Social Security account number of the mother.

Enter "000-00-0000, without hyphens" if the mother does not have a Social Security account.

Enter "999-99-9999, without hyphens" if Social Security number is Unknown.

Item 18. MOTHER EDUCATION

Check the highest grade or college year completed in "regular" schooling. Do not check any levels below the highest one completed.

Do not enter any other kind of schooling such as barber and beauty schools, business or trade schools, and the like. Although these are important, they are not considered "regular" schools for the purposes of this item.

Item 19. DATE LAST NORMAL MENSES BEGAN (MONTH, DAY, YEAR)

Enter the exact date (month, day, and year) of the beginning of the mother's last normal menstrual period as obtained from the physician or hospital record. If the date is not available from these sources, obtain it from the mother. If any part of the date is unknown, enter "Unknown" for that part. Do not leave blank

If the mother had a previous delivery but did not have a resumption of normal menstrual periods between the previous delivery and the time she became pregnant with this child, enter " None since last delivery" instead of the date of last menstrual period she had before the preceding delivery.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-08 for June 4, 2008.

If the exact day is unknown, but the month and year are known, obtain an estimate of the day from the mother or her physician. If an estimate of the day cannot be obtained, enter only the month and year. Enter "Unknown" for the day.

Item 20. CLINICAL ESTIMATE OF GESTATION (WEEKS)

Enter the length of gestation as estimated by the attendant.

Do not compute this information from the date last normal menses began and date of delivery.

If the attendant has not done a clinical estimate of gestation, enter "None." Do not leave this item blank.

Item 21a. PRENATAL CARE BY DOCTOR OR CLINIC MONTH (STAGE) OF PREGNANCY FIRST VISIT MADE

Check the month of pregnancy the mother was in when she first received care from a physician or attended a prenatal clinic for this pregnancy. This does not just refer to the care provided by the attendant at delivery.

Calculate the month of pregnancy from the beginning day of the last normal menstrual period entered in 18 and not from the day of conception. For example: if the last menstrual period began on July 10, 2008, and the first prenatal visit was made on September 16, 2008, two months would have already elapsed between July 10 and September 10, and thus the mother would have been in her third month of pregnancy on September 16 when prenatal care began.

If the length of gestation was more than nine months and the mother was in her tenth month of pregnancy when she made her first prenatal visit, check "9th."

If no prenatal care was received, check "No Care."

Item 21b. PRENATAL CARE BY DOCTOR OR CLINIC NUMBER OF VISITS

Enter the total number of all visits made for medical supervision from a physician and/or clinic during the prenatal period. Do not write in such terms as "Monthly" or "Weekly."

If no prenatal care was received (21a answered "No Care"), check "None."

Item 21c. APPLY PROVIDER OF PRENATAL CARE

If no prenatal care was received (Item 21a answered "No Care" and Item 21b answered "None") check "No Care." If other is checked, specify provider of care.

PREGNANCY HISTORY OF MOTHER--PREVIOUS LIVE BIRTHS (DO NOT INCLUDE THIS CHILD OR CHILDREN ADOPTED BY MOTHER): Items 22a-c

Item 22a. PREVIOUS LIVE BIRTHS NOW LIVING

Enter the number of other children born alive to this mother who were still living at the time of this birth. Do not include this birth or children the mother has adopted.

Check “None” if this was the first live birth to this mother or if all previous children who were born alive were dead when this child was born.

If the certificate is for the first-born member of a plural set, do not include the other members of the set who were born after this child. However, if the certificate is for the second-born member of a plural set, include the first-born member of the set in this count if it was born alive and was still alive when the second-born member was delivered. Similarly, if the certificate is for the third-born member of a plural set, include information about the first- and second-born members if applicable; continue in same manner for quadruplets, etc.

Item 22b. PREVIOUS LIVE BIRTHS NOW DEAD

Enter the number of other children born alive to this mother who were no longer living at the time of this birth. Do not include this birth or children the mother has adopted.

Check “None” if this was the first live birth to this mother or if all previous children who were born alive were still living when this child was born.

If the certificate is for the first-born member of a plural set, do not include the other members of the set who were born after this child. However, if the certificate is for the second-born member of a plural set, include the first-born member of the set in this count if it was born alive but died before the second born member was delivered.

Similarly, if the certificate is for the third-born member of a plural set, include information about the first- and second-born members if applicable; continue in same manner for quadruplets, etc.

Item 22c. DATE OF LAST PREVIOUS LIVE BIRTH (MONTH, DAY, YEAR)

Enter the month, day, and year of the mother's last previous live birth which was included in either Items 22a or 22b. If any part of the date is unknown, enter “Unknown” for that part. Do not leave blank.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-92 for June 4, 1992.

Enter “None” if the mother had not had a previous birth and both 22a and 22b were checked “None.”

If the certificate is for the second-born of a plural set and the first-born member was born alive, enter the date the first-born member was delivered. Similarly, if the certificate is for the third-born, etc. member of a plural set, enter the date of delivery of the last previous member of the set who was born alive. If all previously born members of a plural set were born dead, enter the date of the mother's last delivery that did result in a live birth.

PREGNANCY HISTORY OF MOTHER--OTHER TERMINATIONS (SPONTANEOUS AND INDUCED ABORTIONS, MISCARRIAGES, STILLBIRTHS, FETAL DEATHS): Items 22d-e

Include every recognized loss of a product of conception such as miscarriage, stillbirth, abortion (both induced and spontaneous), and fetal death.

Item 22d. OTHER TERMINATIONS

Enter the total number of fetuses or products of conception that were delivered dead regardless of length of gestation.

Check "None" if this was the first delivery for this mother, or if all previous deliveries resulted in live-born infants.

If the certificate is for the first-born member of a plural set, do not include the other members of the set born after this child. However, if the certificate is for the second-born member of a plural set, and the first-born member was born dead, include the first-born member of the set in this count. Continue in the same manner for third born, etc. members of plural sets.

Item 22e. DATE OF LAST OTHER TERMINATION

Enter the date of the last delivery which did not result in a live birth and was included in 22d. If any part of the date is Unknown, enter "Unknown" for that part. Do not leave blank.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-92 for June 4, 1992.

Enter "None" if the mother had never had a delivery which did not result in a live birth and 22d was checked "None."

If the certificate is for the second-born member of a plural set and the first-born member was born dead, enter the date the first-born member was delivered. Similarly, if the certificate is for the third-born, etc. member of a plural set, enter the date of delivery of the last previous member of the set born dead, if any. If all previously born members of a plural set were born alive, enter the date of the mother's last delivery that did not result in a live birth.

Item 23. MOTHER MARRIED AT BIRTH, CONCEPTION, OR AT ANY TIME BETWEEN?

Check "Yes" if the mother was legally married at the time of conception, at the time of birth, or at any time between conception and birth even though she may have been widowed or divorced at the time the child was born.

If the mother was separated but not divorced, check “Yes” because she was still legally married.

Check “No” if the mother was not legally married at the time of conception, at the time of birth, or at some time in between conception and birth.

Refer to Chart B1 on page 20 for examples.

Chart B1. Summary of Instructions for Items 23. Mother Married, and for Related Items (Exceptions to these rules can be made only upon court order.)

Situation	Mother Married (Item 23)	Father's name (Item 7a), Race (7b), State of Birth (7d), Hispanic Origin (13), Social Security Number (14) and Education (15)	Child's Last Name (Item 1)
Mother legally married at time of child's birth (includes mothers who are separated, regardless of length of separation)	Yes	Name, etc. of mother's legal husband (regardless of who the real father of the child is)	Same as last name of mother's legal husband unless Name of Child Verification signed by both listed parents alters this
Mother not legally married at time of child's birth but legally married at time of conception of child (for practical purposes, consider this to be the date last normal menses began, Item 19) Examples: (a) mother widowed, but husband died on or between date last normal menses began and date of birth of child, (b) mother divorced, but divorce granted on or between date last normal menses began and date of birth of child	Yes (and state whether widowed or divorced and give date of death of husband or date of divorce in Item 24)	Name, etc. of mother's former legal husband (regardless of who the real father of the child is)	Same as last name of mother's legal husband unless Name of Child Verification signed by both listed parents alters this
Mother formerly legally married but not legally married at time of conception or birth of child or at any time between conception and birth – Examples: (a) mother widowed and husband died before conception of child (date last normal menses, Item 19), (b) mother divorced and divorce granted before conception of child (Item 19) and no acknowledged father*	No (and state whether widowed or divorced and give date of death of husband or date of divorce in item 24)	All Items blank	Legal last name of mother at time of birth of child unless Name of Child Verification signed by listed mother alters this
Mother never legally married and no acknowledged father*	No	All Items blank	Legal last name of mother (maiden name) unless Name of Child Verification signed by listed alters this
Mother never legally or formerly legally married but not legally married at time of conception (date last menses began, Item 19) or birth of child or at any time between conception and birth and acknowledged father*	No (and if applicable, state whether widowed or divorced and give date of death of husband or date of divorce in Item 24)	Name, etc, of acknowledged father*	Same as last name of acknowledged father* unless Name of Child Verification signed by both listed parents alters this

*Name of Child Verification completed by both mother and natural father on form prescribed by the Mississippi State Department of Health and filed with birth certificate.

Note: Any type of legal termination of marriage other than divorce – for example, annulment is to be considered in the same way as divorce.

Item 24. IF MOTHER NOW WIDOWED OR DIVORCED, GIVE DATE (MONTH, DAY, YEAR)

Enter the month, day, and year the mother was widowed or divorced. If any part of the date is unknown enter "Unknown" for that part. Do not leave blank.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not used a number for the month such as 6-4-92 for June 4, 1992.

This date MUST be provided in order to use a paternity affidavit if mother is widowed or divorced.

Item 25a. APGAR SCORE 1 MINUTE

Enter the APGAR Score (0-10) as assigned by the delivery room personnel 1 minute after birth.

Item 25b. APGAR SCORE 5 MINUTES

Enter the APGAR Score (0-10) as assigned by the delivery room personnel 5 minutes after birth.

Item 26. DID BABY DIE? (MONTH, DAY, YEAR)

Check "yes" if it is known that the baby died, even if the place of death was at a different location.

Enter month, day, and year of death. If date is unknown, enter "Unknown".

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6 4 08 for June 4, 2008.

Item 27. IS BABY TO BE ADOPTED?

Check "Yes" if mother indicates baby is to be adopted.

If baby is to be adopted, all of the information on the birth certificate should be filled in for the natural mother (and the natural father if mother is married). Do not give any information concerning the adoptive parents.

CHECKBOX ITEMS Items 28a-35

The following items have been formatted into checkboxes rather than open-ended items with the hope of producing higher quality and more complete information. Please review each checkbox listed, and carefully check the appropriate block(s). Clearly mark an "X"

or check the block. The mark should not overlap more than one box. If "other" has been selected for any of these items you must specify the condition.

Item 28a. MEDICAL RISK FACTORS FOR THIS PREGNANCY

Check each of the medical risk factors that the mother experienced during this pregnancy.

If the mother experienced medical risk factor(s) not identified in the list (other infectious diseases, AIDS, or syphilis or drug use) check "Other" and enter the risk factor on the line provided.

If there were no medical risk factors, check "None."

Do not list such things as: repeat C-section, late or inadequate prenatal care, age or education of mother, number of other pregnancies, time since last delivery. (This information is obtained from other items on the certificate.)

Do not list conditions arising during previous pregnancies.

Do not alter the wording on the list of specific conditions (Example: If the mother had syphilis during her pregnancy, do not mark through "Genital herpes" for code 5 and write in "Syphilis." Put it in "Other."

Do not leave this item blank.

This information allows for the identification of specific maternal conditions that are often predictive of poor maternal and infant outcome. It can be used for planning intervention and prevention strategies.

Medical risk factors should be identified from the hospital or physician record.

Item 28b. OTHER RISK FACTORS FOR THIS PREGNANCY

Complete each question/statement.

Check "Yes" for tobacco use if the mother smoked at any time during the pregnancy. (Do not include marijuana, snuff, or chewing tobacco.)

If "Yes" is checked, specify the average number of cigarettes the mother smoked per day during her pregnancy. If, on the average, she smoked less than one cigarette per day, enter "Less than 1."

Do not make an entry of how many packs a day or week or how many cartons a week or month.

Check “Yes” for alcohol use if the mother consumed alcoholic beverages at any time during her pregnancy.

If “Yes” is checked, specify the average number of drinks she consumed per week. If, on the average, she drank less than one drink per week, enter “Less than 1.”

Enter the amount of weight gained by the mother during the pregnancy in pounds. Do not enter the total weight of the mother.

If no weight was gained or if mother lost weight during her pregnancy, enter “None.”

Do not leave this item blank.

Smoking and drinking during pregnancy may have an adverse impact on pregnancy outcome. This information is used to evaluate the relationship between certain lifestyle factors and pregnancy outcome and to determine at what levels these factors clearly begin to affect pregnancy outcome.

Information for this item should be obtained from the mother's medical chart or the physician. If the medical chart is not available or does not include this information and the physician is unavailable, the informant should be asked to respond to these items.

Item 29. COMPLICATIONS OF LABOR AND/OR DELIVERY

Check each medical complication present during labor and/or delivery.

If a complication was present that is not identified in the list, check “Other” and specify the complication on the line provided.

If there were no complications, check “None.”

Do not list such things as: C-sections, premature or other conditions that could be specified in “Medical Risk.”

Do not list conditions arising during previous pregnancies.

Do not list postpartum conditions.

Do not leave this item blank.

This information is used to identify pregnancy complications during labor and delivery and their relationship to method of delivery and birth outcome.

This information should be obtained from the mother's medical chart or the physician.

Item 30. METHOD OF DELIVERY

Check all methods that apply to this delivery. (If "Forceps" and/or "Vacuum" are marked, there should also be a mark by one of the methods in codes 1-4).

Do not leave this item blank.

This information is used to relate method of delivery with birth outcome, to monitor changing trends in obstetric practice, and to determine which groups of women are most likely to have cesarean delivery.

The method of delivery is relevant to the health of mothers, especially if it is by cesarean section. Information from this item can be used to monitor delivery trends across the United States.

This information should be obtained from the mother's medical chart or the physician.

Item 31. OBSTETRIC PROCEDURES

Check each type of procedure that was used during this pregnancy.

If a procedure was used that is not identified in the list, check "Other" and specify the procedure on the line provided.

If no procedures were used, check "None."

Do not list "Epidural" or "C-section."

Do not leave this item blank.

Information on obstetric procedures is used to measure the use of advanced medical technology during pregnancy and labor and to investigate the relationship of these procedures to type of delivery and pregnancy outcome.

This information should be obtained from the mother's medical chart or the physician.

Item 32. MOTHER TRANSFERRED PRIOR TO DELIVERY?

Check "Yes" if the mother was transferred from one facility to another facility before the child was delivered.

If "Yes" is checked, enter the name of the facility that transferred her and the name of the town (or state) where the facility is located. If the mother was transferred more than once, enter the name (and town or state) of the last facility from which she was transferred.

Do not leave this item blank.

This information is used to study transfer patterns and determine whether timely identification and movement of high-risk patients is occurring.

Item 33. CONGENITAL ANOMALIES OF CHILD

Check each anomaly of the child.

Do not include birth injuries.

If an anomaly is present that is not identified in the list, check "Other" and specify the anomaly on the line provided. Note that each group of system related anomalies includes an "Other" category for anomalies related to that particular system. If there is a question as to whether the anomaly is related to a specific system, enter the description of the anomaly in "Other (Specify)" at the bottom of the list.

Do not list "Premature" or "IUGR" or "Respiratory Distress."

Do not leave this item blank.

Information on congenital anomalies is used to identify health problems that require medical care and monitor the incidence of the stated conditions. It is also used to study unusual clusters of selected anomalies, to track trends among different segments of the population, and to relate the prevalence of anomalies to other characteristics of the mother, infant, and the environment.

This information should be obtained from the mother's and infant's physicians or the medical records (obstetric and pediatric).

Item 34. ABNORMAL CONDITIONS OF THE NEWBORN

Check each abnormal condition associated with the newborn infant.

If an abnormal condition is present that is not identified in the list, check "Other" and specify the condition on the line provided.

Do not include congenital anomalies.

Do not leave this item blank.

Information on abnormal conditions of the newborn helps measure the extent infants experience medical problems and can be used to plan for their health care needs. This item also provides a source of information on abnormal outcome in addition to congenital anomaly or infant death. These data allow researchers to estimate the number of high-risk infants who may benefit from special medical services.

This information should be obtained from the mother's and infant's physicians or the medical records (obstetric and pediatric).

Item 35. INFANT TRANSFERRED?

Check “Yes” if the infant was transferred from this facility to another facility after delivery.

If the infant was transferred, enter the name of the facility the infant was transferred to and the name of the town (or state) where the facility is located. If the infant was transferred more that once, enter the name (and town or state) of the first facility to which the infant was transferred.

Do not leave this item blank.

This information is used to examine transfer patterns and perinatal outcomes by type of hospital or level of care. It may also be used to follow up and determine the survival status of an infant transferred to a different facility.

REGISTRATION OF DEATHS

Mississippi statutes applicable to the determination and registration of deaths are §41-36-3, §41-57-1, and §41-57-7. A determination of death must be made in accordance with accepted medical standards. Section §41-57-13 (4) requires that the certifier of the cause of death of a female between the ages of ten (10) and fifty (50) specify whether or not the female was or had been pregnant within 90 days of the date of death. Sections §41-61-51 through §41-61-79 define deaths affecting the public interest and how these shall be handled, and §41-57-13 specifies how a death certificate may be amended.

DETERMINATION OF DEATH

In 1982 the Legislature passed a law which stated that death may be determined by either a) irreversible cessation of circulatory and respiratory functions or b) irreversible cessation of all functions of the entire brain, including the brain stem.

SUMMARY OF GENERAL REQUIREMENTS FOR REGISTRATION OF DEATHS

Rules and regulations pertaining to the registration of Deaths can be obtained from the Mississippi State Department of Health. Rules referenced here can be found in the Rules Governing the Registration and Certification of Vital Events.

Coverage: Every death which occurs in Mississippi. (**Rule 41**)

Place of filing: With Office of Vital Records Registration. (**Rule 41**)

Time allowed: Certificate within five days after death, but medical certification of cause of death by physician within 72 hours after death or by medical examiner within 72 hours of assuming jurisdiction over a death. (**Rules 41, 44**)

Responsibility for preparation of certificate and filing:

1. If in or pronounced dead at an institution:
    a. Name of deceased and hour, date, and place of death, person in charge of the institution. (**Rule 44**)
    b. Medical certification of cause of death, attending physician or medical examiner. (**Rules 43, 44**)
    c. Remainder of certificate and filing, funeral director. (**Rule 44**)

2. If not in or pronounced dead at an institution:
    a. All of certificate except sections for certifier and cause of death, funeral director. (**Rule 45**)
    b. Medical certification of cause of death, attending physician or medical examiner. (**Rule 45**)
    c. Filing, funeral director. (**Rule 45**)

Additional responsibilities:

1. Use of proper form. (**Rules 6, 7**)

2. Completion of certificate in an acceptable manner. (**Rules 6, 7**)

3. Provision of additional information, corrections, or new certificate if so requested by State Registrar because certificate submitted was incomplete or unsatisfactory. (**Rule 7**)

Monthly lists:

1. From funeral directors on the first day of each month, to Office of Vital Records Registration, a list of all persons buried during the preceding month or, if none, a report showing there were none. (**Rule 51-1.**)

2. From hospitals and nursing homes on the first day of each month, to Office of Vital Records Registration, a list of all persons dying in or enroute to the institution during the previous month or, if none, a report showing there were none. (**Rule 51-2.**)

3. From medical examiner/investigators on the first day of every month, to the Office of Vital Records Registration, a report listing all deaths certified during the previous month or, if none, a report showing there were none. (**Rule 51-3.**)

LEGALITY OF DEATH CERTIFICATES

Death certificates are "registered" by the Office of Vital Records Registration of the State Department of Health; that is, they are incorporated into the permanent, official records of the agency. As such they serve as legal documents acceptable in court (Section §41-57-9 of Mississippi Code, 1972, as amended).

CONFIDENTIAL NATURE OF DEATH CERTIFICATES

Death certificates are not classified as public records available for inspection. Instead, every legal and administrative measure possible is employed to protect the family of the deceased from unwarranted disclosure of personal information. Restrictions on access to death certificates are contained in **Rule 9** under **Laws and Rules Encompassing Vital Events**, **General Information**.

Paraphrased here, this rule says that only those with legitimate and tangible interest are entitled to a copy of a vital record. This interest is defined as the immediate family, guardian of an immediate family member, or legal representative of an immediate family member. Proof of relationship will be required of any guardian or legal representative and may be required of family members. Others may prove legitimate and tangible interest either with appropriate documentation or court action.

CERTIFIED COPIES OF DEATH CERTIFICATES

A certified copy may be obtained by anyone with a direct and tangible interest in a death record as defined in **Rule 9**.

Applications should be secured from the Vital Records Office in Jackson. The completed application with the proper fee ($15.00 for the first copy and $5.00 for each additional copy of the same record ordered at the same time) should be sent to:

Mississippi Vital Records
P. O. Box 1700
Jackson, MS 39215-1700

QUESTIONS AND PROBLEMS

If clarification, additional information, or assistance is needed regarding the registration of a death, contact your Vital Records Field Representative, the Supervisor for Vital Records Registration, or the State Registrar.

CERTIFICATE OF DEATH, FORM NO. 511, REVISED 1-2012

The death certificate is a four-part form made up in sets with the copies on paper of different colors.

1. The top copy or original (white) is to be sent to the Office of Vital Records Registration of the State Department of Health by the funeral director or, in the absence of a funeral home, by the physician or county medical examiner, after the entire certificate has been completed. This is the copy that will be the permanent record on file and from which certified copies will be made.

2. The second copy (yellow) may be used as a burial transit permit if the certificate has been completed and signed prior to transit.

3. The third copy (pink) is to be retained by the institution if death occurred in an institution. It is to be removed from the set after the name of the deceased, date and place of death, and pronouncement and medical certification of cause of death have been entered at the institution. The partially completed first, second, and fourth copies are then to be sent to the funeral director for completion of the remaining items. If death did not occur in an institution, the third copy is to be disposed of by the funeral director.

4. The fourth copy (blue) is to be sent to the certifier by the funeral director after the entire certificate has been completed.

Supplies of this form may be obtained from the Office of Vital Records of the State Department of Health.

The top part located above the perforated line will be separated from the certificate before it is filed. A reproduction of the death certificate form appears on the next page.

CERTIFICATE OF DEATH, FORM NO. 511, REVISED 1-2012

FILING DATE

CERTIFICATE OF DEATH

STATE OF MISSISSIPPI

STATE FILE NUMBER **123-**

1. DECEDENT'S LEGAL NAME (First, Middle, Last)	2. SEX	3a. HOUR OF DEATH	3b. DATE OF DEATH (Month, Day, Year)
		m.	

4. RACE (Check one or more races to indicate what the decedent considered himself or herself to be)

☐ White ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Samoan ☐ Asian Indian ☐ Guamanian or Chamorro

☐ Other Asian (Specify)_____ ☐ Other Pacific Islander (Specify)_____

☐ American Indian or Alaska Native (Name of the enrolled tribe or principal tribe)_____ ☐ Other (Specify)_____

5a. AGE AT LAST BIRTHDAY	ONLY IF UNDER 1 YEAR 5b. MOS | 5c. DAYS	ONLY IF UNDER 1 DAY 5d. HOURS | 5e. MINS	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTH PLACE (State or Foreign Country)
Years				

8. PLACE OF DEATH (Check only one box)	IF DEATH OCCURRED IN A HOSPITAL	IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL
	☐ Inpatient ☐ ER/Outpatient ☐ DOA	☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):_____

9a. FACILITY NAME (If not a facility, give street address, route number, or other location) (If hospital, also give ID number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. ZIP CODE	9d. COUNTY OF DEATH

10. DECEDENT'S EDUCATION – Check the box that best describes the highest degree or level of school completed at time of death.

☐ 8th grade or less ☐ 9th – 12th grade, no diploma ☐ High school graduate or GED completed ☐ Some college, no degree ☐ Associate degree (e.g., AA, AS) ☐ Bachelor's degree (e.g., BA, AB, BS)

☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown

11. MARITAL STATUS AT TIME OF DEATH	12. SURVIVING SPOUSE (If wife, give maiden name)	13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No)
☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never married ☐ Unknown		

14. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.

☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino, (Specify)_____

15. SOCIAL SECURITY NUMBER	16a. USUAL OCCUPATION (Kind of work done most of working life)	16b. KIND OF BUSINESS OR INDUSTRY

17a. RESIDENCE – STATE	17b. COUNTY	17c. CITY OR TOWN	17d. ZIP CODE	17e. STREET AND NUMBER OR RURAL LOCATION (Include apartment number)	17f. INSIDE CITY LIMITS (Yes or No)

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

20a. INFORMANT – NAME (Type or print)	20b. RELATIONSHIP TO DECEDENT	20c. MAILING ADDRESS (Street and number, City or town, State, ZIP Code)

21a. DISPOSITION OF BODY (Specify: Burial, Cremation, Removal, etc.)	21b. CEMETERY/CREMATORY – NAME	21c. LOCATION (City and State)	22a. FUNERAL DIRECTOR – SIGNATURE AND LICENSE NUMBER ▶

22b. FUNERAL HOME (Who first assumed custody of body)	22c. FUNERAL HOME LICENSE NUMBER	22d. MAILING ADDRESS (Street and number, City or town, State, ZIP Code)

22e. FUNERAL HOME (If body was transferred prior to disposition)	22f. MAILING ADDRESS (Street and number, City or town, State, ZIP Code)

23a. PERSON WHO PRONOUNCED DEATH – NAME AND TITLE (Type or print)	23b. PRONOUNCED DEAD (Month, Day, Year) ON	23c. PRONOUNCED DEAD (Time) AT m.

24a. NAME OF CERTIFYING PHYSICIAN OR CORONER (Type or print)	24b. MAILING ADDRESS (Street and number, City or town, State, ZIP Code)

This section to be completed by Physician if NOT a medical examiner

25a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

SIGNATURE ▶ MD/DO

25b. DATE SIGNED (Month, Day, Year)	25c. STATE LICENSE NUMBER

25d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or print)

This section to be completed by coroner or medical examiner ONLY

25e. On the basis of examination and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated.

SIGNATURE ▶

25f. TITLE

25g. DATE SIGNED (Month, Day, Year)

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.

		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a)	
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.	(b) DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only):	
	(c) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):	
	(d) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF DEATH ☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year
☐ Yes ☐ Probably ☐ No ☐ Unknown	

This section MUST be completed if Death NOT due to natural causes

32a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY m.	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED

32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

32f. INJURY AT WORK (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town	State

INSTRUCTIONS FOR COMPLETING DEATH CERTIFICATE (EXCEPT ITEMS 23a-32h, PRONOUNCEMENT, CERTIFIER, AND CAUSE OF DEATH, PAGE 41)

All items (Item 1 – 32h) must be completed; however, certain sections or items should be completed only by those responsible for that section or item within the death certificate. If the death is in a hospital or nursing home items 1, 3, 8 9a-9c and 23a-23c are to be completed by the institution; the funeral home is responsible for items 2, 4, 5a - 7, and 10 – 22f; and the certifier is responsible for items 24a- 32h. See **Rules 44** and **45** for deaths in the public interest and at places other than an institution. Do not write or type in the File Date or State File Number space above Item 1, as these will be completed by Vital Records Registration when the record is received for filing.

Under the following circumstances the items specified below should be left blank:

1. Item 5. Age at Last Birthday is broken into a. years, b. months, c. days, d. hours and e. minutes. Only one part of Item 5a - e should be completed. Depending on the age of the decedent, all other parts should be left blank.
2. Item 12 should be blank if the decedent was never married, widowed, or divorced.
3. Item 16a-16b should be blank if the deceased was never regularly employed.

If information is not available for any of the other items, enter "Unknown."

Please take special care in completing the death certificate as it terminates the identity of an individual and all rights and privileges of US Citizenship.

Item 1. DECEDENT'S LEGAL NAME (FIRST, MIDDLE, LAST)

Enter the complete legal name of the decedent, including Sr., Jr., II, etc. if appropriate. Do not enter an initial for first or middle name unless the initial did not stand for a name or the name the initial stood for is not known.

If the deceased was a married woman, enter her given names instead of her husband's name, and enter her middle name instead of her maiden name. For example: "Mary Lynn Jones" instead of "Mrs. Sam Ryan Jones," and "Mary Lynn Jones" instead of "Mary Smith Jones."

If the identity of the deceased is unknown, enter "Unidentified" in this item. Do not use such names as "John Doe" or "Jane Doe."

Item 2. SEX

Enter "Male" or "Female." If sex is undetermined, enter "Unknown".

Item 3a. HOUR OF DEATH

Enter the exact time of death (hour and minute according to local time). If the deceased had been placed on life support, the time of death should be listed as the time they were declared brain dead, not the time they were removed from life support.

Enter 12 noon as "12 Noon." If the time was one minute after 12 noon, enter "12:01 p.m."

Enter 12 midnight as "12 Mid." If the time was one minute after 12 midnight, enter "12:01 a.m."

Item 3b. DATE OF DEATH (MONTH, DAY, YEAR)

Enter the exact month, day, and year that death occurred. If the deceased had been placed on life support, the date of death should be listed as the date they were declared brain dead, not the date they were removed from life support. Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use number for the month such as 6-4-94 for June 4, 1994.

Pay particular attention to the entry of month, day, and year when the death occurs around midnight or on December 31. Consider a death exactly at midnight to have occurred at the end of one day rather than at the beginning of the next day.

Item 4. RACE

Check the box or boxes that indicate the race(s) of the deceased as stated by the informant. If the informant indicates that the deceased was of mixed race, check the box for each race.

If the deceased was of an Asian or Pacific Islander race not shown in the item, check the appropriate "Other" box and fill in the specific race in the blank.

If the deceased was an American Indian, enter the specific name of the Indian tribe in the blank next to this selection.

Items 5a – e. AGE AT LAST BIRTHDAY

Be sure that the age entered is the age of the deceased on the day of death and that it corresponds with the difference between the date of birth entered in Item 6 and the date of death entered in Item 3b. Make an entry only in the one section appropriate for the age of the deceased.

1. If the deceased was 1 or more years old, enter the age at last birthday in Item 5a, Years. Make no entries in Items 5b - e.

2. If the deceased was 1 or more months old but had not reached the 1st birthday, enter the age in Item 5b, Mos. Make no entries in items 5a, 5c - e.

3. If the deceased was 1 or more days old but had not reached the age of 1 month (the day of birth in the month after the month of birth), enter the age in Item 5c, Days. Do not count both the day of birth and the day of death. Make no entries in 5a-b or 5d - e.

4. If the deceased was 1 or more hours old but had not reached 24 hours (1 day), enter the age in Item 5d, Hours. Make no entries in 5a - c or e.

5. If the deceased was less than 1 hour old, enter the age in Item 5e, Mins. Make no entries in 5a-d.

Item 6. DATE OF BIRTH (MONTH, DAY, YEAR)

Enter the exact month, day, and year the deceased was born. Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-28 for June 4, 1928.

Be sure that the age, entered in 5a - e, and the date of birth are in agreement according to the date of death.

Item 7. BIRTH PLACE

If the deceased was born in the United States, enter the name of the state. If the deceased is known to have been born in the United States but the state is unknown, enter "Unknown."

If the deceased was not born in the United States, enter the name of the country. If the deceased is known to have been born in a foreign country but the country is unknown, enter "Unknown."

If no information is available as to whether the deceased was born in the United States or a foreign country, enter "Unknown."

PLACE OF DEATH

For deaths occurring on a moving conveyance within the United States, enter the information for place of death as if the death had occurred at the place where the body was first removed from the conveyance since that is where the death must be registered. However, if the death occurred in international waters or airspace or in a foreign country and the body was first removed from the conveyance in this state, contact the State Registrar for instructions.

Item 8. PLACE OF DEATH

Check only one box in this item. If the death occurred in a hospital or the deceased was pronounced dead at a hospital, check one of the entries: Inpatient, ER/Outpatient, or DOA. If the death occurred somewhere other than a hospital, check one of the entries: Hospice facility, Nursing home/Long term Care facility, Decedent's home, or Other (Specify). If the deceased died at someone's home other than his own, check "other" and specify whose home, for example: "Daughter's home".

Item 9a. FACILITY NAME (if not in a facility, give street address, route number, or other location)

If the death occurred in, or the deceased was pronounced dead at, a hospital or other institution, enter the full name of the hospital or other institution, and the hospital code if in a hospital.

If the death did not occur in, or the deceased was not pronounced dead at, a hospital or other institution, enter the street address or other specific location of the place where the death occurred or the deceased was pronounced dead. The words "Home" or "Residence" are not satisfactory entries; use the street address or road location.

Item 9b. CITY OR TOWN OF DEATH

Enter the name of the city or town where the death occurred or the deceased was pronounced dead. This should be the city or town where the hospital, institution, or other place named in Item 9a is located.

Item 9c. ZIP CODE

Enter the ZIP code for the location where the death occurred or the deceased was pronounced dead.

Item 9d. COUNTY OF DEATH

Enter the name of the county where the death occurred or the deceased was pronounced dead. This should be the county in which the hospital, institution, or other place named in Item 9a is located.

Item 10. DECEDENT'S EDUCATION

Check the box that best describes the highest degree or level of regular school completed by the deceased at the time of death. Check one box only.

Do not consider any other kind of schooling such as barber and beauty schools, business or trade schools, and the like. Although these are important, they are not considered "regular" schools for the purposes of this item.

This item is used in studies of the relationship between education and mortality and provides an indicator of socioeconomic status, which is also closely associated with mortality. This information is valuable in medical studies of causes of death and in prevention programs.

Item 11. MARITAL STATUS AT TIME OF DEATH

Check one box to indicate the marital status of the deceased at the time of death.

If the deceased was separated but not divorced, check the box "Married, but separated."

Check "Married" if the spouse was still alive at the specific time the deceased died even though the spouse may have also died a short time later and before the death certificate for the one who died first was completed.

If a husband and wife died within a few days, hours, or even minutes of each other, complete items 11 and 12 for each person according to his or her status at the moment of death. For example, if the wife died at 9:30 p.m. on May 25, 1994, and the husband died at 11:15 p.m. on the same day, the wife was "Married" at the time she died and her husband's name should be entered in item 12. However, at the time the husband died he was "Widowed," and, because of this, his wife's name should not be entered in item 12.

If a husband and wife are killed at the same time, such as in a motor vehicle accident, the one who is pronounced dead first should be marked "Married" and the name of the spouse should be entered in item 12. The one who is pronounced dead second should be marked "Widowed" and no spouse's name should be entered in item 12. If both are pronounced dead at the exact same time, or if it is not known which one was pronounced dead first, the marital status for both should be marked "Unknown" and no name should be entered in item 12.

Item 12. SURVIVING SPOUSE (If wife, give maiden name)

If the deceased was married at the time of death (Item 11 answered "Married", or "Married, but separated"), enter the complete name of the husband or wife who was still alive at the specific time the deceased died.

If the surviving spouse is the wife, enter her full maiden name instead of her husband's name, for example, "Ann Marie Green" instead of "Mrs. Jack Neal Brown" or "Ann Marie Brown."

Make no entry if there was no surviving spouse at the specific time of death (Item 11 answered "Never married," "Widowed," or "Divorced"). Do not enter the name of the former spouse of a widowed or divorced person.

Item 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No)

If the deceased had ever served in the armed forces of the United States, enter "Yes"; if not, enter "No" regardless of age.

Item 14. DECEDENT OF HISPANIC ORIGIN?

Determine the origin or descent of the deceased as stated by the informant. Origin or descent refers to the nationality group of the person or his or her ancestors before their arrival in the United States (except for American Indians and Alaska natives). The entry is to reflect what the person considered himself or herself to be, and is not based on percentages of ancestry. If the deceased was not of Hispanic origin, check "No, not Spanish/Hispanic/Latino." If the deceased was of Hispanic origin, determine the specific origin, such as Mexican, Puerto Rican, or Cuban, and check the appropriate box. If the deceased was of Hispanic origin but the specific origin is not known, check the box for "Yes, other Spanish/Hispanic/Latino."

This item should be asked independently of the race item.

Item 15. SOCIAL SECURITY NUMBER

Enter the complete Social Security account number of the deceased. Enter "None" if the deceased did not have a Social Security account. Ask to see the Social Security Card or other document that may have the decedent's Social Security Number. If no document is available, question to ensure that the number given is the decedent's and not the informant's. Providing the wrong Social Security Number may cause a disruption of benefits to the informant or decedent's family.

Item 16a. USUAL OCCUPATION (Kind of work done most of working life)

Enter the usual occupation or kind of work the deceased did during most of his or her working life, such as farmer, store manager, janitor, civil engineer, truck driver, registered nurse, college professor, welder, cook, etc. Do not enter "Retired," "Disabled," etc. If the deceased was retired, disabled, or institutionalized, give the occupation followed during most of his or her working life.

Enter "Student" if the deceased was a student at the time of death and had never been regularly employed.

Enter "None" if the deceased had never been regularly employed and was not a student.

Item 16b. KIND OF BUSINESS OR INDUSTRY

Enter the kind of business or industry to which the occupation entered in 16a was related, such as farming, grocery store, construction company, hospital, university, ship building, restaurant, government, etc. Do not enter the name of a company or organization.

Leave this item blank if the deceased was a student and/or had never worked regularly (Item 16a answered "Student" or "None").

RESIDENCE OF DECEASED

The residence of the deceased is the place where the person usually slept. This is not necessarily the same as "Home State," "Voting Residence," or "Legal Residence." Never enter a temporary residence such as one used during a visit, business trip, or vacation. Place of residence during a tour of military duty or during attendance at college is not considered temporary and should, therefore, be shown as place of residence on the certificate. Do not enter a mailing address if it is different from the actual specific location of the deceased's place of residence.

Persons who, at the time of their death, were living in institutions where individuals usually stay for long periods of time, such as penitentiaries, mental institutions, homes for the needy or aged, hospitals for the chronically ill, etc. are considered to be residents of the institution, and all entries in the residence items (17a-f) should reflect this unless the person had been in the institution only a short time.

The place of residence shown should be the actual location of the home, institution, etc., regardless of the mailing address. For example, if the deceased lived in Rankin County and the mailing address was a rural route out of Jackson, the county listed should be Rankin even though the city of Jackson is in Hinds County. The same rule applies if an out-of-state address is involved. For example, if a person whose home was in Marshall County, Mississippi had a Collierville, Tennessee mailing address, Mississippi and Marshall County should be listed as state and county of residence, but the city can be listed as Collierville, Tennessee.

If the deceased was an infant who died in a hospital and had never been taken "home," the entire residence section must be completed, with the place of residence entered being that of the mother.

If the deceased was a child (other than an infant who died in a hospital without ever having been taken "home"), the place of residence entered should be that of the mother or legal guardian unless the child did not live with either. If the child lived with and was taken care of by some other person, the place of residence of that person should be entered. However, if the child was living in an institution where individuals usually stay for long periods of time as specified earlier in this section, enter the location of that institution in the residence items (Items 17a-f).

Item 17a. RESIDENCE STATE

Enter the name of the state in which the deceased person's residence was actually located. See discussion above about what is to be considered a person's residence.

If the deceased was not a U.S. resident, enter the name of the country of residence and the name of the specific area in that country which most closely corresponds to a state.

Item 17b. COUNTY

Enter the name of the county in which the deceased person's residence was actually located.

Item 17c. CITY OR TOWN

Enter the name of the city or town in or near which the deceased person's residence was actually located. This location may be different from the city or town in a mailing address.

Item 17d. ZIP CODE

Enter the Zip Code for the location of the deceased person's residence.

Item 17e. STREET AND NUMBER OR RURAL LOCATION

Enter the number and street name of the place where the deceased lived. If the place where the deceased lived had no number and street name, enter the R.F.D. or route number and box number, showing which of these kinds of numbers was used.

Never enter "General Delivery" or a post office box number in item 17e as they are not locations. However, a route number combined with a box number may be entered in 17e, since the residence can be located from this type of information.

Item 17f. INSIDE CITY LIMITS

Enter "Yes" if the place where the deceased lived was located inside the city limits of an incorporated place named in Item 17c.

Enter "No" if the place where the deceased lived was located outside the city limits of an incorporated place named in Item 17c or was in an unincorporated place.

Item 18. FATHER'S NAME (FIRST, MIDDLE, LAST)

Enter the full name of the father of the deceased.

Item 19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST)

Enter the full name of the mother of the deceased as it was before she was ever married. Do not enter a last name acquired by marriage.

Item 20a. INFORMANT NAME

Enter the name of the person who furnished the personal facts about the deceased and his or her family. Do not leave these items blank.

Do not enter the hospital name if the deceased was an infant. Complete this item in the usual manner by entering the name and mailing address of the parent or other individual who furnished the personal facts about the infant and his or her family.

Item 20b. RELATIONSHIP TO DECEDENT

Enter the relationship of the informant to the decedent.

Item 20c. INFORMANT MAILING ADDRESS

Enter the complete mailing address of the informant whose name appears in Item 20a. (Street and number or route and box number, City or Town, STATE, ZIP Code)

Item 21a. DISPOSITION OF BODY

Specify "Burial," "Cremation," or "Removal," etc., in accordance with the disposition of the body. If the body is to be disposed of by a hospital, enter "Hospital Disposal."

If the body is to be used by a hospital or medical facility or mortuary school for scientific or educational purposes, enter "Body Donation." If the body was removed to another area but the disposition there is not known, enter "Removal." However, if the body was removed to another area and the disposition there is known, enter "Burial," "Cremation," etc.

Item 21b. CEMETERY, CREMATORY NAME

Enter the name of the cemetery or crematory if Item 21a was answered "Burial" or "Cremation."

If the body is to be used by a hospital or medical facility or mortuary school for scientific or educational purposes, enter the name of the hospital or school.

If the body was removed to another area but the disposition is not known, enter "Unknown."

Item 21c. CEMETERY, CREMATORY LOCATION

Enter the name of the city or town and the state where the cemetery or crematory named in Item 21b is located.

If the body is to be used by a hospital or medical facility or mortuary school for scientific or educational purposes, enter the city and state where the hospital or school named in Item 21b is located.

If the body was removed to another area but the disposition is not known, enter "Unknown."

Item 22a. FUNERAL DIRECTOR SIGNATURE AND LICENSE NUMBER

Obtain the signature and license number of the licensed funeral director of the funeral home listed in Item 22b. Rubber-stamp or typed in names are not acceptable.

Item 22b. FUNERAL HOME (WHO FIRST ASSUMED CUSTODY OF BODY)

Enter the name of the funeral home which first assumed custody of the body. If the funeral home is located in Mississippi, also enter the funeral home's 3-digit code in this item.

Item 22c FUNERAL HOME LICENSE NUMBER

Enter the establishment license number of the funeral home that first assumed custody of the body.

Item 22d. FUNERAL HOME MAILING ADDRESS

Enter the complete mailing address of the funeral home named in Item 22b.
(Street and number or route and box number, City or Town, STATE, ZIP Code)

Item 22e. FUNERAL HOME (IF BODY WAS TRANSFERRED PRIOR TO DISPOSITION)

If the body was transferred to another funeral home (other than the one listed in Item 22b) prior to disposition, enter the name of that funeral home in this item.

Item 22f. FUNERAL HOME MAILING ADDRESS

Enter the complete mailing address (Street and number or route and box number, City or town, State, and Zip Code) of the funeral home named in Item 22e.

INSTRUCTIONS FOR COMPLETING DEATH CERTIFICATE ITEMS 23a – 32h, PRONOUNCEMENT, CERTIFIER, AND CAUSE OF DEATH

Complete every item in these sections of the certificate, except:

1. Item 25a - d should be blank if certifier is a medical examiner (coroner).

2. Item 25d should be blank if the attending physician is the same as the physician whose signature appears in Item 25a.
3. Item 25e - g should be blank if certifier is a physician not acting as a medical examiner (coroner).
4. Item 32a - h should be blank if death was due to natural causes rather than accident, suicide, or homicide.

PRONOUNCEMENT

In most cases, the person who pronounces death and the person who certifies to the cause of death will be the same, and that person's name should appear in both items 23a and 24a. However, sometimes the pronouncer and the certifier will be different people. For example, the physician on call in the emergency room may actually pronounce a person dead on arrival, but later the county medical examiner will provide information concerning the cause of death (items 26 – 32h), and complete items 24a and b, and Items 25e - g. In this instance, the name of the emergency room physician should appear in Item 23a.

Item 23a. PERSON WHO PRONOUNCED DEATH NAME AND TITLE

Type or print the name and title of the physician, medical examiner, or other person who actually pronounced death. A signature is not required in this item.

Item 23b. PRONOUNCED DEAD ON (Month, Day, Year)

Enter the month, day, and year the deceased was pronounced dead by the person whose name appears in Item 23a. Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-94 for June 4, 1994.

Item 23c. PRONOUNCED DEAD AT (Time)

Enter the time (hour and minute) the deceased was pronounced dead according to local time. For a 12 hour clock use the a.m./p.m. designation.

Enter 12 noon as "12 Noon." If the time was one minute after 12 noon, enter "12:01 p.m."

Enter 12 midnight as "12 Mid." If the time was one minute after 12 midnight, enter "12:01 a.m."

CERTIFIER

The certifier is the person who provides the information regarding cause of death and who signs a statement to the effect that the cause of death is as stated on the certificate. Since it is not always possible to determine these facts with absolute certainty, the

certification statements are qualified by the terms “to the best of my knowledge” and “in my opinion.”

Item 24a. NAME OF CERTIFYING PHYSICIAN OR CORONER

Type or print the name of the physician or medical examiner who certifies to the cause of death and whose signature appears in 25a or 25e.

Item 24b. CERTIFIER MAILING ADDRESS

Enter the complete mailing address of the person whose name appears in Item 24a. (Street and number or route and box number, City or Town, State, ZIP Code)

CERTIFICATION BY PHYSICIAN NOT ACTING AS MEDICAL EXAMINER

This section is to be used only if the certifier named in Item 24a is a physician not acting as a medical examiner. It should be completed by the physician in charge of the deceased person's care for the illness or condition resulting in death. If this section is completed, Items 25e-g should be blank.

Item 25a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated, SIGNATURE

Obtain the signature of the physician (as specified in the preceding paragraph) who provides the information regarding cause of death. The physician should verify that the entries for cause of death (26-32h) are correct before signing the certificate.

Item 25b. DATE SIGNED (Month, Day, Year)

Enter the date the certifier whose signature appears in 25a signed the certificate. Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-94 for June 4, 1994.

Item 25c. STATE LICENSE NUMBER

Enter the Mississippi medical license number of the physician whose signature appears in Item 25a.

Item 25d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER

If the certifier whose signature appears in Item 25a was not the attending physician, enter the name of the attending physician here.

Make no entry if the certifier was the attending physician.

CERTIFICATION BY MEDICAL EXAMINER

This section is to be used only if the certifier named in Item 24a is a medical examiner (coroner). This includes a physician serving as a medical examiner for this death. If this section is completed, Items 25a-d should be blank.

Item 25e. On the basis of examination and/or investigation, in my opinion death occurred due to the cause(s) and manner as stated, SIGNATURE

Obtain the signature of the medical examiner who provides the information regarding cause of death. The medical examiner should verify that the entries for cause of death (26-32h) are correct before signing the certificate.

Item 25f. TITLE

Enter the title of the official whose signature appears in Item 25e. If the medical examiner is a physician, enter "MD" in addition to the official title.

Item 25g. CERTIFIER DATE SIGNED (Month, Day, Year)

Enter the date the certifier whose signature appears in Item 25e signed the certificate. Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-94 for June 4, 1994.

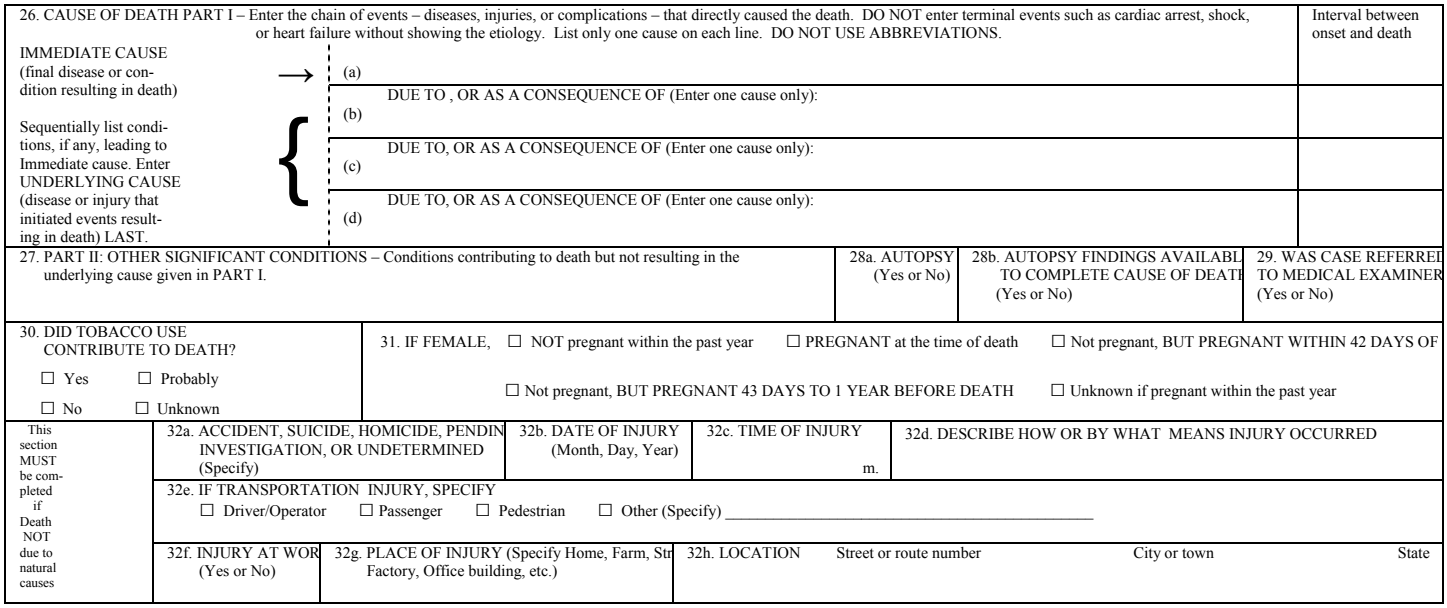
CAUSE OF DEATH

A cause of death is a disease, abnormality, injury, or other condition or event that contributed directly or indirectly to death. Death often results from the combined effect of two or more conditions. These conditions may be completely unrelated, arising independently of each other; or they may be causally related to each other, that is, one condition may lead to another which in turn leads to a third condition, etc.

Since the cause-of-death section on a death certificate is an important source of data for medical research and public health programs, it is essential that the certifier submit a correct, complete, and legible statement of the causal and pathological sequence of events leading to death. For the certifier, this is not only a legal responsibility but also an opportunity to contribute to one of the largest and most widely used compilations of information on causes of death in existence.

The cause-of-death section of the certificate follows guidelines recommended by the World Health Organization for obtaining comparable mortality data throughout the world.

This section, which is reproduced below, is designed to elicit the opinion of the certifier as to the underlying cause of death, with this to be indicated by the way in which the subsections for immediate cause, antecedent causes, and contributing causes are completed.



26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS. — Interval between onset and death

IMMEDIATE CAUSE (final disease or condition resulting in death) → (a)

Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.

(b) DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only):

(c) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):

(d) DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.

28a. AUTOPSY (Yes or No)

28b. AUTOPSY FINDINGS AVAILABL TO COMPLETE CAUSE OF DEATI (Yes or No)

29. WAS CASE REFERRED TO MEDICAL EXAMINER (Yes or No)

30. DID TOBACCO USE CONTRIBUTE TO DEATH?
☐ Yes ☐ Probably
☐ No ☐ Unknown

31. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF
☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes

32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)

32b. DATE OF INJURY (Month, Day, Year)

32c. TIME OF INJURY m.

32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED

32e. IF TRANSPORTATION INJURY, SPECIFY
☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

32f. INJURY AT WOR (Yes or No)

32g. PLACE OF INJURY (Specify Home, Farm, Str Factory, Office building, etc.)

32h. LOCATION Street or route number City or town State

If a death was due to an accident, suicide, or homicide, all items (26-32h) in the cause section must be completed. If a death was due to natural causes rather than an accident, suicide, or homicide, Items 32a-h should be left blank and only Items 26-31 completed. See Examples 1-9 on pages 54 - 65.

It is not necessary that the cause-of-death section be completed in the certifier's handwriting. If possible, the information should be typed. However, the certifier must then carefully review the entries to verify that the information was correctly transcribed.

Abbreviations should not be used for names of diseases, etc. as some are subject to varying interpretations. For example, "CRF" may be interpreted as either chronic respiratory failure or chronic renal failure.

Item 26. PART I, DEATH CAUSED BY:

List the causes in reverse chronological order with the immediate cause on the top line and the underlying cause that started the sequence of events that led to death on the lowest line used in Part I.

Enter only one cause per line.

Use as many lines in Part I as necessary to show the sequence of events that led to death. If the sequence to be entered consists of more than four causes, see illustration below for the method to be used in recording the causes.

26. CAUSE OF DEATH	PART I. – Enter the chain of events – diseases, injuries or complications – that directly caused the death. DO NOT enter terminal events such as cardiac, arrest, shock, o without showing the etiology. List only one cause on each line. DO NOT USE APPREVIATIONS.	Interval between onset and death
IMMEDAITE CAUSE (final disease or con dition resulting in death) →	(a) **Asphyxia**	**Minutes**
Sequentially list condi tions if any, leading to Immediate cause, Enter UNDERLYING CAUSE (disease or injury that Initiated events result ing in death) LAST {	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only) (b) **Cerebellar hemorrhage**	**Hours**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only) (c) **Cerebral arteriosclerosis**	**About 3 yrs**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only) **(d) Hypertension** (~~b~~) **(e) Heart disease**	**3 years +** **15 years**

Do not enter the mode of dying (such as "Heart failure" or "Respiratory failure") since it is only a symptom of the fact that death occurred and does not provide any information about the cause of death.

If there is real doubt as to the causes leading to death, qualifying phrases such as "possible" or "probable" may be used to reflect this uncertainty.

If knowledge of the case is so meager that the cause is not known, enter "Unknown"; do not leave Part I blank.

Line (a) IMMEDIATE CAUSE

Enter the direct or immediate cause of death. This is the disease, injury, complication, etc. that directly preceded death.

The entry on line (a) can be the sole entry in Part I if there was only one condition that led to death.

There must always be an entry on line (a).

Line (b) DUE TO, OR AS A CONSEQUENCE OF:

Enter the disease, injury, complication, etc., if any, that gave rise to the direct or immediate cause listed on line (a).

The condition entered here must be considered to have been antecedent to the immediate cause, both with respect to time and etiological or pathological relationship.

If it is believed to have prepared the way for the immediate cause, the entry on line (b) can be considered as antecedent to the cause listed on line (a) even though a long interval of time had elapsed since its onset.

Line (c) DUE TO, OR AS A CONSEQUENCE OF:

Enter the disease, injury, complication, etc., if any, that gave rise to the cause listed on line (b).

The condition entered here must be considered to have been antecedent to the cause listed on line (b), both with respect to time and etiological or pathological relationship.

The entry on line (c) can be antecedent to the cause listed on line (b) even though a long interval of time had elapsed since its onset.

Line (d) DUE TO, OR AS A CONSEQUENCE OF:

Enter the disease, injury, complication, etc., if any, that gave rise to the cause listed on line (c).

The condition entered here must be considered to have been antecedent to the cause listed on line (c), both with respect to time and etiological or pathological relationship.

The entry on line (c) can be antecedent to the cause listed on line (b) even though a long interval of time had elapsed since its onset.

INTERVAL BETWEEN ONSET AND DEATH

For every cause listed in Part I, enter the interval between the onset of that cause and death.

Normally the intervals should be progressively longer for each antecedent cause since they are listed in reverse chronological order.

The interval may be given in minutes, hours, days, weeks, months, or years. If the time of onset is obscure, use an approximation such as "4-5 years" or "About 2 months." If the time of onset is unknown, enter "Unknown." Do not leave the interval blank.

If death was caused by an accident, suicide, or homicide, at least two lines in Part I must be completed. Enter the result (for example, "Fracture of skull" or "Third degree burns over 75 percent of body") of the external cause on the higher of the two lines used, and enter the antecedent event (for example, "Struck by falling tree limb" or "Trapped in burning house") that produced the injury on the lower of the two lines used. Even though an event is antecedent to the injury it produces, the two are almost simultaneous and, therefore, the same time interval can be entered for both.

Item 27. PART II, OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I

Enter any other important disease or condition that was present at the time of death and may have contributed to death but was not related to the immediate cause of death listed on line (a) in Part I. For example, if a person who died of cancer of the breast also had hypertensive heart disease that contributed to the death, the hypertensive heart disease should be entered in Part II.

If there were no other significant conditions, enter "None."

Item 28a. AUTOPSY

Enter "Yes" if a partial or complete autopsy was performed; otherwise, enter "No."

Item 28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH?

Enter "Yes" if there was an autopsy performed and the findings were available to the Certifier at the time the cause of death section was completed. Otherwise, enter "No".

Item 29. WAS CASE REFERRED TO MEDICAL EXAMINER?

Enter "Yes" if the medical examiner was contacted in reference to this case; otherwise, enter "No." Enter "Yes" if the medical examiner was informed of the case, regardless of whether this official actually investigated the case or certified to the facts of death.

Item 30. DID TOBACCO USE CONTRIBUTE TO DEATH?

Check the appropriate box: "Yes," "No," "Probably," or "Unknown."

Item 31 IF FEMALE, SPECIFY

If female, check the selection that best fits the situation.

If decedent is not female, leave blank.

EXTERNAL CAUSES (Accident, Suicide, Homicide) This section MUST be completed if Death NOT due to natural causes.

This section is to be used only if an external event caused or contributed to the death. It must be completely filled in for every such death to supplement Parts I and II of the cause-of-death statement as they cannot provide all of the detailed information needed to fully describe the circumstances and events related to an external cause. All items must be completed even if no decision has been reached as to whether the external cause was an accident, suicide, or homicide.

Item 32a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED

If it has been determined whether the event that caused or contributed to the death was an accident, suicide, homicide, enter the decision reached.

The category entered on the death certificate is not necessarily the same as the category that might be decided upon in a court of law. For the purposes of a death certificate, "Suicide" includes all deaths from injuries that were intentionally self-inflicted. "Homicide" includes all deaths from injuries purposely inflicted by another person.

If no determination has been made because an investigation is incomplete or autopsy results have not been received, enter "Pending investigation" or "Pending autopsy results." Do not hold the death certificate for longer than 72 hours while awaiting the results of an autopsy or other investigation. Later, when the results of the autopsy or investigation are received, contact the Office of Vital Records Registration and ask for a "STATEMENT TO AMEND CAUSE OF DEATH" form. This form can then be used to revise item 32a (or any other part of the CAUSE OF DEATH section) to reflect the findings of the autopsy or investigation.

If, after thorough investigation, no determination could be made, enter "Undetermined."

Do not leave this item blank if an external cause was involved.

Item 32b. DATE OF INJURY (Month, Day, Year)

Enter the exact month, day, and year the injury occurred. Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-94 for June 4, 1994.

Item 32c. TIME OF INJURY

Enter the exact time (hour and minute) the injury occurred. If you use a 12 hour clock be sure to designate a.m./p.m.

Enter 12 noon as "12 Noon." If the time was one minute after 12 noon, enter "12:01 p.m."

Enter 12 midnight as "12 Mid." If the time was one minute after 12 midnight, enter "12:01 a.m."

If the exact time is not known, estimate the time.

Item 32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED

Enter a concise description of how the injury occurred. In some instances, this entry may be the same as a cause listed in Parts I or II if that cause completely described what happened to produce the injury. In other instances, the entry in Item 32d must provide greater detail than a cause listed in Parts I or II.

The specific information needed in Item 32d for major types of external causes is as follows:

Motor vehicle accident
1. Location - street, highway, private driveway, parking lot, private road, etc.
2. Description - collision (specify train, automobile, motorcycle, bicycle, animal, person, etc.), loss of control
3. Type of vehicle(s) involved – car, pickup, SUV, bicycle, etc.

Water transport accident
1. Watercraft accident (if any) - sinking, overturning, fire, explosion, collision, etc.
2. Type of injury - drowning, caused by machinery, fall (from where to where), burn, etc.
3. Identity of deceased - occupant of small boat, crew of watercraft, swimmer, water skier, etc.

Poisoning
Name of specific solid, liquid, or gas - aspirin, Darvon, ethyl alcohol, floor polish, butane gas, exhaust gas from motor vehicle (not in transit), etc.

Fall
1. From what or into what if from one level to another - stairs, ladder, bed, roof, tree, cliff, bridge, manhole, ditch, etc.
2. Due to what if on same level - slipping on ice, mud, oil, stumbling over curb, rug, toy, etc. Whether caused by seizure or epileptic attack.

Burn
By what - fire, steam, boiling water, cigarette, welding torch, lye, etc.
   a. If fire, where - private dwelling, other building, outdoors.
   b. If fire, whether there was an explosion,

c. If normal or controlled fire, source - space heater (gas), fireplace, wood cook stove, bonfire, etc.
d. If other fire, what was on fire - clothing only, bed only, matches or gasoline only, house, hotel, theater, grass, forest, etc.

Drowning (other than in water transport)
1. Activity involved - swimming, water-skiing, scuba diving, fishing (not from boat), surf boarding, taking bath, underwater construction or repair, etc.
2. Whether activity was recreational or for other purposes

Suffocation, entry of foreign body
1. Whether suffocation, asphyxiation, or other injury
2. Object responsible - blanket, plastic bag, abandoned refrigerator, falling dirt, piece of meat, bone, seed, marble, etc.
3. Part of body, if any, the object entered or lodged in - nose, mouth, trachea, esophagus, rectum, ear, eye, etc.
4. Other conditions or events - asleep in cradle, cave-in of embankment, choked and regurgitated food, etc.

Struck by or against
1. Object - brick, baseball, tree, hammer, another person, etc.
2. How and whether in sports or in a crowd - crushed against wall in a crowd, abdomen stepped on during football game, collapse of building in storm, looked back while roller-skating and ran into side of rink, etc.

Machinery and tools
1. Specific type of machine or tool - chain saw, reaper, crane, bulldozer, power press, textile machine, lawn mower, electric knife, axe, pitchfork, etc.
2. Description of event - caught in reaper, hit by crane, crushed by bulldozer which overturned on slope, struck by axe head which came off handle, etc.

Firearms
1. Type of gun – hand gun, rifle, shotgun, BB gun, machine gun, etc.
2. If accident, self-inflicted or inflicted by another person
3. If injuries resulted from legal intervention (action taken by law enforcement or military personnel on duty in the course of maintaining order, attempting to make an arrest, etc.), so state and give means of inflicting injury such as revolver, tear gas, bayonet, club, etc.

Item 32e. IF TRANSPORTATION INJURY, SPECIFY

If death was caused by any kind of transportation injury, check the box which describes the status of the deceased at the time the incident occurred. If the status of the deceased is unknown, check the box for "Other" and write "Unknown" in the blank.

Item 32f. INJURY AT WORK (Yes or No)

Enter “Yes” if injury occurred while deceased was at work; otherwise enter “No.”

Item 32g. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.)

Enter the type of place where the injury occurred. See additional examples below:

Highway, Woods, Swimming Pool, Grocery Store, Lake, Auto Repair Shop, River Parking lot, Stadium, School, Park, Jail

Item 32h. LOCATION (Street or route number, City or Town, State)

Enter the complete address of the place where the injury occurred.

EXAMPLES OF STATEMENT OF CAUSE OF DEATH

On the following pages examples which illustrate the proper completion of the cause section of a death certificate are presented. For each example, a case summary is given, and below that is a reproduction of the cause-of-death section showing how it should be filled in for that case. Comments calling attention to specific items or requirements are also provided. This series of examples should be reviewed in the order in which the cases are presented for the best understanding of the way in which statements of cause of death should be entered.

Examples 1-6 illustrate deaths due to natural causes and Examples 7-9 illustrate deaths due to external causes (accident, suicide, and homicide). There are examples of medical examiner's cases as well as cases certified to by physicians not acting as medical examiners.

CAUSE OF DEATH - EXAMPLE 1.

Case summary:

Shortly after dinner on the day prior to admission to the hospital, a 48-year-old male developed a cramping, epigastric pain which radiated to the back and which was followed by nausea and vomiting. The pain was not relieved by position or antacids. The pain persisted and 24 hours after onset, the patient sought medical consultation. Past history revealed excessive alcohol intake and intermittent episodes of similar epigastric pain during the past two years. The patient denied diarrhea, constipation, hematemesis, or melena. He was admitted to the hospital with a diagnosis of an acute exacerbation of chronic pancreatitis. Radiological findings included widening of the duodenal "C" loop and blurring of the left psoas muscle margin. Serum amylase was 450 Somogyi units. The day after admission, the patient seemed to improve. However, that evening, he became disoriented, restless, and hypotensive. In spite of intravenous fluids and norepinephrine, the patient remained hypotensive and died 8 hours later.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Hypotension**	**8 hours**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST. {	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Recurrent pancreatitis**	**2 years**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c) **Chronic alcoholism**	**About 3 years**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
NONE	**Yes**	**Yes**	**No**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF
☐ Yes ☐ Probably ☐ No **X** Unknown	☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY m.	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State

Comments:

The sequence of events leading to death is entered in Part I with the immediate cause on the top line and the underlying cause that started the sequence on the lowest line used.

A time interval is given for each cause with each one progressively longer even though the exact time of onset of the cause on line (c) was not known.

An autopsy was performed (Item 28a), and the findings were available when completing the cause of death (Item 28b).

No other significant conditions that could have contributed to death were found (Part II).

There was no reason to inform the medical examiner of this case (Item 29).

Since death was due to natural causes, Items 32a-h are left blank.

CAUSE OF DEATH - EXAMPLE 2.

Case summary:

A 31-year-old female was admitted to the hospital because of melena. A diagnosis of multiple polyps of the colon with carcinomatous transformation was made, and a total colectomy with an ileorectal anastomosis was done. The patient was also treated with adjuvant 5-fluorouracil. Two years later, a defect was seen on liver scan, and the carcinoembryonic antigen was elevated. A liver biopsy revealed metastatic carcinoma consistent with a primary carcinoma in the colon. Four months later, the patient entered the hospital for the last time with the chief complaints of nausea, vomiting, diplopia, and vertigo. Her condition progressively deteriorated with clinical evidence of liver failure, widespread metastatic disease, and cachexia. She died four weeks after admission.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Widespread**	**Several months**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST. {	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Malignant change in polyps of colon**	**2 1/2 years**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c) **Polyposis coli**	**Approx 10 yrs**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
NONE	**Yes**	**Yes**	**No**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE,
☐ Yes ☐ Probably	**X** NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS O
X No ☐ Unknown	☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY m.	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State

Comments:

The primary site of the cancer is clearly shown.

In this case the pre-cancerous condition was known and is also shown.

The condition on line (c) was considered antecedent to the cause entered on line (b) even though a long period of time had elapsed since its onset.

Since the deceased was a female of child-bearing age, Item 31 is checked “Not pregnant within the past year” to indicate her pregnancy status.

CAUSE OF DEATH - EXAMPLE 3.

Case summary:

A 65-year-old female was first seen complaining of dyspnea and substernal pain precipitated by exertion. The ECG response to exercise on the treadmill was a depression in the ST segments of 1.5 mV. The patient's symptoms were alleviated by Dyazide and sublingual nitroglycerin for about four years, but then the frequency and severity of angina increased. Propranolol was prescribed. Ten months later the patient developed chills, fever, and pleuritic pain following the onset of influenza. X-ray of the chest revealed patchy involvement of both lungs. The leukocyte count was 20,000. Blood culture was positive for pneumococci. Seventy-two hours after penicillin therapy was initiated, temperature returned to normal and symptoms subsided. A month later patient was admitted to hospital following prolonged precordial pain radiating to left arm and jaw. Pulse was 160. The ECG revealed characteristic Q waves and elevation in the ST segments. Five days after admission, death occurred as a result of rupture of the myocardium with hemopericardium and tamponade.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Rupture of myocardium**	**Nine months**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Acute myocardial infarction**	**6 days**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c) **Chronic ischemic heart disease**	**5 years**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
Influenza, Pneumococcal pneumonia	**No**	**No**	**No**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF
☐ Yes ☐ Probably ☐ No **X** Unknown	☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY m.	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State

Comments:

The influenza and pneumonia which occurred within the chronology of Part I are entered, not in Part I, but in Part II since they contributed to death but were not related to the immediate cause (rupture of myocardium) on line (a).

Since there was no autopsy performed (Item 28a), the answer in Item 28b must be “No”.

Since the deceased was not of child-bearing age, it was not necessary to check a box in Item 31.

CAUSE OF DEATH - EXAMPLE 4.

Case summary:

A 59-year-old male was admitted to the hospital with complaints of vomiting, high fever, and severe headache. After examination and tests, a diagnosis of viral encephalitis was made. The examination also showed severe generalized arteriosclerosis of about 10 years standing and moderate varicose veins of the lower extremities. In spite of treatment, the patient's condition rapidly deteriorated and he died three days later.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Viral encephalitis**	**4 days**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b)	
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c)	
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
Generalized arteriosclerosis	**No**	**No**	**No**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF
☐ Yes ☐ Probably **X** No ☐ Unknown	☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY m.	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State

Comments:

Death was caused by a single, acute illness rather than a sequence of events occurring over a period of years. However, generalized arteriosclerosis, a chronic condition of long duration, was considered by the certifier to have contributed to death even though it was not related to the viral encephalitis. The other condition, varicose veins, was not considered to have even contributed to death.

Note that, in this example, death was caused by an acute illness with a chronic illness as a contributory cause. In contrast, Example 3 shows an instance in which a chronic disease caused death but acute diseases were contributory causes.

CAUSE OF DEATH - EXAMPLE 5.

Case summary:

An 88-year-old female was taken to a physician's office late one afternoon because of abdominal pain that had persisted for two days. The pain had been mild at first but had become severe on the day she was seen by the physician. An additional symptom was bile-stained vomitus. After examination and X-rays, a diagnosis of strangulated femoral hernia was made. The patient was hospitalized that evening, and additional X-rays, tests, and examination were consistent with that diagnosis. Surgery was considered imperative despite her advanced age and weakened condition, and an operation to release the strangulated hernia was undertaken in the early hours of the morning. About 45 minutes after the surgery began, cardiac arrest occurred. Measures undertaken to restore the heart function failed and she was pronounced dead.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Cardiac arrest**	**15 min**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST. {	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Herniorrhapy**	**1 hour**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c) **Strangulated femoral hernia**	**3 days**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
NONE	**No**	**No**	**No**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF
☐ Yes ☐ Probably **X** No ☐ Unknown	☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY m.	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State

Comments:

The immediate cause was a surgical complication. Therefore the operation is listed on line (b) as the antecedent cause. The condition for which the surgery was performed is listed on line (c) revealing the true underlying cause.

CAUSE OF DEATH - EXAMPLE 6.

Case summary:

A 24-year-old female who was employed by a department store did not report for work on a Monday morning as expected. After several unsuccessful attempts to reach her by phone, two co-workers went to the apartment complex where she lived alone. Her car was there, but she did not answer the door. They persuaded the apartment manager to unlock the door for them and found her dead in the bedroom. The medical examiner who was called ordered an autopsy and made other investigations. He found that she had been diagnosed as diabetic eight months prior to death. Her disease was controlled by insulin and diet, but on a previous occasion direct regulation of her diabetes by her physician had been necessary because of her carelessness in taking insulin. In addition, she had not returned to her physician for a scheduled check-up three weeks earlier. The autopsy findings were consistent with diabetic coma; no other condition which could have caused death was found.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Diabetic coma**	**14 hours**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Diabetes mellitus**	**8 months**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c)	
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
NONE	**Yes**	**Yes**	**Yes**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE,
☐ Yes ☐ Probably ☐ No ☐ Unknown	☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF ☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH **X** Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY m.	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State

Comments:

The circumstances of this death were such that investigation by a medical examiner was required even though there was no evidence of violence.

Since the deceased was a female of child bearing age, a response is required in Item 31.

CAUSE OF DEATH - EXAMPLE 7.

Case summary:

A 60-year-old male was discovered dead in his back yard by neighbors. There was a large wound in his chest, and a hunting rifle was on the ground beside him. An autopsy and ballistics test were ordered by the medical examiner. After hearing the results of the autopsy and testimony from several family members and neighbors, the medical examiner ruled that death was due to an accidental gunshot wound sustained while cleaning a gun.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Pulmonary hemorrhage**	**5 - 10 minutes**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Discharge of gun into lower right chest**	**5 - 10 minutes**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c)	
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
NONE	**Yes**	**Yes**	**Yes**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE,
☐ Yes ☐ Probably **X** No ☐ Unknown	☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF ☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDIN INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	Accident	**Aug. 7, 1989**	**5:00** p.m.	**Deceased was cleaning rifle when it accidentally discharged**
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State
	No	**Home - yard**	**492 Oak Street, Leeburg, MS**	

Comments:

Both the external event and the result it produced are entered in Part I as is necessary for every death due to an external cause. They are entered on separate lines.

Even though the event was antecedent to the injury, the two were almost simultaneous and the same interval is shown for both.

Since death was not due to natural causes all parts of Items 32a - h are filled in.

The entry in Item 32a establishes that this death was accidental and supplements the medically oriented causes listed in Part I.

The statement in Item 32d confirms information in Part I, line (b) and in Item 32a as well as providing all additional facts needed. It describes how the injury occurred, provides

the gun type, reveals that the gun was not fired by another person, and makes clear that this self-inflicted injury was accidental rather than intentional (suicide).

Other facts that will permit precise analysis of the circumstances of deaths due to external causes are entered in Items 32b, c, e-h.

CAUSE OF DEATH - EXAMPLE 8.

Case summary:

A 54-year-old male was found dead in an automobile in a closed garage. The motor was running and a hose extended from the passenger compartment of the car to the exhaust pipe. Relatives indicated that the deceased had been despondent for some time because of an inoperable malignancy that had been discovered, and letters found in the car indicated intent to take his own life because of this condition. The medical examiner was called and ruled that the cause of this death was suicide.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Carbon monoxide poisoning**	**Unknown**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Inhalation of automobile exhaust fumes**	**Unknown**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c)	
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
Cancer of the stomach	**No**	**No**	**Yes**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE,
☐ Yes ☐ Probably **X** No ☐ Unknown	☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF ☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	Suicide	**May 5, 1989**	**Unknown** m.	**Inhaled exhaust from car with motor running in closed garage**
	32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
	32f. INJURY AT WOR (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, St Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State
	No	**Private garage**	**898 Sylvan Road, Alexandria, MS**	

Comments:

The external event and injury causing death are entered in Part I. Cancer of the stomach is listed in Part II showing that it was not related to the immediate cause but that it contributed to death.

All parts of Items 32a - h are filled in as required for death due to external causes.

The description in Item 32d supplements the entry on line (b) in Part I by stating the methodology used in the suicide.

CAUSE OF DEATH - EXAMPLE 9.

Case summary:

A 19-year-old male who was playing cards at a private club accused one of the other players of cheating. After arguing a while, they went outside, followed by a number of other persons who were also at the club. A fist fight began and a few minutes later he was stabbed in the neck by the other person who had suddenly pulled out a knife. He fell dead almost immediately. Testimony of witnesses at the scene provided evidence that led to a ruling by the medical examiner that death was due to homicide.

Death certificate:

26. CAUSE OF DEATH PART I – Enter the chain of events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.		Interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) →	(a) **Severed carotid artery**	**Few seconds**
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST.	DUE TO , OR AS A CONSEQUENCE OF (Enter one cause only): (b) **Stabbed in neck**	**Few seconds**
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c)	
	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (d)	

27. PART II: OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not resulting in the underlying cause given in PART I.	28a. AUTOPSY (Yes or No)	28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)
NONE	**No**	**No**	**Yes**

30. DID TOBACCO USE CONTRIBUTE TO DEATH?	31. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF
☐ Yes ☐ Probably **X** No ☐ Unknown	☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year

This section MUST be completed if Death NOT due to natural causes	32a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)	32b. DATE OF INJURY (Month, Day, Year)	32c. TIME OF INJURY	32d. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED
	Homicide	**Apr. 23, 1989**	**2:10** p m.	**Stabbed in neck with knife by another person during fight**

32e. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____			
32f. INJURY AT WORK (Yes or No)	32g. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.)	32h. LOCATION Street or route number	City or town State
No	**Grounds of private club**	**643 Old Post Road, Hemburg, MS**	

Comments:

The external event and injury produced are entered in Part I as required for all deaths due to external causes.

The event is identified as a homicide in Item 32a, and the description given in Item 32d verifies that the case qualifies for classification as a homicide on the death certificate in that the injuries were "purposely inflicted by another person." This designation is independent of whatever verdict might be rendered in a court of law.

The instrument and circumstances of the event are also revealed in Item 32d.

REPORTING OF SPONTANEOUS FETAL DEATHS

DEFINITION OF FETAL DEATH

"Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles.

QUESTIONS

If clarification, additional information, or assistance is needed regarding the reporting of a fetal death, contact the Office of Vital Records, Mississippi State Department of Health.

REPORT OF SPONTANEOUS FETAL DEATH, FORM NO. 553

Supplies of this form may be obtained from:

Office of Vital Records
Mississippi State Department of Health
P. O. Box 1700
Jackson, Miss. 39215-1700
601-576-7960

REPORT OF SPONTANEOUS FETAL DEATH IN MISSISSIPPI

(Gestation 20 or more completed weeks from beginning of last normal menstrual period **OR** weight of 350 or more grams)
(See back of form for definition and reporting instructions)

PLEASE* TYPE *OR* PRINT *WITH BLACK INK

FETUS

1. FETUS – NAME (First, Middle, Last) | 2a. DATE OF DELIVERY (Month, Day, Year) | 2b. HOUR OF DELIVERY (m.)
3. SEX | 4a. THIS DELIVERY SINGLE, TWIN, TRIPLET, ETC. (Specify) | 4b. IF NOT SINGLE DELIVERY, BORN FIRST, SECOND, ETC. (Specify)
5. WEIGHT (Enter only in the type of measure on the scales used) — lbs. | ozs. | OR | grams | 6a. COUNTY OF DELIVERY
6b. HOSPITAL OR CLINIC - NAME (If not in either, give street address or route number) | 6c. CITY OR TOWN OF DELIVERY

FATHER

7a. FATHER - NAME (First, Middle, Last) | 7b. RACE (Specify White, Black, American Indian, etc.) | 7c. DATE OF BIRTH (Month, Day, Year) | 7d. STATE OF BIRTH
7e. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.) | 7f. OCCUPATION (During last year) | 7g. BUSINESS OR INDUSTRY (During last year)
7h. SOCIAL SECURITY NUMBER | 7i. EDUCATION (Check ONLY THE HIGHEST level COMPLETED) — Elementary or High School 0 1 2 3 4 5 6 7 8 9 10 11 12 | COLLEGE YEARS 1 2 3 4 5+

MOTHER

For RESIDENCE items, enter actual location of home rather than mailing address.

8a. MOTHER - NAME (First, Middle, Maiden) | 8b. RACE (Specify White, Black, American Indian, etc.) | 8c. DATE OF BIRTH (Month, Day, Year) | 8d. STATE OF BIRTH
8e. ORIGIN OR DESCENT (Specify Cuban, Afro-American, Mexican, etc.) | 8f. OCCUPATION (During last year) | 8g. BUSINESS OR INDUSTRY (During last year)
8h. SOCIAL SECURITY NUMBER | 8i. EDUCATION (Check ONLY THE HIGHEST level COMPLETED) — Elementary or High School 0 1 2 3 4 5 6 7 8 9 10 11 12 | COLLEGE YEARS 1 2 3 4 5+
9a. RESIDENCE - STATE | 9b. COUNTY | 9c. CITY OR TOWN | 9d. INSIDE CITY LIMITS (Specify Yes or No) | 9e. STREET AND NUMBER OR RURAL LOCATION
10a. MAILING ADDRESS - STREET AND NUMBER OR ROUTE AND BOX NUMBER | 10b. CITY OR TOWN | 10c. STATE AND ZIP CODE

PREGNANCY HISTORY OF MOTHER

LIVE BIRTHS (Do NOT include children adopted by mother) | PREVIOUS OTHER TERMINATIONS (Spontaneous and Induced Abortions, Miscarriages, Stillbirths, and Fetal Deaths) (Do NOT include this fetus)

11a. NOW LIVING ☐ None or ____ Number | 11b. NOW DEAD ☐ None or ____ Number | 11d. OTHER TERMINATIONS ☐ None or ____ Number
11c. DATE OF LAST LIVE BIRTH (Month, Day, Year) | 11e. DATE OF LAST PREVIOUS OTHER TERMINATION (Month, Day, Year)
12. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year) | 13. IS MOTHER MARRIED? (Or was she married at any time between the conception and delivery of this fetus) (Specify Yes or No)

PRENATAL CARE BY DOCTOR OR CLINIC — 14a. MONTH (STAGE) OF PREGNANCY FIRST VISIT MADE: No Care ☐ | 1st ☐ | 2nd ☐ | 3rd ☐ | 4th ☐ | 5th ☐ | 6th ☐ | 7th ☐ | 8th ☐ | 9th ☐ | 14b. NUMBER OF VISITS ☐ None or ____ Total

CHECK ALL THAT APPLY — 14c. PROVIDER OF PRENATAL CARE: No Care ☐ 0 | M.D. ☐ 1 | CNM/CNP ☐ 2 | H.D. ☐ 3 | OTHER, Specify ☐ 4

MEDICAL AND HEALTH INFORMATION

15a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

☐ 01 Anemia (Hct.< 30/Hgb. < 10)
☐ 02 Cardiac disease
☐ 03 Acute or chronic lung disease
☐ 04 Diabetes
☐ 05 Genital herpes
☐ 06 Hydramnios/Oligohydramnios
☐ 07 Hemoglobinopathy
☐ 08 Hypertension, chronic
☐ 09 Hypertension, pregnancy-associated
☐ 10 Eclampsia
☐ 11 Incompetent cervix
☐ 12 Previous infant 4000+ grams
☐ 13 Previous preterm or small-for-gestational-age infant
☐ 14 Renal disease
☐ 15 Rh sensitization
☐ 16 Uterine bleeding
☐ 00 None
☐ 17 Other ____ (Specify)

15b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items)

Tobacco use during pregnancy..... Yes ☐ No ☐
Average number of cigarettes per day ____
Alcohol use during pregnancy..... Yes ☐ No ☐
Average number drinks per week ____
Weight gained during pregnancy ____ lbs.

16. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)

☐ 01 Febrile (>100°F, or 38°C.)
☐ 02 Meconium, moderate/heavy
☐ 03 Premature rupture of membrane (>12 hours)
☐ 04 Abruptio placenta
☐ 05 Placenta previa
☐ 06 Other excessive bleeding
☐ 07 Seizures during labor
☐ 08 Precipitous labor (< 3 hours)
☐ 09 Prolonged labor (> 20 hours)
☐ 10 Dysfunctional labor
☐ 11 Breech/Malpresentation
☐ 12 Cephalopelvic disproportion
☐ 13 Cord prolapse
☐ 14 Anesthetic complications
☐ 15 Fetal distress
☐ 00 None
☐ 16 Other ____ (Specify)

17. METHOD OF DELIVERY (Check all that apply)

☐ 01 Vaginal
☐ 02 Vaginal birth after previous C-section
☐ 03 Primary C-section
☐ 04 Repeat C-section
☐ 05 Forceps
☐ 06 Vacuum
☐ 07 Hysterotomy/Hysterectomy

18. OBSTETRIC PROCEDURES (Check all that apply)

☐ 01 Amniocentesis
☐ 02 Electronic fetal monitoring
☐ 03 Induction of labor
☐ 04 Stimulation of labor
☐ 05 Tocolysis
☐ 06 Ultrasound
☐ 00 None
☐ 07 Other ____ (Specify)

19. MOTHER TRANSFERRED PRIOR TO DELIVERY?
☐ No ☐ Yes
If Yes, enter name of facility transferred from:

20. CONGENITAL ANOMALIES OF FETUS (Check all that apply)

☐ 01 Anencephalus
☐ 02 Spina bifida/Meningocele
☐ 03 Hydrocephalus
☐ 04 Microcephalus
☐ 05 Other central nervous system anomalies (Specify) ____
☐ 06 Heart malformations
☐ 07 Other circulatory/respiratory anomalies (Specify) ____
☐ 08 Rectal atresia/stenosis
☐ 09 Tracheo-esophageal fistula/Esophageal atresia
☐ 10 Omphalocele/Gastroschisis
☐ 11 Other gastrointestinal anomalies (Specify) ____
☐ 12 Malformed genitalia
☐ 13 Renal agenesis
☐ 14 Other urogenital anomalies (Specify) ____
☐ 15 Cleft lip/palate
☐ 16 Polydactyly/Syndactyly/Adactyly
☐ 17 Club foot
☐ 18 Diaphragmatic hernia
☐ 19 Other musculoskeletal/integumental anomalies (Specify) ____
☐ 20 Down's syndrome
☐ 21 Other chromosomal anomalies (Specify) ____
☐ 00 None
☐ 22 Other ____ (Specify)

CAUSE OF FETAL DEATH

PART I
21a. Fetal or maternal condition directly causing fetal death — IMMEDIATE CAUSE (Enter one cause only): (a) — Specify fetal or maternal
21b. Fetal and/or maternal conditions, if any, giving rise to immediate cause, stating underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (b) — Specify fetal or maternal
DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c) — Specify fetal or maternal

PART II
22. OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER - Conditions contributing to fetal death but not resulting in the underlying cause given in PART I

23. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN (Specify)
24. PHYSICIAN'S ESTIMATE OF LENGTH OF GESTATION ____ completed weeks
25. AUTOPSY (Yes or No)

ATTENDANT AT DELIVERY

26a. NAME AND TITLE (Type or print) | 26b. MAILING ADDRESS (Street and number or route and box number, City or town, State, Zip Code)

PERSON FILING THIS REPORT

27a. Name (Type or print) | 27b. TITLE

MISSISSIPPI STATE DEPARTMENT OF HEALTH — Revised 02/13/02 — Form No. 553

SPECIFIC INSTRUCTIONS FOR COMPLETING SPONTANEOUS FETAL DEATH REPORT

Complete every item on the report, except:

First and middle names in item 1 can be blank if child was not named. Item 4b should be blank if single birth. Item 7a- 7i should be blank if mother is not married and there was no acknowledged father (13 answered "No").

ITEM 1. FETUS NAME (FIRST, MIDDLE, LAST)

If the parents did not select given names, enter the last name only.

Entries of Jr., II, etc. following the last name are acceptable.

Last name (Surname):

If the mother was married at the time of delivery (13 answered "Yes"), enter the last name of the mother's husband unless both parents have signed an affidavit to do otherwise. Note that a woman who is separated but not divorced is considered to be still married.

If the mother was married at or after the time of conception but was widowed or divorced at the time of delivery (Item 13 answered "Yes"), enter the last name of the deceased or divorced husband.

For a child born to a mother who was not married at the time of conception or birth or at any time in between BUT there is an acknowledged father (Item 13 answered "No"), enter the last name of the acknowledged father unless both parents have signed an affidavit to do otherwise.

If the mother was not married at the time of conception or delivery or at any time in between and there is no acknowledged father (Item 13 answered "No"), enter the last name of the mother unless them mother has signed an affidavit to do otherwise.

ITEM 2a. DATE OF DELIVERY (MONTH, DAY, YEAR)

Enter the exact month, day, and year the fetus was delivered.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-94 for June 4, 1994.

Pay particular attention to the entry of month, day, and year when the delivery occurs around midnight or on December 31. Consider a delivery exactly at midnight to have occurred at the end of one day rather than at the beginning of the next day.

ITEM 2b. HOUR OF DELIVERY

Enter the exact time (hour and minute) the fetus was delivered according to local time.

Enter 12 noon as "12 Noon." If the time was one minute after 12 noon, enter "12:01 p.m."

Enter 12 midnight as "12 Mid." If the time was one minute after 12 midnight, enter "12:01 a.m."

ITEM 3. SEX

Enter "Male" or "Female."

If the sex could not be determined, enter "Undetermined."

ITEM 4a and 4b PLURALITY AND BIRTH ORDER

When a plural delivery occurs, prepare a separate record for each child or fetus even if they are Siamese twins. File certificates relating to the same plural set at the same time. However, do not hold completed certificates while waiting for uncompleted ones if this will result in late filing. If any members of a plural set were born alive, write a note on the back of the reports for members born specifying which members of the set were born alive. Similarly, if any members of a plural set were delivered in another county or state, write a note on the back of the reports being submitted from your county stating where the other members of the set were born.

THIS DELIVERY SINGLE, TWIN, TRIPLET, ETC.

Specify whether this was a single delivery, twin, triplet, quadruplet, etc.

IF NOT SINGLE DELIVERY, BORN FIRST, SECOND, ETC.

If this was a plural delivery, specify the order in which this fetus was delivered - first, second, etc.

Make no entry if this was a single delivery.

ITEM 5. WEIGHT (ENTER ONLY IN THE TYPE OF MEASURE ON THE SCALES USED)

Enter the weight of the fetus as it is recorded in the hospital or clinic record or as measured by the attendant at a delivery not in a hospital or clinic.

Enter the weight either in the section for pounds and ounces or in the section for grams, depending on the scales used. Do not enter in both types of measurement and do not convert from one measure to the other.

If the fetus was not weighed, write "Not weighed." Do not use a dash or other symbol which has no specific meaning to indicate that the fetus was not weighed.

If weight is in pounds and ounces, make an entry in both pounds and ounces even if one of the entries is "0."

PLACE OF DELIVERY (Items 6a – c):

For deliveries occurring on a moving conveyance within the United States, enter the information for place of delivery as if the delivery had occurred at the place where the fetus was first removed from the conveyance. However, if the delivery occurred in international waters or airspace or in a foreign country and the fetus was first removed from the conveyance in this state, contact the Office of Vital Records for instructions.

Item 6a. COUNTY OF DELIVERY

Enter the name of the county where the delivery occurred. This should be the county in which the hospital, clinic, or other place named in 6b is located.

Item 6b. HOSPITAL OR CLINIC NAME (IF NOT IN EITHER, GIVE STREET ADDRESS OR ROUTE NUMBER)

If the delivery occurred in a hospital or clinic, enter the full name of the hospital or clinic and the hospital or clinic code.

If the delivery occurred enroute to a hospital or clinic, enter the name of the hospital or clinic, add the word "Enroute," and enter the hospital or clinic code.

If the delivery did not occur in or enroute to a hospital or clinic, enter the street address or other specific location of the place where the delivery occurred. The word "Home" is not a satisfactory entry.

Item 6c. CITY OR TOWN OF DELIVERY

Enter the name of the city or town where the delivery occurred. This should be the city or town where the hospital, clinic, or other place named in item 6b is located.

Item 7a. FATHER NAME (FIRST, MIDDLE, LAST)

If the fetus was:

Delivered to a mother who was married at the time of delivery (Item 13 answered “Yes”), enter the name of her husband. Note that a woman who is separated but not divorced is considered to be still married.

Delivered to a mother who was married at or after the time of conception but was widowed or divorced at the time of delivery (Item 13 answered “Yes”), enter the name of the deceased or divorced husband.

Delivered to a mother who was not married at the time of conception or delivery or at any time in between BUT there is an acknowledged father (Item 13 answered “No”), enter the name of the acknowledged father.

Delivered to a mother who was not married at the time of conception or delivery or at any time in between and no acknowledged father (13 answered “No”), make no entry regarding the father's name.

Entries of Jr., Sr., II, etc. following the last name are acceptable.

ITEM 7b. FATHER RACE (SPECIFY WHITE, BLACK, AMERICAN INDIAN, ETC.)

Enter the race of the father as it is obtained from the father, mother, or other informant.

For groups other than white, black, or American Indian, enter the national origin of the father such as Chinese, Japanese, Korean, Filipino, Hawaiian, etc.

If it is necessary to abbreviate the race because of lack of space, do not use a single-letter abbreviation such as “C” because it would not be enough to identify the race.

If the informant indicates that the father is of mixed race, enter both races or national origins.

Make no entry if the father's name is not entered in 7a (Item 13 answered “NO”).

ITEM 7c. FATHER DATE OF BIRTH (MONTH, DAY, YEAR)

Enter the exact month, day, and year the father was born.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-8 for June 4, 1968.

Make no entry if the father's name is not entered in 7a (Item 13 answered “No”).

ITEM 7d. FATHER STATE OF BIRTH

If the father was born in the United States, enter the name of the state.

If the father is known to have been born in the United States but the state is unknown, enter “U.S. Unknown.”

If the father was not born in the United States, enter the name of the country.

If the father is known to have been born in a foreign country but the country is unknown, enter “Foreign Unknown.”

If no information is available as to whether the father was born in the United States or a foreign country, enter “Unknown.”

Make no entry if the father's name is not entered in item 7a (Item13 answered “No”).

ITEM 7e. FATHER ORIGIN OR DESCENT (SPECIFY CUBAN, AFRO AMERICAN, MEXICAN, ETC.)

Enter the origin or descent of the father as it is obtained from the father, mother, or other informant.

Origin or descent refers to the nationality group of the person or his ancestors before their arrival in the United States (except for American Indians and Alaska natives). The entry is to reflect what the person considers himself to be, and is not based on percentages of ancestry.

Do not enter a religious group such as Jewish, Muslem, Protestant, etc. Obtain the country of origin or nationality group.

Do not enter “White” or “Caucasian.”

If the father is of mixed origin or descent, enter all groups named.

If, after explanation of the meaning of this item, the person does not identify with any foreign nationality and considers himself to be “American,” enter “American.”

This item should be asked independently of the race item. Even though the entries for the two items could be the same for Alaska natives, American Indians, Chinese, Hawaiians, Japanese, etc., both items must be completed.

Make no entry if the father's name is not entered in item 7a (Item 13 answered “No”).

ITEM 7f. FATHER OCCUPATION (DURING LAST YEAR)

Enter the information even if the father was retired, disabled, or institutionalized at the time of fetal death.

Enter the occupation of the father during the last year. The occupation is the kind of work the father did during most of the previous year, such as claims adjuster, farmhand, etc.

If the father did not work during the previous 12 months, report his occupation as "Unemployed."

Enter "Student" if the father was a student and was never regularly employed or employed full time during the year prior to delivery.

Make no entry if the father's name is not entered in item 7a (Item 13 answered "No").

ITEM 7g. FATHER BUSINESS OR INDUSTRY (DURING LAST YEAR)

Enter the kind of business or industry to which the occupation listed in item 7f was related, such as insurance, farming, etc.

Do not enter firm or organization names.

If the father did not work during the previous 12 months, report the industry as "None."

Make no entry if the father's name is not entered in item 7a (Item 13 answered "No").

ITEM 7h. FATHER SOCIAL SECURITY NUMBER

Enter the complete Social Security account number of the father.

Enter "None" if the father does not have a Social Security account.

Make no entry if the father's name is not entered in item 7a (Item 13 answered "No").

ITEM 7i. FATHER EDUCATION

Check the highest grade or college year completed in "regular" schooling. Do not check any levels below the highest one completed.

Do not enter any other kind of schooling such as barber and beauty schools, business or trade schools, and the like. Although these are important, they are not considered "regular" schools for the purposes of this item.

Make no entry if the father's name is not entered in item 7a (Item 13 answered "No").

ITEM 8a. MOTHER NAME (FIRST, MIDDLE, MAIDEN)

Enter the full maiden name of the mother.

Do not enter a last name acquired by marriage.

ITEM 8b. MOTHER RACE

Enter the race of the mother as it is obtained from the father, mother, or other informant. For groups other than white, black, or American Indian, enter the national origin of the mother such as Chinese, Japanese, Korean, Filipino, Hawaiian, etc.

If it is necessary to abbreviate the race because of lack of space, do not use a single-letter abbreviation such as "C" because it would not be enough to identify the race.

If the informant indicates that the mother is of mixed race, enter both races or national origins.

ITEM 8c. MOTHER DATE OF BIRTH (MONTH, DAY, YEAR)

Enter the exact month, day, and year the mother was born.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-68 for June 4, 1968.

ITEM 8d. MOTHER STATE OF BIRTH

If the mother was born in the United States, enter the name of the state.

If the mother is known to have been born in the United States but the state is unknown, enter "U.S Unknown."

If the mother was not born in the United States, enter the name of the country.

If the mother is known to have been born in a foreign country but the country is unknown, enter "Foreign Unknown."

If no information is available as to whether the mother was born in the United States or a foreign country, enter "Unknown."

ITEM 8e. MOTHER ORIGIN OR DESCENT

Enter the origin or descent of the mother as it is obtained from the father, mother, or other informant. Origin or descent refers to the nationality group of the person or her ancestors before their arrival in the United States (except for American Indians and Alaska natives). The entry is to reflect what the person considers herself to be, and is not based on percentages of ancestry.

Do not enter a religious group such as Jewish, Muslem, Protestant, etc. Obtain the country of origin or nationality group.

Do not enter “White” or “Caucasian.”

If the mother is of mixed origin or descent, enter all groups named.

If, after explanation of the meaning of this item, the person does not identify with any foreign nationality and considers herself to be “American,” enter “American.”

This item should be asked independently of the race item. Even though the entries for the two items could be the same for Alaska natives, American Indians, Chinese, Hawaiians, Japanese, etc., both items must be completed.

ITEM 8f. MOTHER OCCUPATION (DURING LAST YEAR)

Enter the information even if the mother was retired, disabled, or institutionalized at the time of fetal death.

Enter the occupation of the mother during the last year. The occupation is the kind of work the mother did during most of the previous year, such as homemaker store manager, etc. Even if the mother resigned her employment early in the pregnancy, that occupation should be reported.

If the mother did not work outside her home in the previous 12 months, report her occupation as “Homemaker”.

Enter “Student” if the mother was a student and was never regularly employed or employed full time during the year prior to delivery.

ITEM 8g. MOTHER BUSINESS OR INDUSTRY (DURING LAST YEAR)

Enter the kind of business or industry to which the occupation listed in item 8f was related, such as own home, retail clothing, etc. Do not enter firm or organization names.

If the mother did not work outside her home in the previous 12 months, report her industry as “Own home.”

Information from these items is useful in studying occupationally related fetal mortality and in identifying job related risk areas. These items are used to obtain information on the potential impact of the work environment on the fetus. Researchers believe that the occupational hazards (exposures) to the mother which have the most deleterious effect on the fetus are those that occur during the pregnancy, particularly early in the pregnancy.

ITEM 8h. MOTHER SOCIAL SECURITY NUMBER

Enter the complete Social Security account number of the mother.

Enter “None” if the mother does not have a Social Security account.

Item 8i. MOTHER EDUCATION

Check the highest grade or college year completed in "regular" schooling. Do not check any levels below the highest one completed.

Do not enter any other kind of schooling such as barber and beauty schools, business or trade schools, and the like. Although these are important, they are not considered "regular" schools for the purposes of this item.

MOTHER'S RESIDENCE (Items 9a – c):

Mother's residence is the place where she has set up house keeping and where she usually sleeps. This is not necessarily the same as her "Home State," "Voting Residence," or "Legal Residence." Never enter a temporary residence such as one used during a visit, business trip, or vacation. Residence for a short time at the home of a relative, friend, or home for unwed mothers for the purpose of awaiting the birth of a child is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should, therefore, be shown as place of residence of mother on the report.

The place of residence shown should be the actual location of the mother's home regardless of the mailing address. For example, if a mother lives in Rankin County and her mailing address is a rural route out of Jackson, the county listed should be Rankin even though the city of Jackson is in Hinds County. The same rule applies if an out-of-state address is involved. For example, if a mother whose home is in Marshall County, Mississippi has a Collierville, Tennessee mailing address, Mississippi and Marshall County should be listed as state and county of residence, but the city can be listed as Collierville, Tennessee, outside.

Item 9a.. MOTHER'S RESIDENCE STATE

Enter the name of the state in which the mother's place of residence is actually located. This may differ from the state she uses in her mailing address.

If the mother is not a U.S. resident, enter the country of residence.

Item 9b. MOTHER'S RESIDENCE COUNTY

Enter the name of the county in which the mother's place of residence is actually located.

Item 9c. MOTHER'S RESIDENCE CITY OR TOWN

Enter the name of the city or town in or near which the mother's place of residence is actually located. This may differ from the city or town she uses in her mailing address.

Item 9d. MOTHER'S RESIDENCE INSIDE CITY LIMITS

Enter “Yes” if the place where the mother lives is located inside the city limits of an incorporated place named in 9c.

Enter “No” if the place where the mother lives is located outside the city limits of an incorporated place named in 9c or is in an unincorporated place.

Item 9e. MOTHER'S RESIDENCE STREET AND NUMBER OR RURAL LOCATION

Enter the number and street name of the place where the mother lives.

If the place where the mother lives has no number and street name, enter the R.F.D. or route number and box number, showing which of these kinds of numbers was used.

Do not enter “ General Delivery” or” P.O. Box” in this if the street the mother lives on has no name or route number or highway number, enter “No named street.”

Statistics on fetal deaths are tabulated by place of residence of the mother. These data are used in planning for and evaluating community services and facilities, including maternal health programs. “Inside City Limits” is used to properly assign residence to either the city or the remainder of the county. ZIP Code information may also be used for environmental impact studies for small geographic areas.

Item 10a. MOTHER'S MAILING ADDRESS STREET AND NUMBER OR ROUTE AND BOX NUMBER

Enter the street and number or other specific information needed for addressing mail to the mother. This may be different from the location information entered in 9e.

Item 10b. MOTHER'S MAILING ADDRESS CITY OR TOWN

Enter the city or town used in addressing mail to the mother. This may be different from the city or town of location entered in 9c.

Item 10c. MOTHER'S MAILING ADDRESS STATE AND ZIP CODE

Enter the state and ZIP code used in addressing mail to the mother. This may be different from the state of location entered in 9a.

PREGNANCY HISTORY OF MOTHER LIVE BIRTHS (DO NOT INCLUDE CHILDREN ADOPTED BY MOTHER) Items 11a – c.

Item 11a. LIVE BIRTHS NOW LIVING

Enter the number of children born alive to this mother who were still living at the time this fetus was delivered. Do not include children the mother has adopted.

Check "None" if this was the first delivery for this mother or if all previous children who were born alive were dead when this fetus was delivered.

If the report is for the first-born member of a plural set, do not include the other members of the set who were born after this fetus was delivered. However, if the report is for the second-born member of a plural set, include the first-born member of the set in this count if it was born alive and was still alive when the second-born member was delivered. Similarly, if the report is for the third-born member of a plural set, include information about the first-and second-born members if applicable; continue in same manner for quadruplets, etc.

Item 11b. LIVE BIRTHS NOW DEAD

Enter the number of children born alive to this mother who were no longer living at the time this fetus was delivered. Do not include children the mother had adopted.

Check "None" if this was the first delivery for this mother or if all previous children who were born alive were still living when this fetus was delivered.

If the report is for the first-born member of a plural set, do not include the other members of the set who were born after this fetus was delivered. However, if the report is for the second-born member of a plural set, include the first-born member of the set in this count if it was alive but died before the second-born member was delivered. Similarly, if the report is for the third-born member of a plural set, include information about the first- and second-born members if applicable; continue in same manner for quadruplets, etc.

Item 11c. DATE OF LAST LIVE BIRTH (MONTH, DAY, YEAR)

Enter the month, day, and year of the mother's last live birth which was included in either items 11a or 11b.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-92 for June 4, 1992.

Enter "None" if the mother had not had a live birth before this fetus was delivered and both item 11a and item 11b were checked " None."

If the report is for the second-born of a plural set and the first-born member was born alive, enter the date the first-born member was delivered. Similarly, if the certificate is for the third-born, etc. member of a plural set, enter the date of delivery of the last

previous member of the set who was born alive. If all previously born members of a plural set were born dead, enter the date of the mother's last delivery that did result in a live birth.

PREGNANCY HISTORY OF MOTHER--PREVIOUS OTHER TERMINATIONS SPONTANEOUS AND INDUCED ABORTIONS, MISCARRIAGES, STILLBIRTHS, FETAL DEATHS) (DO NOT INCLUDE THIS FETUS): (Items 11d –e)

Include every recognized loss of a product of conception such as miscarriage, stillbirth, abortion (both induced and spontaneous), and fetal death.

Item 11d. PREVIOUS OTHER TERMINATIONS

Enter the number of fetuses or products of conception that were previously delivered dead, regardless of length of gestation, after the last normal menstrual period began. (Use calculated length of gestation rather than estimated length.)

Check “None” if this was the first delivery for this mother, or if all previous deliveries resulted in live-born infants.

If the report is for the first-born member of a plural set, do not include the other members of the set born after this fetus was delivered. However, if the report is for the second-born member of a plural set, and the first born member was born dead, include the first-born member of the set in this count. Continue in same manner for third-born, etc. members of plural sets.

Item 11e. DATE OF LAST PREVIOUS OTHER TERMINATION INDICATED IN 11d (MONTH, DAY, YEAR)

Enter the date of the last previous delivery which did not result in a live birth and was included in.

Spell out or abbreviate the name of the month (Jan.,Feb., etc.). Do not use a number for the month such as 6-4-92 for June 4, 1992.

Enter “None” if the mother had never previously had a delivery which did not result in a live birth and 11d was checked “None.”

If the report is for the second-born member of a plural set and the first-born member was born dead, enter the date the first-born member was delivered. Similarly, if the report is for the third-born, etc. member of a plural set, enter the date of delivery of the last previous member of the set born dead, if any. If all previously born members of a plural set were born alive, enter the date of the mother's last delivery that did not result in a live birth.

Item 12. DATE LAST NORMAL MENSES BEGAN (MONTH, DAY, YEAR)

Enter the exact date (month, day, and year) of the beginning of the mother's last normal menstrual period as obtained from the physician or hospital record. If the date is not available from these sources, obtain it from the mother.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-4-93 for June 4, 1993.

If the exact day is unknown, but the month and year are known, obtain an estimate of the day from the mother or her physician. If an estimate of the day cannot be obtained, enter only the month and year. Enter “Unknown” for the day.

Chart F1 – Summary of Instructions for Item 13. Is Mother Married? and for Related Items (Exceptions to these rules cam be made only upon court order.)

Situation	Mother Married (Item 12)	Father's name (Item 7a), Race (7b), Date of Birth (7c), Origin (7e), Occupation (7f)< Business or Industry (7g), and Education (7h)	Child's Last Name (Item 1)
Mother legally married at time of child's birth (includes mothers who are separated, regardless of length of separation)	Yes	Name, etc. of mother's legal husband (regardless of who the real father of the child is)	Same as last name of mother's legal husband unless Name of Child Verification signed by both listed parents alters this
Mother not legally married at time of child's birth but legally married at time of conception of child (for practical purposes, consider this to be the date last normal menses began, Item 12) Examples: (a) mother widowed, but husband died on or between date last normal menses began and date of birth of child, (b) mother divorced, but divorce granted on or between date last normal menses began and date of birth of child	Yes (and state whether widowed or divorced and give date of death of husband or date of divorce)	Name, etc. of mother's former legal husband (regardless of who the real father of the child is)	Same as last name of mother's legal husband unless Name of Child Verification signed by both listed parents alters this
Mother formerly legally married but not legally married at time of conception or birth of child or at any time between conception and birth – Examples: (a) mother widowed and husband died before conception of child (date last normal menses, Item 12), (b) mother divorced and divorce granted before conception of child (Item 19) and no acknowledged father*	No (and state whether widowed or divorced and give date of death of husband or date of divorce)	All Items blank	Legal last name of mother at time of birth of child unless Name of Child Verification signed by listed mother alters this
Mother never legally married and no acknowledged father*	No	All Items blank	Legal last name of mother (maiden name) unless Name of Child Verification signed by listed alters this
Mother never legally or formerly legally married but not legally married at time of conception (date last menses began, Item 12) or birth of child or at any time between conception and birth and acknowledged father*	No (and if applicable, state whether widowed or divorced and give date of death of husband or date of divorce)	Name, etc, of acknowledged father*	Same as last name of acknowledged father* unless affidavit signed by both listed parents alters this

*****Name of Child Verification, Form 535 completed by both mother and natural father on form prescribed by Mississippi State Department of Health and filed with fetal death report.

NOTE: Any type of legal termination of marriage other than divorce – for example, annulment – is to be considered the same was as divorce.

Item 13. IS MOTHER MARRIED? (OR WAS SHE MARRIED AT ANY TIME BETWEEN THE CONCEPTION AND DELIVERY OF THIS FETUS)

Enter "Yes" if the mother was legally married at the time of conception, at the time of delivery, or at any time between conception and delivery even though she may have been widowed or divorced at the time of delivery. If the mother was widowed or divorced also enter complete date of death of husband or date of divorce.

If the mother was separated but not divorced, enter "Yes" because she was still legally married.

Enter "No" if the mother was not legally married at the time of conception, at the time of delivery, or at some time in between conception and delivery. If mother was widowed or divorced, also enter complete date of death of husband or date of divorce.

Refer to Chart F1 on page 80 for examples.

PRENATAL CARE BY DOCTOR OR CLINIC. (Items 14a – c)**.**

Item 14a MONTH (STATE) OF PREGNANCY FIRST VISIT MADE
Check the month of pregnancy the mother was in when she first received care from a physician or attended a prenatal clinic for this pregnancy.

Calculate the month of pregnancy from the beginning day of the last normal menstrual period entered in 12 and not from the day of conception. For example: if the last menstrual period began on July 10, 1993, and the first prenatal visit was made on September 16,1993, two months would have already elapsed between July 10 and September 10, and thus the mother would have been in her third month of pregnancy on September16 when prenatal care began.

If the length of gestation was more than nine months and the mother was in the tenth month of pregnancy when she made her first prenatal visit, check "9th."

If no prenatal care was received, check "No Care."

Item 14b. NUMBER OF VISITS

Enter the total number of all visits made for medical supervision from a physician and/or clinic during the prenatal period. Do not write in such terms as "Monthly" or "Weekly."

If no prenatal care was received (14a answered "No Care"), check "None."

Item 14c. CHECK ALL THAT APPLY PROVIDER OF PRENATAL CARE

Check all that apply.

If no prenatal care was received (14a answered "No care" and 14b answered "None") check "No care."

MEDICAL AND HEALTH INFORMATION (Items 15a - 20)

The following items have been formatted into check boxes rather than open ended items with the hope of producing higher quality and more complete information. Please review each checkbox listed, and carefully check the appropriate block(s). Clearly mark an "X" or check the block. The mark should not overlap more than one box.

Item 15a. MEDICAL RISK FACTORS FOR THIS PREGNANCY

Check each of the medical risk factors that the mother experienced during this pregnancy.

Complications should be entered even if they are a part of the cause of fetal death in item 21.

If the mother experienced medical risk factor(s) not identified in the list (other infectious diseases, AIDS, or syphilis or drug use) check "Other" and enter the risk factor on the line provided.

If there were no medical risk factors, check "None."

Do not list such things as: repeat c section, late or inadequate prenatal care, age or education of mother, number of other pregnancies, time since last delivery. (This information is obtained from other items on the record.)

Do not list conditions arising during previous pregnancies.

Do not alter the wording on the list of specific conditions (Ex: If the mother had syphilis during her pregnancy, do not mark through "Genital herpes" for code 5 and write in "Syphilis." Put it in "Other."

Do not leave this item blank.

This information allows for the identification of specific maternal conditions that are often predictive of poor maternal and infant outcome. It can be used for planning intervention and prevention strategies.

Medical risk factors should be identified from the hospital or physician record.

Item 15b. OTHER RISK FACTORS FOR THIS PREGNANCY

Complete each question/statement.

Check "Yes" for tobacco use if the mother smoked at any time during the pregnancy. (Do not include marijuana, snuff, or chewing tobacco.)

If "Yes" is checked, specify the average number of cigarettes the mother smoked per day during her pregnancy. If, on the average, she smoked less than one cigarette per day, enter "Less than 1."

Do not make an entry of how many packs a day or week or how many cartons a week or month.

Check "Yes" for alcohol use if the mother consumed alcoholic beverages at any time during her pregnancy.

If "Yes" is checked, specify the average number of drinks she consumed per week. If, on the average, she drank less than one drink per week, enter "Less than1."

Enter the amount of weight gained by the mother during the pregnancy in pounds. Do not enter the total weight of the mother.

If no weight was gained, enter "None."

If the mother lost weight during her pregnancy, enter the amount of weight lost ("Lost 10 pounds").

Do not leave this item blank.

Smoking and drinking during pregnancy may have an adverse impact on pregnancy outcome. This information is used to evaluate the relationship between certain lifestyle factors and pregnancy outcome and to determine at what levels these factors clearly begin to affect pregnancy outcome.

Information for this item should be obtained from the mother's medical chart or the physician. If the medical chart is not available or does not include this information and the physician is unavailable, the informant should be asked to respond to these items.

Item 16. COMPLICATIONS OF LABOR AND/OR DELIVERY

Check each medical complication present during labor and/or delivery.

Check complications here even if they are a part of the cause of fetal death in item 21.

If a complication was present that is not identified in the list, check “Other” and specify the complication on the line provided.

If there were no complications, check “None.”

Do not list such things as: c section, premature or other conditions that should be specified in “Medical Risk.”

Do not list conditions arising during previous pregnancies.

Do not list post partum conditions.

Do not leave this item blank.

This information is used to identify pregnancy complications during labor and delivery that are associated with fetal deaths and their relationship to method of delivery and pregnancy outcome.

This information should be obtained from the mother's medical chart or the physician.

Item 17. METHOD OF DELIVERY

Check all methods that apply to this delivery. (If “Forceps” and/or “Vacuum” are marked, there should also be a mark by one of the methods in codes 01 or 04.

Do not leave this item blank.

This information is used to relate method of delivery with birth outcome, to monitor changing trends in obstetric practice, and to determine which groups of women are most likely to have cesarean delivery.

The method of delivery is relevant to the health of mothers, especially if it is by cesarean section. Information from this item can be used to monitor delivery trends across the United States.

This information should be obtained from the mother's medical chart or the physician.

Item 18. OBSTETRIC PROCEDURES

Check each type of procedure that was used during this pregnancy.

If a procedure was used that is not identified in the list, check “Other” and specify the procedure on the line provided.

If no procedures were used, check “None.”

Do not list “Epidural” or “C section.”

Do not leave this item blank.

Information on obstetric procedures is used to measure the use of advanced medical technology during pregnancy and labor and to investigate the relationship of these procedures to type of delivery and pregnancy outcome.

This information should be obtained from the mother's medical chart or the physician.

Item 19. MOTHER TRANSFERRED PRIOR TO DELIVERY?

Check “Yes” if the mother was transferred from one facility to another facility before the child was delivered.

If “Yes” is checked, enter the name of the facility that transferred her and the name of the town (or state) where the facility is located. If the mother was transferred more than once, enter the name (and town or state) of the last facility from which she was transferred.

Do not leave this item blank.

This information is used to study transfer patterns and determine whether timely identification and movement of high risk patients is occurring.

Item 20. CONGENITAL ANOMALIES OF FETUS

Check each anomaly of the fetus.

Do not include birth injuries.

If an anomaly is present that is not identified in the list, check “Other” and specify the anomaly on the line provided. Note that each group of system related anomalies includes an “Other” category for anomalies related to that particular system. If there is a question as to whether the anomaly is related to a specific system, enter the description of the anomaly in “Other (Specify)” at the bottom of the list.

If there are no congenital anomalies of this fetus, check none.

Do not list “Premature” or “IUGR.”

Do not leave this item blank.

Information on congenital anomalies is used to identify health problems that would have required medical care had the infant been born alive. It is important for monitoring the incidence of these conditions among all known products of conception. Collection of this

information is also necessary to study unusual clusters of selected anomalies and to track trends among different segments of the population.

This information should be obtained from the medical chart or the physician.

CAUSE OF FETAL DEATH (Items 21a – c and Items 22 – 25)

The section for cause of fetal death is similar to that on the Certificate of Death. Instructions for preparing the statement of cause of death should be used as guidelines for the statement on the fetal death report (see pages 27-63 in the chapter relating to death certificates). However, the fetal death report differs somewhat from the death certificate in that space is provided for designating whether each cause entered in the sequence is maternal or fetal.

In addition, there is an item (23) for specifying whether the fetus died before labor, during labor, or during delivery and also an item (24) for entering the physician's estimate of the length of gestation. The section for cause of fetal death is reproduced below. Information for the items in this section should be provided by the attendant at delivery whose name is entered in 26a.

CAUSE OF FETAL DEATH	21. PART I	Fetal or maternal Condition directly Causing fetal death	IMMEDIATE CAUSE (Enter one cause only) (a)	Specify fetal or maternal
		Fetal and/or maternal conditions. If any, giving rise to immediate cause, stating underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (b)	Specify fetal or maternal
			DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only): (c)	Specify fetal or Maternal
	22. PART II	OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER – Conditions contributing to fetal death but not resulting in the underlying cause given in PART I		
	23 FETUS DIES BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN (Specify)		24. PHYSICIAN'S ESTIMATE OF LENGTH OF GESTATION_____ completed weeks	25. AUTOPSY (Yes or No)

Items 21a – 21c PART I

Enter on line (a) the fetal or maternal condition directly causing the fetal death.

Enter on lines (b) and (c) the fetal and/or maternal conditions, if any, giving rise to the immediate cause entered on line (a), stating the underlying cause last.

Enter only one cause per line.

For each cause listed, specify whether the condition was fetal or maternal.

Item 22. PART II, OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER

Enter any conditions that contributed to the fetal death but were not related to the immediate cause listed on line (a) in Part I.

Item 23. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN

State whether the fetus died before labor, during labor, or during delivery if known.

If it is not known when the fetus died, enter "Unknown"; do not leave this item blank.

Item 24. PHYSICIAN'S ESTIMATE OF LENGTH OF GESTATION

Enter the attending physician's estimate of the length of gestation of this pregnancy in completed weeks.

Item 25. AUTOPSY

Enter "Yes" if an autopsy was performed; otherwise, enter "No."

ATTENDANT AT DELIVERY (Items 26a – 26b)

Item 26a. NAME AND TITLE

Enter the full name of the physician or other person in attendance at this delivery. Type or print; no signature is required.

Item 26b. ATTENDANT AT DELIVERY—MAILING ADDRESS

Enter the title of the person whose name is entered in 26a.

PERSON FILING THIS REPORT (Items 27a – 27b)

Item 27a NAME

Enter the name of the person who prepared this report. Type or print; no signature is required.

Item 27b. PERSON FILING THIS REPORT TITLE

Enter the title or position of the person whose name is entered in 27a.

DISPOSITION OF DEAD FETUS

The State Board of Health does not by regulation require disposition of a dead fetus by any particular method. In the absence of specific instructions from the next of kin, a dead fetus may be disposed of after 48 hours, preferably by burial in a recognized cemetery or by cremation.

41-39-1. Disposition of tissue or external member of human body and dead fetus.

Any physician removing or otherwise acquiring any tissue of the human body may, in his discretion, after making or causing to be made such scientific examination of the same as he may deem appropriate or as may be required by law, custom or rules and regulations of the hospital or other institution in which the tissue may have been removed or acquired, authorize disposition of the same by incineration, cremation, burial or other sanitary method approved by the State Board of Health, unless he shall have been furnished prior to removal or acquisition of the tissue, or at any time prior to its disposal, a written request that the same be delivered to the patient or someone in his behalf or, if death has occurred, to the person claiming the dead body for burial or cremation. No such tissue shall be delivered, however, except as may be permitted by rules and regulations of the State Board of Health. Any hospital or other institution acquiring possession of any such tissue, and not having written instructions to the contrary from the attending physician, the patient or the person claiming a dead body for burial or cremation, or someone in their behalf, may immediately dispose of the same as herein above provided.

However no external member of the human body may be so disposed of within 48 hours of its removal or acquisition unless consent thereto be obtained in writing from the patient or the person authorizing the medical or surgical treatment of the patient, and no dead fetus shall be so disposed of within the same period of time unless consent thereto be obtained in writing from the mother of the dead fetus or her spouse. For the purposes of this section, an external member of the human body is defined as an arm or one or more joints thereof, a hand, a finger or one or more joints thereof, a leg or one or more joints thereof, a foot, a toe or one or more joints thereof, an ear or the greater part thereof, or the nose or the greater part thereof. For the purposes of this section and the succeeding section, a dead fetus is defined as a product of human conception, exclusive of its placenta or connective tissue, which has suffered death prior to its complete expulsion or extraction from the mother, as established by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

REPORTING OF INDUCED TERMINATIONS OF PREGNANCY

DEFINITION OF INDUCED TERMINATION OF PREGNANCY

"Induced termination of pregnancy" means the intentional termination of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus.

QUESTIONS

If clarification, additional information, or assistance is needed regarding the reporting of an induced termination of pregnancy, contact the Office of Vital Records, Mississippi State Department of Health.

Supplies of form 550, Report of Induced Termination of Pregnancy Performed in Mississippi may be obtained from:

Office of Vital Records
Mississippi State Department of Health
P. O. Box 1700
Jackson, Ms 39215-1700
601-576-7981

REPORT OF INDUCED TERMINATION OF PREGNANCY PERFORMED IN MISSISSIPPI

Confidential record for medical and health use
(SEE BACK OF FORM FOR DEFINITION AND REPORTING INSTRUCTIONS)

PLEASE TYPE OR PRINT IN BLACK INK

DATE OF PREGNANCY TERMINATION

1. Month Day Year

PLACE OF TERMINATION

2. County | 3. City or Town

4. Facility Name (If not hospital or clinic, give address or other identification)

PATIENT INFORMATION

5. Residence (Enter actual location rather than mailing address)
a. State | b. County | c. City or Town | d. Inside City Limits? ☐ Yes ☐ No

6. Patient's Identification Number Assigned By Facility | 7. Age | 8. Married? 1 ☐ Yes 2 ☐ No

9. Race (Check only one box)
1 ☐ White 2 ☐ Black 3 ☐ American Indian 4 ☐ Other (Specify) _____

10. Origin or Descent (Specify Cuban, Afro-American, Mexican, etc)

11. Education (Specify only HIGHEST grade COMPLETED)
Elementary OR Secondary (0-12) | College (1-4, 5+)

12. Previous Pregnancies (Complete all four sections; enter number or check None)

Live Births		Other Terminations	
a. Now Living	b. Now Dead	c. Spontaneous Abortions, Miscarriages, Stillbirths and Fetal Deaths	d. Induced Abortions (Do NOT include this termination)
Number _____ None 00 ☐	Number _____ None 00 ☐	Number _____ None 00 ☐	Number _____ None 00 ☐

MEDICAL INFORMATION FOR THIS TERMINATION

13. Clinical Estimate of Completed Weeks of Gestation _____ Weeks

14. Date Last Normal Menses Began (Month, Day, Year)

15. Type of Termination Procedure (Check only one)
1 ☐ Suction Curettage
2 ☐ Medical (Nonsurgical), Specify Medication(s) _____
3 ☐ Dilation and Evacuation (D&E)
4 ☐ Intra-Uterine Instillation (Saline or Prostaglandin)
5 ☐ Sharp Curettage (D&C)
6 ☐ Hysterotomy/Hysterectomy
7 ☐ Other (Specify) _____

ATTENDING PHYSICIAN

16. Name (Type or Print)

PERSON COMPLETING REPORT

17. Name (Type or Print)

18. Title

MISSISSIPPI STATE DEPARTMENT OF HEALTH 02/25/02 Form No. 550

SPECIFIC INSTRUCTIONS FOR COMPLETING REPORT OF INDUCED TERMINATION OF PREGNANCY

Complete every item on the report.

DATE OF PREGNANCY TERMINATION

Item 1 MONTH, DAY, YEAR

Enter the exact month, day, and year the pregnancy termination occurred. The date the pregnancy was actually terminated should be entered. This may not necessarily be the date the procedure was begun.

For termination procedures performed by medical (nonsurgical) methods, the date of the termination should be recorded as the actual date the initial dosage of medication(s) was (were) given not the actual date of expulsion of pregnancy.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-5-99 for June 5, 1999.

PLACE OF TERMINATION (Items 2 – 4)

Item 2. COUNTY

Enter the name of the county where the induced termination of pregnancy was performed. This should be the county in which the hospital, clinic, or other place named in 4 is located.

Item 3. CITY OR TOWN

Enter the name of the city or town where the induced termination of pregnancy was performed. This should be the city or town where the hospital, clinic, or other place named in 4 is located.

Item 4. FACILITY NAME

If the induced termination of pregnancy was performed in a hospital or in a clinic which is physically situated within a hospital or is administratively a part of a hospital, enter the full name of the hospital and the hospital code.

If the induced termination of pregnancy was performed in a freestanding clinic which is physically and administratively separate from any hospital and which has an administrator, enter the full name of the clinic and the clinic code.

If the induced termination of pregnancy was performed in a clinic which does not have an administrator, in a physician's office, or in some other place, enter the name of the clinic, the name of the office (for example, "Dr. Smith's office"), or name or street address of the specific other place.

PATIENT INFORMATION (Items 5a – 12d)

Patient's residence is the place where she has set up house-keeping and where she usually sleeps. This is not necessarily the same as her "Home State," "Voting Residence," or "Legal Residence." Never enter a temporary residence such as one used during a visit, business trip, or vacation. Residence for a short time at the home of a relative or friend is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should, therefore, be shown as place of residence of patient on the report.

The place of residence shown should be the actual location of the patient's home regardless of the mailing address. For example, if a patient lives in Rankin County and her mailing address is a rural route out of Jackson, the county listed should be Rankin even though the city of Jackson is in Hinds County. The same rule applies if an out-of-state address is involved. For example, if a patient whose home is in Marshall County, Mississippi has a Collierville, Tennessee mailing address, Mississippi and Marshall County should be listed as state and county of residence, but the city can be listed as Collierville, Tennessee, outside.

Item 5a. STATE

Enter the name of the state in which the patient's place of residence is actually located. This may differ from the state she uses in her mailing address.

If the patient is not a U.S. resident, enter the country of residence.

Item 5b. COUNTY

Enter the name of the county in which the patient's place of residence is actually located.

Item 5c. CITY OR TOWN

Enter the name of the city or town in or near which the patient's place of residence is actually located. This may differ from the city or town she uses in her mailing address.

Item 5d. INSIDE CITY LIMITS?

Check "Yes" if the place where the patient lives is located inside the city limits of an incorporated place named in 5c.

Check "No" if the place where the patient lives is located outside the city limits of an incorporated place named in 5c or is in an unincorporated place.

Item 6. PATIENT'S IDENTIFICATION NUMBER ASSIGNED BY FACILITY

Do not write or stamp the patient's name here or anywhere on the form.

Enter either the patient number assigned by the facility in its usual record-keeping procedures or a special number assigned for this report. The number used must enable the facility staff to

access the medical file of the patient if it should be necessary in order to answer a query because an item was overlooked, not clear, etc.

Item 7. AGE

Enter the age of the patient on her last birthday.

Item 8. MARRIED?

Check "Yes" if the patient is currently legally married.

If the patient is currently separated but not divorced, check "Yes" because she is still legally married.

Check "No" if the patient has never been legally married or is currently widowed or divorced.

Item 9. RACE

Check the appropriate box if the patient is white, black, or an American Indian.

For groups other than white, black, or American Indian, check "Other" and enter the race or national origin of the patient such as Chinese, Japanese, Korean, Filipino, Hawaiian, etc.

If the patient is of mixed race, check "Other" and enter both races or national origins.

Item 10. ORIGIN OR DESCENT (SPECIFY CUBAN, AFRO-AMERICAN, MEXICAN, ETC)

Enter the origin or descent of the patient as it is obtained from patient. Origin refers to the nationality group of the person or her ancestors before their arrival in the United States (except American Indians and Alaska natives). The entry is to reflect what the person considers herself to be, and is not based on percentages of ancestry.

Do not enter a religious group such as Jewish, Muslem, Protestant, etc. Obtain the country of origin or nationality group.

Do not enter "White" or "Caucasian."

If the patient is of mixed origin or descent, enter all groups named.

If, after explanation of the meaning of this item, the patient does not identify with any foreign nationality and considers herself to be "American," enter "American."

This item should be asked independently of the race item. Even though the entries for the two items could be the same for Alaska natives, American Indians, Chinese, Hawaiians, Japanese, etc., both items must be completed.

Item 11. EDUCATION

Enter the highest grade or college year completed in "regular" schooling. Do not enter any levels below the highest one completed.

Do not enter any other kind of schooling such as barber and beauty schools, business or trade schools, and the like. Although these are important, they are not considered "regular" schools for the purposes of this item.

PATIENT--PREVIOUS PREGNANCIES (COMPLETE ALL FOUR SECTIONS; ENTER NUMBER OR CHECK NONE) (Items 12a – 12d)

Item 12a. LIVE BIRTHS NOW LIVING

Enter the number of children born alive to this patient who were still living at the time of this termination. Do not include children the patient has adopted.

If none, check "None."

Item 12b. LIVE BIRTHS NOW DEAD

Enter the number of children born alive to this patient who were no longer living at the time of this termination. Do not include children the patient had adopted.

If none, check "None."

Item 12c. OTHER TERMINATIONS SPONTANEOUS ABORTIONS, MISCARRIAGES, STILLBIRTHS, AND FETAL DEATHS

Enter the number of fetuses or products of conception delivered dead from pregnancies that ended by spontaneous abortion, miscarriage, stillbirth, or fetal death. Do not include pregnancy terminations (abortions) that were induced with intention other than to produced a live-born infant or to remove a dead fetus.

If none, check "None."

Item 12d. OTHER TERMINATIONS INDUCED ABORTIONS
Enter the number of previous induced abortions or terminations of pregnancy which this patient has had. Do not include this one.

Do not include spontaneous abortions, miscarriages, etc.; include only the abortions or terminations that were induced with the intention other than to produce a live-born infant or to remove a dead fetus.

If none, check "None."

MEDICAL INFORMATION FOR THIS TERMINATION (Items 12 – 15)

Item 13. CLINICAL ESTIMATE OF LENGTH OF GESTATION

Enter the attending physician's estimate of the length of gestation of this pregnancy in completed weeks.

For termination procedures performed by medical (non-surgical) methods, gestational age should be recorded as the gestational age of the pregnancy as of the day the initial dosage of medication(s) was (were) given.

Item 14. DATE LAST NORMAL MENSES BEGAN (MONTH, DAY, YEAR)

Enter the exact date (month, day, and year) of the beginning of the patient's last normal menstrual period as obtained from the hospital or clinic record or the patient.

Spell out or abbreviate the name of the month (Jan., Feb., etc.). Do not use a number for the month such as 6-5-99 for June 5, 1999.

If the exact day is unknown, but the month and year are known, obtain an estimate of the day from the patient or her physician. If an estimate of the day cannot be obtained, enter only the month and year. Enter "Unknown" for the day.

Item 15. TYPE OF TERMINATION PROCEDURE

Check the type of procedure that actually terminated this pregnancy.

If "Medical" is selected the medication must be in which was used must be specified

If the type of procedure is not listed, check "Other" and specify what that procedure was.

Check only one procedure - the one which, in the attending physician's judgement, was the primary one that actually induced termination.

Refer to Appendix A for definition of type of procedures.

Item 16. ATTENDING PHYSICIAN

Enter the full name of the attending physician. Type or print; no signature is required.

PERSON COMPLETING THIS REPORT (Items 17 – 18)

Item 17. NAME

Enter the name of the person who prepared this report. Type or print; no signature is required.

Item 18 TITLE

Enter the title or position of the person who prepared this report.

APPENDIX A

Definitions of induced termination of pregnancy procedures.

Suction Curettage (Also known as vacuum aspiration) - In this procedure the cervical canal is dilated by the successive insertion of instruments of increasing diameter called dilators. When the opening is large enough, a flexible tube (cannula) is inserted into the uterine cavity, and the fetal and placental tissues are then suctioned out by an electric vacuum pump.

Medical (Nonsurgical) - This nonsurgical procedure involves the administration of a medication or medications to induce an abortion. Medications (e.g. methotrexate, mifepristone, misoprostol, etc.) are used most frequently early in the first trimester of pregnancy. However, some medications (e.g. prostaglandin suppositories, injectable prostaglandins, etc.) may also be administered during the second trimester of pregnancy to induce abortion. Medications may be administered orally, by injection, or intra-vaginally.

Dilation and Evacuation (D&E) - This procedure, used most frequently in the second trimester, involves opening the cervix (dilation) and using primarily sharp techniques, but also suction and other instrumentation such as forceps for evacuation.

Intra-Uterine Instillation (Saline or Prostaglandin) - This procedure involves either withdrawing a portion of amniotic fluid from the uterine cavity by a needle inserted through the abdominal wall and replacing this fluid with a concentrated salt solution (known as saline instillation, saline abortion, or saline amniotic fluid exchange) or injecting a prostaglandin - - a substance with hormonelike activity -- into the uterine cavity through a needle inserted through the abdominal wall (known as intra-uterine prostaglandin instillation). The saline instillation process induces labor, which results in the expulsion of the usually dead fetus approximately 24 to 48 hours later. The interval between prostaglandin injection and expulsion tends to be shorter than in a saline abortion.

Sharp Curettage (Also known as dilatation and curettage, D&C, or surgical curettage) - This procedure involves the dilation of the cervix as in suction, although usually to a larger diameter. The fetal and placental tissues are then scraped out with a curette, which resembles a small spoon.

Hysterotomy - Hysterotomy involves surgical entry into the uterus, as in cesarean section, that removes a fetus that is too small to survive even with extraordinary life support measures. Hysterotomy is usually performed only if other abortion procedures fail.

Hysterectomy - is a procedure in which the uterus is removed either with the fetus inside or after the fetus has been removed. It is usually performed only when a pathological condition of the uterus, such as fibroid tumors, warrants its removal or when a woman desires sterilization.