



Commonwealth of Massachusetts
Registry of Vital Records and Statistics
REPORT OF FETAL DEATH

Form R304-102014 Page 1 of 4
FOR STATE USE ONLY
State File #
Date Received by Registrar

INSTRUCTIONS: Complete a Report of Fetal Death only for fetal deaths of 20 weeks or more gestation OR of a weight of 350 grams or more. A fetal death occurs when the fetus shows no signs of life at the time of expulsion or extraction. Complete front and reverse sides of form within 10 days and send original copy to the Registry of Vital Records and Statistics/Natality Data Unit-FD, 150 Mt. Vernon Street, 1st Floor, Dorchester, MA 02125. When forwarding for disposition permit: Do not send the original to the local Board of Health. Photocopy and forward only Page 1 of 4 AND Page 2 of 4 (Cause of Death/Certifier Info) of this form. The original report must be sent to the Registry of Vital Records and Statistics, an agency within the Massachusetts Department of Public Health.

Facility	1 Facility ID		2 Facility Name			3 City, Town, or Location of Delivery		
	4 Place Where Delivery Occurred (Check one)					5 Zip Code of Delivery		6 County of Delivery
		<input type="checkbox"/> Hospital		<input type="checkbox"/> Home Delivery: Planned to deliver at home?				
		<input type="checkbox"/> Clinic/Doctor's office		<input type="checkbox"/> Unknown				
		<input type="checkbox"/> Freestanding birthing center		<input type="checkbox"/> Other (specify) _____				
Fetus	Name of Fetus (optional-at the discretion of the parents)				8 Time of Delivery (24 hr)	9 Sex	10 Weight of Fetus (grams)	11 Obstetric Estimate of Gestation at Delivery (completed weeks)
	7a First Name					<input type="checkbox"/> Male		
	7b Middle Name					<input type="checkbox"/> Female		
7c Last Name					<input type="checkbox"/> Unknown			
				12 Date of Delivery (Month, Day, Year)				
				13 Plurality (specify)		14 Birth Order (specify if plural birth)	15 Clinical Estimate of Gestation (in weeks)	
				<input type="checkbox"/> Single <input type="checkbox"/> Other _____		<input type="checkbox"/> 1 st <input type="checkbox"/> 3 rd		
				<input type="checkbox"/> Twin		<input type="checkbox"/> 2 nd <input type="checkbox"/> Other _____		
Mother/Parent	Mother's Name					16b Middle Name		
	16a First Name							
	16c Last Name					16d Surname at Birth or Adoption (Maiden Name)		
	17 Date of Birth (Month, Day, Year)					18 Birthplace (City/Town, State, Country)		
	19a Residence of Mother- Number and Street Address							
19b Apt #		19c City/Town		19d County		19e State	19f Zip Code	19g Inside City Limits? (if not MA resident)
								<input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status	20 Mother's Marital Status							
	<input type="checkbox"/> Married				<input type="checkbox"/> Widowed			
<input type="checkbox"/> Never Married				<input type="checkbox"/> Divorced				
Father/Parent	Father's Name					21b Middle Name		
	21a First Name							
	21c Last Name					21d Surname at Birth or Adoption		
22 Date of Birth (Month, Day, Year)					23 Birthplace (City/Town, State, Country)			
24 Method of Disposition				25 Place of Disposition				
<input type="checkbox"/> Burial				25a Name _____ 25b City/Town, State: _____				
<input type="checkbox"/> Cremation				(i.e., cemetery, crematory, hospital, etc.)				
<input type="checkbox"/> Entombment				25c Funeral Service Licensee (if any): _____ 25d License# _____				
<input type="checkbox"/> Removal from state				25e Name of Facility (if any): _____				
<input type="checkbox"/> Donation				25f Date of Disposition: _____				
<input type="checkbox"/> Medical waste				(Month, Day, Year)				
<input type="checkbox"/> Other (specify): _____								
26 Board of Health Info (NOTE: This Report <u>MUST</u> be destroyed within 30 days after city/town issuance of a burial permit. <u>DO NOT</u> return to RVRs.)								
26a Date Report Was Received: _____				26b City/Town of Board of Health: _____				



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Cause/Conditions Contributing to Fetal Death

Cause of Fetal Death

27a Initiating Cause/Condition
(Among the choices below, please select the ONE which most likely began the sequence of events resulting in the death of the fetus)

Maternal Conditions/Diseases (specify)

Complications of Placenta, Cord, or Membranes
 Rupture of membranes prior to onset of labor
 Abruptio placenta
 Placental insufficiency
 Prolapsed cord
 Chorioamnionitis
 Other (specify) _____

Other Obstetrical or Pregnancy Complications (specify)

Fetal Anomaly (specify)

Fetal Injury (specify)

Fetal Infection (specify)

Other Fetal Conditions/Disorders (specify)

Unknown

27b Other Significant Causes or Conditions
(Select or specify all other conditions contributing to death in Item 27b)

Maternal Conditions/Diseases (specify)

Complications of Placenta, Cord, or Membranes
 Rupture of membranes prior to onset of labor
 Abruptio placenta
 Placental insufficiency
 Prolapsed cord
 Chorioamnionitis
 Other (specify) _____

Other Obstetrical or Pregnancy Complications (specify)

Fetal Anomaly (specify)

Fetal Injury (specify)

Fetal Infection (specify)

Other Fetal Conditions/Disorders (specify)

Unknown

28 Estimated Time of Fetal Death

Dead at time of first assessment, no labor ongoing
 Dead at time of first assessment, labor ongoing
 Died during labor, after first assessment
 Unknown time of fetal death

29 Was the case referred to a Medical Examiner?
 Yes No

30 Was an autopsy performed?
 Yes
 No
 Planned

31 Was a histological placental examination performed?
 Yes
 No
 Planned

32 Were autopsy or histological placental examination results used in determining the cause of fetal death?
 Yes
 No
 Not Applicable

Certifier

I HEREBY CERTIFY that this delivery occurred on the date stated and the product of conception was not a live birth.

Is Certifier a Medical Examiner?
 Yes No
33a

Signature of Certifier or Medical Examiner
33b

Type or Print-Name of Certifier or Medical Examiner
33d

Title MD DO NP
33a

License#: _____
33c

Certifier Street # and Address
33f

City/Town State Zip Code
33g 33h 33i

Attendant
(if different)

Type or Print-Name of Attendant
34a

Title MD DO CNM/CM Other Midwife Other (Specify) _____
34b

License # _____
34c



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Prenatal Care Information				
35 Date of First Prenatal Care Visit	36 Date of Last Prenatal Care Visit	37 Total # of prenatal care visits for this pregnancy (If none, enter "0")	38 Did mother get WIC food for herself during this pregnancy?	39 Insurance (Prenatal Care Source of Payment)
MM / DD / YYYY <input type="checkbox"/> No Prenatal Care	MM / DD / YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown	<input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Indian Health Service <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Other Government (Fed, State, Local) <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Pregnancy History				
40 Number of Previous Live Births: Now Living	41 Number of Previous Live Births: Now Dead	42 Date of Last Live Birth	43 Number of Other Pregnancy Outcomes (do not include this fetus):	44 Date of Last Other Pregnancy Outcome
# _____ <input type="checkbox"/> None	# _____ <input type="checkbox"/> None	MM / DD / YYYY	# _____ <input type="checkbox"/> None	MM / DD / YYYY
45 Date Last Normal Menses Began	46 Mother's Weight at Delivery	47 Mother's Prepregnancy Weight	48 Mother's Height	
MM / DD / YYYY	_____ (pounds)	_____ (pounds)	_____ (feet) _____ (inches)	
Delivery Information				
49a Fetal presentation at delivery (Check one)	49b Final route and method of delivery (Check one)	49c Hysterotomy/Hysterectomy	50a Was mother transferred for maternal medical or fetal indications for delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other	<input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	50b If yes, enter name of facility mother transferred from: _____	
Medical Information				
51 Risk Factors in this pregnancy (Check all that apply)		52 Infections Present and/or Treated During This Pregnancy (Check all that apply)		53 Congenital Anomalies of the Fetus (Check all that apply)
<input type="checkbox"/> Diabetes – Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Diabetes – Gestational (Diagnosis in this pregnancy) <input type="checkbox"/> Hypertension – Prepregnancy (Chronic) <input type="checkbox"/> Hypertension – Gestational (PIH, preeclampsia) <input type="checkbox"/> Hypertension – Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Pregnancy resulted from infertility treatment (If checked, please see <i>Birth Trends and Technologies</i> section) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many _____ <input type="checkbox"/> None of the above		<input type="checkbox"/> Chlamydia <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Listeria <input type="checkbox"/> Syphilis <input type="checkbox"/> Parvovirus <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> None of the above		<input type="checkbox"/> Anencephaly <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Hypospadias <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Omphalocele <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> None of the above
54 Maternal Morbidity (Check all that apply) Complications associated with labor and delivery				
<input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Third or fourth degree perineal laceration		<input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> None of the above		
55 Birth Trends and Technologies: If Mother/Parent took any fertility drugs or received any medical procedures from a doctor, nurse, or other health care worker to help get pregnant with this current pregnancy (this may include infertility treatments such as fertility-enhancing drugs or assisted reproductive technology), check all that apply:				
<input type="checkbox"/> Fertility-enhancing drugs <input type="checkbox"/> Artificial insemination <input type="checkbox"/> Intrauterine insemination		<input type="checkbox"/> Assisted reproductive technology <input type="checkbox"/> Other medical treatment Other (Specify) _____		<input type="checkbox"/> Anonymous egg donor <input type="checkbox"/> Anonymous sperm donor <input type="checkbox"/> Surrogacy <input type="checkbox"/> None of these apply
Reported Alcohol and Tobacco Use				
56 Cigarette Smoking Before and During Pregnancy (For each time period, enter either the average number of cigarettes or the average number of packs of cigarettes smoked per day. If none, enter "0".)		57 Alcohol Use Before and During Pregnancy (For each time period, enter the number of drinks mother had in an average week. If none, enter "0".)		
3 months before pregnancy	Second 3 months of pregnancy	3 months before pregnancy	Second 3 months of pregnancy	
# _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Packs	# _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Packs	# _____	# _____	
First 3 months of pregnancy	Third Trimester of pregnancy	First 3 months of pregnancy	Third Trimester of pregnancy	
# _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Packs	# _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Packs	# _____	# _____	



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Demographic Information

58 Mother/Parent Race (May check more than one race)		59 Mother/Parent Ethnicity (May check more than one ethnicity)	
<input type="checkbox"/> American Indian/Alaska Native/Native American <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Hispanic/Latina/Black <input type="checkbox"/> Hispanic/Latina/White <input type="checkbox"/> Hispanic/Latina/Other ...Specify (Other Hispanic Latina) <hr/> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other ...Specify (Other) <hr/> <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		<input type="checkbox"/> African ...Specify (African) <hr/> <input type="checkbox"/> African American <input type="checkbox"/> American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Brazilian <input type="checkbox"/> Cambodian <input type="checkbox"/> Cape Verdean <input type="checkbox"/> Caribbean Islander ...Specify (Caribbean Islander) <hr/> <input type="checkbox"/> Chinese <input type="checkbox"/> Colombian <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> European ...Specify (European) <hr/> <input type="checkbox"/> Filipino	
		<input type="checkbox"/> Guatemalan <input type="checkbox"/> Haitian <input type="checkbox"/> Honduran <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Mexican, Mexican American, Chicana <input type="checkbox"/> Middle Eastern ...Specify (Middle Eastern) <hr/> <input type="checkbox"/> Native American/American Indian/Alaskan Native ...Specify (Tribe) <hr/> <input type="checkbox"/> Portuguese <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Russian <input type="checkbox"/> Salvadoran <input type="checkbox"/> Vietnamese	
		<input type="checkbox"/> Other Asian ...Specify (Other Asian) <hr/> <input type="checkbox"/> Other Central American ...Specify (Other Central American) <hr/> <input type="checkbox"/> Other Pacific Islander ...Specify (Other Pacific Islander) <hr/> <input type="checkbox"/> Other Portuguese ...Specify (Other Portuguese) <hr/> <input type="checkbox"/> Other South American ...Specify (Other South American) <hr/> <input type="checkbox"/> Other ...Specify (Other) <hr/> <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
60 Mother/Parent Education (Check the box that best describes the highest degree or level of school completed at the time of delivery)			
<input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th -12 th grade, no diploma <input type="checkbox"/> High School graduate or GED completed		<input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Certificate <input type="checkbox"/> Associate Degree	
		<input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate or Professional Degree	
		<input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
61 Mother/Parent Occupation		62 Mother/Parent Industry	
63 Father/Parent Race (May check more than one race)		64 Father/Parent Ethnicity (May check more than one ethnicity)	
<input type="checkbox"/> American Indian/Alaska Native/Native American <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Hispanic/Latino/Black <input type="checkbox"/> Hispanic/Latino/White <input type="checkbox"/> Hispanic/Latino/Other ...Specify (Other Hispanic Latino) <hr/> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other ...Specify (Other) <hr/> <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		<input type="checkbox"/> African ...Specify (African) <hr/> <input type="checkbox"/> African American <input type="checkbox"/> American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Brazilian <input type="checkbox"/> Cambodian <input type="checkbox"/> Cape Verdean <input type="checkbox"/> Caribbean Islander ...Specify (Caribbean Islander) <hr/> <input type="checkbox"/> Chinese <input type="checkbox"/> Colombian <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> European ...Specify (European) <hr/> <input type="checkbox"/> Filipino	
		<input type="checkbox"/> Guatemalan <input type="checkbox"/> Haitian <input type="checkbox"/> Honduran <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Mexican, Mexican American, Chicano <input type="checkbox"/> Middle Eastern ...Specify (Middle Eastern) <hr/> <input type="checkbox"/> Native American/American Indian/Alaskan Native ...Specify (Tribe) <hr/> <input type="checkbox"/> Portuguese <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Russian <input type="checkbox"/> Salvadoran <input type="checkbox"/> Vietnamese	
		<input type="checkbox"/> Other Asian ...Specify (Other Asian) <hr/> <input type="checkbox"/> Other Central American ...Specify (Other Central American) <hr/> <input type="checkbox"/> Other Pacific Islander ...Specify (Other Pacific Islander) <hr/> <input type="checkbox"/> Other Portuguese ...Specify (Other Portuguese) <hr/> <input type="checkbox"/> Other South American ...Specify (Other South American) <hr/> <input type="checkbox"/> Other ...Specify (Other) <hr/> <input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
65 Father/Parent Education (Check the box that best describes the highest degree or level of school completed at the time of delivery)			
<input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th -12 th grade, no diploma <input type="checkbox"/> High School graduate or GED completed		<input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Certificate <input type="checkbox"/> Associate Degree	
		<input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate or Professional Degree	
		<input type="checkbox"/> Unknown <input type="checkbox"/> Refused	
66 Father/Parent Occupation		67 Father/Parent Industry	