Commonwealth of Massachusetts
Registry of Vital Records and Statistics

REPORT OF FETAL DEATH

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)*

- ☐ Hospital
- ☐ Home Delivery: Planned to deliver at home? ☐ Yes ☐ No
- ☐ Clinic/Doctor's office
- ☐ Unknown
- ☐ Freestanding birthing center
- ☐ Other *(specify)* _____

5 **Zip Code of Delivery**

6 **County of Delivery**

Fetus

Name of Fetus (optional-at the discretion of the parents)

7a *First Name*

7b *Middle Name*

7c *Last Name*

8 **Time of Delivery** *(24 hr)*

9 **Sex**
- ☐ Male
- ☐ Female
- ☐ Unknown

10 **Weight of Fetus** *(grams)*

11 **Obstetric Estimate of Gestation at Delivery** *(completed weeks)*

12 **Date of Delivery** *(Month, Day, Year)*

13 **Plurality** (*specify*)
☐ Single ☐ Other_____
☐ Twin

14 **Birth Order** (*specify if plural birth*)
☐ 1st ☐ 3rd
☐ 2nd ☐ Other _____

15 **Clinical Estimate of Gestation** *(in weeks)*

Mother/Parent

Mother's Name

16a *First Name*

16b *Middle 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)* ☐ Yes ☐ No

Marital Status

20 **Mother's Marital Status**

- ☐ Married
- ☐ Never Married
- ☐ Widowed
- ☐ Divorced

Father/Parent

Father's Name

21a *First Name*

21b *Middle 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

- ☐ Burial
- ☐ Cremation
- ☐ Entombment
- ☐ Removal from state
- ☐ Donation
- ☐ Medical waste
- ☐ Other (*specify*):_____

25 Place of Disposition

25a Name _____ 25b City/Town, State:_____
(i.e., cemetery, crematory, hospital, etc.)

25c Funeral Service Licensee *(if any)*: _____ 25d License# _____

25e Name of Facility (*if any*): _____

25f Date of Disposition: _____
(Month, Day, Year)

26 Board of Health Info (NOTE: This Report MUST be destroyed within 30 days after city/town issuance of a burial permit. DO NOT return to RVRS.)

26a **Date Report Was Received:** _____ 26b **City/Town of Board of Health:** _____

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Cause of Fetal Death

Cause/Conditions Contributing to 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)*	27b **Other Significant Causes or Conditions** *(Select or specify all other conditions contributing to death in Item 27b)*
Maternal Conditions/Diseases (*specify*) _____	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)* _____	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)* _____	Other Obstetrical or Pregnancy Complications *(specify)* _____
Fetal Anomaly *(specify)* _____	Fetal Anomaly *(specify)* _____
Fetal Injury *(specify)* _____	Fetal Injury *(specify)* _____
Fetal Infection *(specify)* _____	Fetal Infection *(specify)* _____
Other Fetal Conditions/Disorders *(specify)* _____	Other Fetal Conditions/Disorders *(specify)* _____
☐ Unknown	☐ Unknown

28 **Estimated Time of Fetal Death**	29 **Was the case referred to a Medical Examiner?**	31 **Was a histological placental examination performed?**	32 **Were autopsy or histological placental examination results used in determining the cause 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	☐ Yes ☐ No **30 Was an autopsy performed?** ☐ Yes ☐ No ☐ Planned	☐ Yes ☐ No ☐ Planned	☐ 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)

Title ☐ MD ☐ DO ☐ NP (33c)

_____
Type or Print-Name of Certifier or Medical Examiner (33d)

License#:_____ (33e)

_____
Certifier Street # and Address (33f)

_____
City/Town (33g) State (33h) Zip Code (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 ☐No Prenatal Care	_____/_____/_____ MM / DD / YYYY		☐Yes ☐No ☐Refused ☐Unknown	☐Medicaid ☐Private Insurance ☐Self-pay ☐Indian Health Service	☐CHAMPUS/TRICARE ☐Other Government (Fed, State, Local) ☐Other _____ ☐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**
#_____ ☐None	#_____ ☐None	_____/_____ MM / YYYY	# _____ ☐None	_____/_____ MM / 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?** ☐Yes ☐No 50b **If yes, enter name of facility mother transferred from:** _____
☐Cephalic ☐Breech ☐Other	☐Vaginal/Spontaneous ☐Vaginal/Forceps ☐Vaginal/Vacuum ☐Cesarean If cesarean, was a trial of labor attempted? ☐Yes ☐No	☐Yes ☐No	

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)*
☐Diabetes – Prepregnancy (Diagnosis prior to this pregnancy) ☐Diabetes – Gestational (Diagnosis in this pregnancy) ☐Hypertension – Prepregnancy (Chronic) ☐Hypertension – Gestational (PIH, preeclampsia) ☐Hypertension – Eclampsia ☐Previous preterm birth ☐Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) ☐Pregnancy resulted from infertility treatment (If checked, please see ***Birth Trends and Technologies*** section) ☐Mother had a previous cesarean delivery If yes, how many _____ ☐None of the above	☐Chlamydia ☐Cytomegalovirus ☐Gonorrhea ☐Group B Streptococcus ☐Listeria ☐Syphilis ☐Parvovirus ☐Toxoplasmosis ☐Other (*Specify*) _____ ☐None of the above	☐Anencephaly ☐Cleft Lip with or without Cleft Palate ☐Cleft Palate alone ☐Congenital diaphragmatic hernia ☐Cyanotic congenital heart disease ☐Down Syndrome ☐Karyotype confirmed ☐Karyotype pending ☐Gastroschisis ☐Hypospadias ☐Limb reduction defect (excluding congenital amputation and dwarfing syndromes) ☐Meningomyelocele/Spina bifida ☐Omphalocele ☐Suspected chromosomal disorder ☐Karyotype confirmed ☐Karyotype pending ☐None of the above

54 Maternal Morbidity *(Check all that apply)* Complications associated with labor and delivery

☐Admission to intensive care unit ☐Maternal transfusion ☐Ruptured uterus ☐Third or fourth degree perineal laceration	☐Unplanned hysterectomy ☐Unplanned operating room procedure following delivery ☐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:

☐Fertility-enhancing drugs ☐Artificial insemination ☐Intrauterine insemination	☐Assisted reproductive technology ☐Other medical treatment Other (*Specify*) _____	☐Anonymous egg donor ☐Anonymous sperm donor	☐Surrogacy ☐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".)*

3 months before pregnancy	*Second 3 months of pregnancy*
#_____ ☐Cigarettes ☐Packs	#_____ ☐Cigarettes ☐Packs
First 3 months of pregnancy	***Third Trimester of pregnancy***
#_____ ☐Cigarettes ☐Packs	#_____ ☐Cigarettes ☐Packs

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*
#_____	#_____
First 3 months of pregnancy	***Third Trimester of pregnancy***
#_____	#_____

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Demographic Information

58 **Mother/Parent Race** *(May check more than one race)*

- ☐ American Indian/Alaska Native/Native American
- ☐ Asian
- ☐ Black
- ☐ Guamanian or Chamorro
- ☐ Hispanic/Latina/Black
- ☐ Hispanic/Latina/White
- ☐ Hispanic/Latina/Other
  …Specify (Other Hispanic Latina)
  _____
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ White
- ☐ Other Pacific Islander
- ☐ Other
  …Specify (Other)
  _____
- ☐ Refused
- ☐ Unknown

59 **Mother/Parent Ethnicity** *(May check more than one ethnicity)*

- ☐ African
  ….Specify (African)
  _____
- ☐ African American
- ☐ American
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander
  …Specify (Caribbean Islander)
  _____
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European
  …Specify (European)
  _____
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicana
- ☐ Middle Eastern
  …Specify (Middle Eastern)
  _____
- ☐ Native American/American Indian/Alaskan Native
  ...Specify (Tribe)
  _____
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other Asian
  …Specify (Other Asian)
  _____
- ☐ Other Central American
  ….Specify (Other Central American)
  _____
- ☐ Other Pacific Islander
  ...Specify (Other Pacific Islander)
  _____
- ☐ Other Portuguese
  …Specify (Other Portuguese)
  _____
- ☐ Other South American
  …Specify (Other South American)
  _____
- ☐ Other
  …Specify (Other)
  _____
- ☐ Unknown
- ☐ Refused

60 **Mother/Parent Education** *(Check the box that best describes the highest degree or level of school completed at the time of delivery)*

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High School graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Certificate
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate or Professional Degree
- ☐ Unknown
- ☐ Refused

61 **Mother/Parent Occupation**

62 **Mother/Parent Industry**

63 **Father/Parent Race** *(May check more than one race)*

- ☐ American Indian/Alaska Native/Native American
- ☐ Asian
- ☐ Black
- ☐ Guamanian or Chamorro
- ☐ Hispanic/Latino/Black
- ☐ Hispanic/Latino/White
- ☐ Hispanic/Latino/Other
  …Specify (Other Hispanic Latino)
  _____
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ White
- ☐ Other Pacific Islander
- ☐ Other
  …Specify (Other)
  _____
- ☐ Refused
- ☐ Unknown

64 **Father/Parent Ethnicity** *(May check more than one ethnicity)*

- ☐ African
  ….Specify (African)
  _____
- ☐ African American
- ☐ American
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander
  …Specify (Caribbean Islander)
  _____
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European
  …Specify (European)
  _____
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicano
- ☐ Middle Eastern
  …Specify (Middle Eastern)
  _____
- ☐ Native American/American Indian/Alaskan Native
  ...Specify (Tribe)
  _____
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other Asian
  …Specify (Other Asian)
  _____
- ☐ Other Central American
  ….Specify (Other Central American)
  _____
- ☐ Other Pacific Islander
  ...Specify (Other Pacific Islander)
  _____
- ☐ Other Portuguese
  …Specify (Other Portuguese)
  _____
- ☐ Other South American
  …Specify (Other South American)
  _____
- ☐ Other
  …Specify (Other)
  _____
- ☐ Unknown
- ☐ Refused

65 **Father/Parent Education** *(Check the box that best describes the highest degree or level of school completed at the time of delivery)*

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High School graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Certificate
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate or Professional Degree
- ☐ Unknown
- ☐ Refused

66 **Father/Parent Occupation**

67 **Father/Parent Industry**