APPENDIX V: BIRTH AND DEATH CERTIFICATES

212131
LOCAL FILE NUMBER

Washington State Department of Health

CERTIFICATE OF LIVE BIRTH

146
STATE FILE NUMBER

1. CHILD'S NAME First Middle LAST		2. SEX (M /F)	3. DATE OF BIRTH (MO, DAY, YR)	4. TIME OF BIRTH
5.TYPE OF BIRTHPLACE (SPECIFY TYPE) ❑ 1 HOSPITAL ❑ 3 BIRTH CENTER ❑ 5 HOME ❑ 2 ENROUTE ❑ 4 CLINIC/DOCTOR'S OFF. ❑ 6 OTHER	6. NAME OF FACILITY / IF NOT A FACILITY ENTER NAME OF PLACE AND ADDRESS	7. CITY / TOWN / LOCATION		8. COUNTY OF BIRTH
9. I CERTIFY THAT THIS CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED. Signature X	10. DATE SIGNED (MO, DAY, YR)	11. ATTENDANT'S NAME AND TITLE (If other than certifier)(Type or Print)		
12. CERTIFIER--NAME AND TITLE (Type or print)	13. ATTENDANT'S MAILING ADDRESS (street / box no., city, state, ZIP code)			
14. FATHER'S NAME First Middle Last		15. DATE OF BIRTH (MO, DAY, YR)	16. STATE OF BIRTH (If not USA give country)	
17. MOTHER'S NAME First Middle MAIDEN		18. DATE OF BIRTH (MO, DAY, YR)	19. STATE OF BIRTH (If not USA give country)	
20. MOTHER'S RESIDENCE (number and street)	21. CITY / TOWN / LOCATION	22. INSIDE CITY LIMITS Yes No	23. COUNTY	24. STATE / ZIP CODE
25. HOW LONG AT CURRENT RESIDENCE? Yrs. Mos.	26. MOTHER'S MAILING ADDRESS (If different than residence)			
27. NAME OF INFORMANT (Type or print)	28. RELATION TO CHILD	29. PARENT(S) REQUEST FOR SOCIAL SECURITY NUMBER ISSUANCE (allow up to six months) 1 ❑ Yes 2 ❑ No		
30. REGISTRAR (signature) X	31. DATE FILED BY LOCAL REGISTRAR			
32. RECORD AMENDMENT (state registrar use only)	DOCUMENTARY EVIDENCE	REVIEWED BY	DATE	
33. FATHER'S SOCIAL SECURITY NUMBER	34. MOTHER'S SOCIAL SECURITY NUMBER			

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY--DETACH FROM CERTIFICATE BEFORE PERMANENT FILING

	35.OF HISPANIC ORIGIN OR DESCENT? If yes specify Mexican, Puerto Rican, Spanish, etc.	36.RACE (American Indian, White, Black, Asian/ Pacific Islander (Specify subgroup), etc.)	37.OCCUPATION (Worked during last year) (registered nurse, personnel manager)	38.TYPE OF BUSINESS OR INDUSTRY (hospital, newspaper publishing)	39.EDUCATION (specify only highest grade completed) (Elementary / HS (0-12) College (1-4 or 5+)
FATHER	35a. 1 ❑ Yes 2 ❑ No Specify:	36a.	37a.	38a.	39a.
MOTHER	35b. 1 ❑ Yes 2 ❑ No Specify	36b.	37b.	38b.	39b.
CHILD	PARENTAL IDENTIFICATION OF CHILD'S 40. OF HISPANIC ORIGIN OR DESCENT? If yes, specify, Mexican, Puerto Rican, Spanish, etc. ETHNICITY AND RACE (Items 40 and 41) 1 ❑ Yes 2 ❑ No Specify:		41. RACE (American Indian, White, Black, Asian Pacific Islander (Specify subgroup), etc.)		

42. PRIOR LIVE BIRTHS (Do not include this birth) ❑ NONE NOW LIVING NOW DEAD NUMBER DATE LAST LIVE BIRTH (MO, YR)	43. OTHER TERMINATIONS (Not live births) ❑ NONE 20 WEEKS OR MORE LESS THAN 20 WEEKS DATE LAST SPONTANEOUS OUTCOME (MO, YR)	NUMBER SPONTANEOUS	NUMBER INDUCED (Any gest. age) DATE LAST INDUCED (MO, YR)	44. TOTAL PRIOR PREGNANCIES	45. CLINICAL ESTIMATE OF GESTATION (WEEKS)
				46. DATE LAST NORMAL MENSES BEGAN (MO, DAY, YR)	47. IS MOTHER MARRIED? 1 ❑ YES 2 ❑ NO

48. MONTH OF PREGNANCY PRENATAL CARE BEGAN (1st, 2nd, 3rd, etc.)	49. TOTAL NUMBER OF PRENATAL VISITS (If none, enter 0)	50. PRINCIPAL SOURCE OF PAYMENT FOR PRENATAL CARE 1 ❑ Medicaid 3 ❑ Commercial Ins 5 ❑ HMO 2 ❑ Self pay 4 ❑ Charity care 6 ❑ Other	51. DURING PREGNANCY MOTHER PARTICIPATED IN (check all that apply) 1 ❑ WIC 2 ❑ First Steps 3 ❑ AFDC 4 ❑ Services from Local Health Dept.	52. DID MOTHER SMOKE AT ANY TIME DURING 1 ❑ YES 2 ❑ NO Average no. cigarettes per day?___

53. PLURALITY--Single, Twin, Triplet, etc. (Specify)	54. IF NOT SINGLE BIRTH--born 1st, 2nd, 3rd, etc. (Specify)	55. BIRTHWEIGHT lbs. ozs. or grams	56. APGAR SCORE 1 Min.	5 Min.	57. INFANT TRANSFERRED TO ANOTHER FACILITY? 1 ❑ YES 2 ❑ NO 3 ❑ UNK.	58. MOTHER TRANSFERRED AFTER ATTEMPTED DELIVERY 1 ❑ YES 2 ❑ NO If yes, from ❑ Birth Ctr. ❑ Home ❑ Other

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NUMBER

Washington State Department of Health

CERTIFICATE OF DEATH

146

STATE FILE NUMBER

DECEDENT

1. NAME First Middle Last	2. SEX (M /F)	3. DEATH DATE (Mo., Day, Yr)

4. AGE LAST BIRTH-DAY (Yrs)	5. UNDER 1 YEAR MOS DAYS	6. UNDER 1 DAY HOURS MINS	7. BIRTHDATE (Mo. Day Yr)	8. BIRTHPLACE (City, State or Foreign Country)	9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No)	10. COUNTY OF DEATH

11. CITY, TOWN OR LOCATION OF DEATH	12. PLACE OF DEATH--X BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1. HOME 2. IN TRANSPORT 3. EMERG. RM/OUT PTN 4. HOSP. 5. NUR HOME 6. OTHER PLACE	13. SMOKING IN LAST 15 YEARS? (Yes/No)

14. MARITAL STATUS--Married, Never Married, Widowed, Divorced (Specify)	15. SURVIVING SPOUSE (if wife, give maiden name)	16. SOCIAL SECURITY NO.	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+)

18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED)	19. KIND OF BUSINESS OR INDUSTRY	20. Was decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify:	21. RACE (Specify)

22. RESIDENCE--NUMBER AND STREET	23. CITY/TOWN, OR LOCATION	24. INSIDE CITY LIMITS? (Yes / No)	25A. COUNTY	25B. LENGTH OF RES. IN CO.	26. STATE	27. ZIP CODE

PARENTS

28. FATHER'S NAME--FIRST, MIDDLE, LAST	29. MOTHER'S NAME--FIRST, MIDDLE, MAIDEN SURNAME

30. INFORMANT--NAME	31. MAILING ADDRESS STREET OR RFD NO. CITY OR TOWN STATE ZIP

DISPOSITION

32. BURIAL, CREMATION REMOVAL, OTHER (Specify)	33. DATE (Mo., Day, Yr)	34. CEMETERY/CREMATORY--NAME	35. LOCATION--CITY/TOWN, STATE

36. FUNERAL DIRECTOR SIGNATURE	37. NAME OF FACILITY	38. ADDRESS OF FACILITY

CERTIFIER

TO BE COMPLETED ONLY BY **CERTIFYING PHYSICIAN**	TO BE COMPLETED ONLY BY **MEDICAL EXAMINER OR CORONER**
39. **TO THE BEST OF MY KNOWLEDGE**, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE X	43. ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE X

40. DATE SIGNED (Mo., Day, Yr)	41. HOUR OF DEATH (24 Hrs.)	44. DATE SIGNED (Mo., Day, Yr)	45. HOUR OF DEATH (24 Hrs)

42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	46. PRONOUNCED DEAD (Mo., Day, Yr)	47. HOUR PRONOUNCED DEAD (24 Hrs.)

48. NAME AND ADDRESS OF CERTIFIER--PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)	49. ME/CORONER FILE NUMBER

CAUSE OF DEATH

50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH:

IMMEDIATE CAUSE (Final disease or condition resulting in death). DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST.	A.	INTERVAL BETWEEN ONSET AND DEATH
	DUE TO, OR AS A CONSEQUENCE OF: B.	INTERVAL BETWEEN ONSET AND DEATH
	DUE TO, OR AS A CONSEQUENCE OF: C.	INTERVAL BETWEEN ONSET AND DEATH
	DUE TO, OR AS A CONSEQUENCE OF: D.	INTERVAL BETWEEN ONSET AND DEATH

51. OTHER SIGNIFICANT CONDITIONS--CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE:	52. AUTOPSY? (Yes / No)	53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No)

54. ACC. SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)	55. INJURY DATE (Mo, Day, Yr)	56. HOUR OF INJURY (24 Hrs)	57. DESCRIBE HOW INJURY OCCURRED:

58. INJURY AT WORK? (Yes / No)	59. PLACE OF INJURY--AT HOME, FARM, STREET, FACTORY, OFFICE BLDG, ETC. (Specify)	60. LOCATION--STREET OR RFD NO., CITY/TOWN, STATE

61. RECORD AMENDMENT (Register use only) ITEM DOCUMENTARY EVIDENCE REVIEWED BY DATE	62. REGISTRAR SIGNATURE X	63. DATE RECEIVED (Mo., Day, Yr.)

FOR INSTRUCTIONS SEE BACK AND HANDBOOK

DOH 110-008 (Rev. 7/91) (formerly dshs 9-150)

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