



# Panel: Registration at VSU and Tips for Completing Forms

PANELIST: ALICE WHITLEY, BELINDA ALBA, DANIELLE IRVIN-ANDERSON

FACILITATOR: SOO TEAL

# Agenda

- ▶ Birth Certificates (VS-111 REV 1/05)
- ▶ Death Certificates (VS-122 REV 1/06)
  - Amendment to Medical Certification of Certificate of Death (VS 174 REV 1/2009)
- ▶ Fetal Death Certificates (VS-133 REV 1/06)
- ▶ Marriage Licenses (VS-180 REV 6/15)
- ▶ Suits Affecting Family Relationship (VS-165 REV 7/15)

# Birth Certificates

## ► Things to check for:

### ❑ Alterations

- ❖ White Out
- ❖ Mark Through
- ❖ Damaged Records
  - Cuts, Tears, and Stains

### ❑ Paper Format

- ❖ Outdated Form
- ❖ Margins
- ❖ Not Meeting State Specifications
  - 24lb, Acid Free Light Cockle
  - 25% White Cotton
  - ¾" Left Side Margin
  - ¾" from Top Edge of Paper to first line
- ❖ Xerox Copies not accepted

### ❑ Ink Color and Problems

- ❖ Not Durable **Black** or **Blue** Ink
- ❖ Smearred Ink

### ❑ Missing Information

- ❖ Father's Information (15-17) can be left blank.
- ❖ If the Father's information is complete, the mother's must be marked married on Item 22 or there has to be an AOP included.

### ❑ Illegible Writing

- ❖ Date Certified
- ❖ Signature of Certifier
- ❖ Registrar File Number
- ❖ Date Received by Local Registrar
- ❖ Signature Stamp (No Double Stamping)

### ❑ Incorrect Registrar

- ❖ Wrong Registrar Signing for Records
- ❖ Records Filed in Wrong County

STATE OF TEXAS CERTIFICATE OF BIRTH BIRTH NUMBER

1. Child's Name First Middle Last Suffix  
**Simon Says**

2. Date of Birth (mm/dd/yyyy)  
**04/16/2015**

3. Sex  
**Na.**

4a. Place of Birth - County  
**Dallas**

4b. City or Town (if outside city limits, give precinct no.)  
**Dallas**

5. Time of Birth  
**Unknown**

6a. Plurality - Single, Twin, Triplet, etc.  
**Unknown**

6b. Hospital or Birthing Center (if not at home, give full address)  
**Unknown**

7a. Place of Birth  
 Clinic / Doctor's Office  
 Licensed Birthing Center  
 Hospital  
 Home Birth (Planned to deliver at home?)  
 Other (Specify): **Infant left at Fire Station**

7b. Name of Hospital or Birthing Center (if not at home, give full address)  
**2600 Harry Gorilla Dallas TX 75219**

8a. Attendant's Name, NPI, and Mailing Address  
**Sally Pancake, CPS Caseworker  
 1123 Rainbow Lane, STE 104  
 Dallas, TX 75247**

8b.  MD  DO  CNM  Midwife  Other (Specify): **CPS**

8c. Attendant  
**Martha Pickle**

8d. Date Signed  
**11/4/2015**

9a. Certifier - I certify that this child was born alive

10. Mother's Name Prior to First Marriage First Middle Last  
**Unknown**

11. Date of Birth (mm/dd/yyyy)  
**Unknown**

12. Birthplace (State, Territory, or Foreign Country)  
**Unknown**

13a. Residence - State  
**Unknown**

13b. County  
**Unknown**

13c. City, Town, or Location  
**Unknown**

13d. Rural Location  
**Unknown**

13e. Zip Code  
**UNK**

13f. Inside City Limits  
 Yes  No **UNK**

14. Mother's Mailing Address:  Same As Residence, or:  
**Unknown**

15. Father's Name First Middle Last Suffix  
**Unknown**

16. Date of Birth (mm/dd/yyyy)  
**Unknown**

17. Birthplace (State, Territory, or Foreign Country)  
**Unknown**

18a. Local File Number  
**11/04/2015**

18b. Date Received by Local Registrar  
**11/04/2015**

18c. Signature of Local Registrar  
**Jane Doe**

19. Mother's Current Legal Name First Middle Last  
**Unknown**

20. SSN of Mother  
**Unknown**

21. SSN of Father  
**Unknown**

22. Mother Married?  
 Yes  No

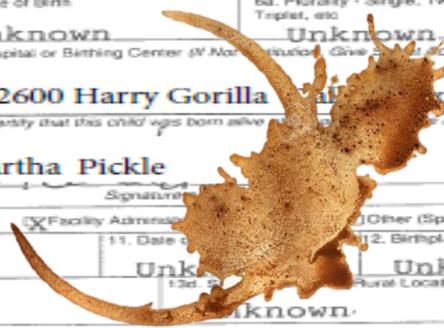
23. I consent for my baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers.  
 Yes  No

24. SSN for your new baby?  
 Yes  No

25. Signature of Parent - I have reviewed the information that it is correct.  
**K. K. K.**

26. Father's mailing address:  Same as Mother  
**Unknown**

No Coffee Stains



No Double Stamping

15. Father's Name First Middle Last Suffix  
**John Deer Pancake Jr**

16. Date of Birth (mm/dd/yyyy)  
**Unknown**

17. Birthplace (State, Territory, or Foreign Country)  
**Unknown**

18a. Local File Number  
**Unknown**

18b. Date Received by Local Registrar  
**Unknown**

18c. Signature of Local Registrar  
**Unknown**

19. Mother's Current Legal Name First Middle Last  
**Unknown**

20. SSN of Mother  
**Unknown**

21. SSN of Father  
**Unknown**

22. Mother Married?  
 Yes  No

23. I consent for my baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers.  
 Yes  No

24. SSN for your new baby?  
 Yes  No

25. Signature of Parent - I have reviewed the information that it is correct.  
**Unknown**

26. Father's mailing address:  Same as Mother  
**Unknown**

If there is a Father on the Birth Record AND Mother Married is marked No **THERE MUST BE AN AOP PROCESSED**

STATE OF TEXAS

CERTIFICATE OF BIRTH

BIRTH NUMBER 142-13-168257

1. Child's Name First Middle Last Suffix			2. Date of Birth (mm/dd/yyyy)		3. Sex
4a. Place of Birth - County		4b. City or Town (if outside city limits, give precinct no.)		5. Time of Birth	6a. Plurality - Single, Twin, Triplet, etc.
6b. If Plural Birth, Born 1st, 2nd, 3rd, etc.		7a. Place of Birth <input type="checkbox"/> Clinic / Doctor's Office <input type="checkbox"/> Licensed Birthing Center <input type="checkbox"/> Hospital <input type="checkbox"/> Home Birth (Planned to deliver at home?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Specify):			
7b. Name of Hospital or Birthing Center (If Not Institution, Give Street Address)		Facility NPI:			
8a. Attendant's Name, NPI, and Mailing Address			8b. Certifier - I certify that this child was born alive at the place and time and on the date as stated.		
			Signature and Title		Date Signed
8b. <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM <input type="checkbox"/> Midwife <input type="checkbox"/> Other (Specify):			9b. <input type="checkbox"/> Attendant <input type="checkbox"/> Facility Administrator / Designee <input type="checkbox"/> Other (Specify):		
10. Mother's Name Prior to First Marriage First Middle Last			11. Date of Birth (mm/dd/yyyy)		12. Birthplace (State, Territory, or Foreign Country)
13a. Residence - State	13b. County	13c. City, Town, or Location		13d. Street Address or Rural Location	
13a. Zip Code	13f. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Mother's Mailing Address: <input type="checkbox"/> Same As Residence, or:			
15. Father's Name First Middle Last Suffix			16. Date of Birth (mm/dd/yyyy)		17. Birthplace (State, Territory, or Foreign Country)
18a. Local File Number <b>02-001-13</b>		18b. Date Received by Local Registrar		18c. Signature of Local Registrar	
CONFIDENTIAL INFORMATION FOR MEDICAL AND PUBLIC HEALTH USE - THE FOLLOWING INFORMATION WILL NOT BE SHOWN ON CERTIFIED COPIES					
19. Mother's Current Legal Name First Middle Last		20. SSN of Mother		21. SSN of Father	
22. Mother Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. I consent for my baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers. <input type="checkbox"/> Yes <input type="checkbox"/> No		24. SSN for your new baby? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Signature of Parent - I have reviewed the information above and agree that it is correct.	
26. Father's mailing address: <input type="checkbox"/> Same as Mother					
27. Mother's Education (Check the box that best describes the highest degree or level of school completed at the time of delivery)		28. Mother of Hispanic Origin? (Check the box that best describes whether the mother is Spanish/Hispanic/Latino. Check the "No" box if mother is not Spanish/Hispanic/Latino)		29. Mother's Race (Check one or more races to indicate what the mother considers herself to be)	
<input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		<input type="checkbox"/> No, not Spanish, Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____	
30. Father's Education (Check the box that best describes the highest degree or level of school completed at the time of delivery)		31. Father of Hispanic Origin? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)		32. Father's Race (Check one or more races to indicate what the father considers himself to be)	
<input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		<input type="checkbox"/> No, not Spanish, Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____	
Usual Occupation (homemaker, student, teacher, clerk, programmer, attorney, realtor, artist, nurse, etc.)		33. Mother		34. Father	
Type of Business/Industry (retail, consulting, education, farming, government, manufacturing, etc.)		35. Mother		36. Father	
PREGNANCY HISTORY		38. Source of Prenatal Care (check all that apply)		40. Mother's Prepregnancy	
				41. Mother's Weight at Delivery	

Items 1-18 C should be complete

Item 2: Date of Birth

Item 9A: Certifier and Date Certified

Item 18A: Local File Number

Item 18B: Date Received by Local

Item 18C: Signature of Local

2 Digit Registrar Number

2 Digit Year

MENTION IN THIS FORM CAN BE 2-10 YEARS IN PRISON AND A FINE OF UP TO \$5000.

# Dates Not Flowing

**Item 4A and Item 18C:**  
Wrong Registrar Signing for Records OR Records Filed in Wrong County

**Item 2, 9A and 18B:**  
Date Received by Registrar BEFORE Date of Birth and BEFORE Date Certified

**Item 2 and Item 18A:**  
Date of Birth AND Registrar File Number do not match

**Item 2 and 18B:**  
Date of Birth AFTER Date Certified

STATE OF TEXAS				CERTIFICATE OF BIRTH				BIRTH NUMBER	
1. Child's Name - First			Middle		Last		Suffix	2. Date of Birth (mm/dd/yyyy)	3. Sex
4a. Place of Birth - County				5. City or Town (if outside city limits, give precinct no.)		5. Time of Birth		6. Maturity - Single, Twin, Triplet, etc.	
7a. Place of Birth				7b. Name of Hospital or Birthing Center (If Not Institution, Give Street Address)					
8a. Attendant's Name, NPI, and Mailing Address				8b. Certifier - I certify that this child was born alive at the place and time and on the date as stated.					
8b. <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM <input type="checkbox"/> Midwife <input type="checkbox"/> Other (Specify):				9a. Certifier - I certify that this child was born alive at the place and time and on the date as stated.					
10. Mother's Name Prior to First Marriage - First Middle Last				11. Date of Birth (mm/dd/yyyy)		12. Birthplace (State, Territory, or Foreign Country)			
13a. Residence - State		13b. County		13c. City, Town, or Locality					
13a. Zip Code		13f. Inside City Limits		14. Mother's Mailing Address: <input type="checkbox"/> Same As Residence, or:					
15. Father's Name - First Middle Last		16. Date of Birth (mm/dd/yyyy)		17. Birthplace (State, Territory, or Foreign Country)					
18a. Local File Number		18b. Date Received by Local Registrar		18c. Signature of Local Registrar					
CONFIDENTIAL INFORMATION FOR MEDICAL AND PUBLIC HEALTH USE - THE FOLLOWING INFORMATION WILL NOT BE SHOWN ON CERTIFIED COPIES									
19. Mother's Current Legal Name - First Middle Last				20. SSN of Mother		21. SSN of Father			
22. Mother Married? <input type="checkbox"/> Yes <input type="checkbox"/> No		23. I consent for my baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers. <input type="checkbox"/> Yes <input type="checkbox"/> No		24. SSN for your new baby? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Signature of Parent - I have reviewed the information above and agree that it is correct.			
26. Father's mailing address. <input type="checkbox"/> Same as Mother									

<p>27. <b>Mother's Education</b> (Check the box that best describes the highest degree or level of school completed at the time of delivery)</p> <p><input type="checkbox"/> 8th grade or less</p> <p><input type="checkbox"/> 9th - 12th grade, no diploma <b>Unknown</b></p> <p><input type="checkbox"/> High school graduate or GED completed</p> <p><input type="checkbox"/> Some college credit, but no degree</p> <p><input type="checkbox"/> Associate degree (e.g., AA, AS)</p> <p><input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)</p> <p><input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)</p> <p><input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)</p>	<p>28. <b>Mother of Hispanic Origin?</b> (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)</p> <p><input type="checkbox"/> No, not Spanish, Hispanic/Latina <b>Unknown</b></p> <p><input type="checkbox"/> Yes, Mexican, Mexican American, Chicana</p> <p><input type="checkbox"/> Yes, Puerto Rican</p> <p><input type="checkbox"/> Yes, Cuban</p> <p><input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____</p>	<p>29. <b>Mother's Race</b> (Check one or more races to indicate what the mother considers herself to be)</p> <p><input type="checkbox"/> White <b>Unknown</b></p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____</p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian (Specify) _____</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Other Pacific Islander (Specify) _____</p> <p><input type="checkbox"/> Other (Specify) _____</p>															
<p>30. <b>Father's Education</b> (Check the box that best describes the highest degree or level of school completed at the time of delivery)</p> <p><input type="checkbox"/> 8th grade or less</p> <p><input type="checkbox"/> 9th - 12th grade, no diploma <b>Unknown</b></p> <p><input type="checkbox"/> High school graduate or GED completed</p> <p><input type="checkbox"/> Some college credit, but no degree</p> <p><input type="checkbox"/> Associate degree (e.g., AA, AS)</p> <p><input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)</p> <p><input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)</p> <p><input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)</p>	<p>31. <b>Father of Hispanic Origin?</b> (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)</p> <p><input type="checkbox"/> No, not Spanish, Hispanic/Latino <b>Unknown</b></p> <p><input type="checkbox"/> Yes, Mexican, Mexican American, Chicano</p> <p><input type="checkbox"/> Yes, Puerto Rican</p> <p><input type="checkbox"/> Yes, Cuban</p> <p><input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____</p>	<p>32. <b>Father's Race</b> (Check one or more races to indicate what the father considers himself to be)</p> <p><input type="checkbox"/> White <b>Unknown</b></p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____</p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian (Specify) _____</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Other Pacific Islander (Specify) _____</p> <p><input type="checkbox"/> Other (Specify) _____</p>															
<p>Usual Occupation (homemaker, student, teacher, clerk, programmer, attorney, realtor, artist, nurse, etc.)</p>	<p>33. Mother <b>Unknown</b></p>	<p>34. Father <b>Unknown</b></p>															
<p>Type of Business/Industry (retail, consulting, education, farming, government, manufacturing, etc.)</p>	<p>35. Mother <b>Unknown</b></p>	<p>36. Father <b>Unknown</b></p>															
<b>PREGNANCY HISTORY</b>																	
<p>PREVIOUS LIVE BIRTHS (Do not include this child)</p>		<p>OTHER PREGNANCY OUTCOMES</p>															
<p>37a. Now Living</p> <p>Number <b>UNK</b></p> <p><input type="checkbox"/> None</p>	<p>37b. Now Dead</p> <p>Number <b>UNK</b></p> <p><input type="checkbox"/> None</p>	<p>37d.</p> <p>Number <b>UNK</b></p> <p><input type="checkbox"/> None</p>															
<p>37c. Date of Last Live Birth (mm/dd/yyyy)</p> <p><b>Unknown</b></p>	<p>37e. Date Last Other Pregnancy Ended (mm/dd/yyyy)</p> <p><b>Unknown</b></p>	<p>39. Mother's Medicaid Number</p> <p><b>Unknown</b></p>															
<p>45. <b>Cigarette Smoking Before and During Pregnancy</b> For each time period, enter the number of cigarettes or the number of packs of cigarettes smoked. If NONE, ENTER "0".</p> <p>Average number of cigarettes or packs of cigarettes smoked per day.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><b>Unknown</b></td> <td style="width: 33%; text-align: center;"># of cigarettes</td> <td style="width: 33%; text-align: center;"># of packs</td> </tr> <tr> <td>Three months before pregnancy _____</td> <td>OR _____</td> <td></td> </tr> <tr> <td>First three months of pregnancy _____</td> <td>OR _____</td> <td></td> </tr> <tr> <td>Second three months of pregnancy _____</td> <td>OR _____</td> <td></td> </tr> <tr> <td>Third trimester of pregnancy _____</td> <td>OR _____</td> <td></td> </tr> </table>	<b>Unknown</b>	# of cigarettes	# of packs	Three months before pregnancy _____	OR _____		First three months of pregnancy _____	OR _____		Second three months of pregnancy _____	OR _____		Third trimester of pregnancy _____	OR _____		<p>46. Principal source of payment for this delivery</p> <p><input type="checkbox"/> Private insurance <b>Unknown</b></p> <p><input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> Self-pay</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>40. Mother's Prepregnancy Weight (pounds) <b>UNK</b></p> <p>41. Mother's Weight at Delivery (pounds) <b>UNK</b></p> <p>42. Mother's Height (feet/inches) <b>UNK</b></p> <p>43. Date Last Normal Menstrual Began (mm/dd/yyyy) <b>UNK</b></p> <p>PRENATAL CARE <input type="checkbox"/> No Prenatal Care</p> <p>44a. Date of First Visit (mm/dd/yyyy) <b>Unknown</b></p> <p>44b. Date of Last Visit (mm/dd/yyyy) <b>Unknown</b></p> <p>44c. Number of Prenatal Visits <b>Unknown</b></p> <p>47. Did mother get WIC food for herself during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Unknown</b></p> <p>48. Mother transferred for maternal medical or fetal indications for this delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Unknown</b></p> <p>If Yes, enter the name of facility mother transferred from: _____</p>
<b>Unknown</b>	# of cigarettes	# of packs															
Three months before pregnancy _____	OR _____																
First three months of pregnancy _____	OR _____																
Second three months of pregnancy _____	OR _____																
Third trimester of pregnancy _____	OR _____																

**REMEMBER:**  
Each item  
number  
**CANNOT**  
be left blank

# Death Certificates

## ► Things to check for:

### ❑ Alterations

- ❖ White Out
- ❖ Mark Through
- ❖ Damaged Records
  - Cuts, Tears, and Stains

### ❑ Paper Format

- ❖ (VS 112 REV 1/2006)
- ❖ Margins
- ❖ Not Meeting State Specifications
  - 24lb, Acid Free Light Cockle
  - 25% White Cotton
  - ¾" Left Side Margin
  - ¾" from Top Edge of Paper to first line
- ❖ Xerox Copies not accepted

### ❑ Require Information

- ❖ Date Certified
- ❖ Signature of Certifier
- ❖ Registrar File Number
- ❖ Date Received by Local Registrar
- ❖ Signature Stamp (No Double Stamping)

### ❑ Registration District

- ❖ Wrong Registrar Signing for Records
- ❖ Records Filed in Wrong County

### ❑ Query Letters

- ❖ Contact Nosology 512-776-7359

- **Item 1:** If name is Unknown, put Case Number.
- **Item 3:** Write out Sex
- **Item 5:** If baby is under 1 minute – you HAVE to put at least 1 minute.  
We do not accept 0 or unknown.
- **Item 13:** If Other, must specify IE) highway
- **Item 14:** County of Death
- **Item 15:** If outside of city limits, MUST include precinct number
- **Item 17:** Informant's Name and Relationship

STATE OF TEXAS		CERTIFICATE OF DEATH				STATE FILE NUMBER	
1. LEGAL NAME OF DECEASED (include AKA's, if any) (First, Middle, Last)					(Maiden)	2. DATE OF DEATH - ACTUAL OR PRESUMED (mm-dd-yyyy)	
Sally Jane Mouse					HORN	November 2, 2015	
3. SEX	4. DATE OF BIRTH (mm-dd-yyyy)	5. AGE-Last Birthday (Years)	IF UNDER 1 YR MO	IF UNDER 1 DAY DAYS	IF UNDER 1 DAY HOURS	IF UNDER 1 DAY MIN	6. BIRTHPLACE (City & State or Foreign Country)
FEMALE	JUNE 25, 1934	81				1	CENTRALIA, OK
7. SOCIAL SECURITY NUMBER		8. MARITAL STATUS AT TIME OF DEATH			9. SURVIVING SPOUSE'S NAME (if wife, give name prior to first marriage)		
456-65-6544		<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Unknown			Michael Mouse		
10a. RESIDENCE STREET ADDRESS					10b. APT. NO.	10c. CITY OR TOWN	
123 Disney Street						ALPINE	
10d. COUNTY		10e. STATE		10f. ZIP CODE		10g. INSIDE CITY LIMITS?	
BREWSTER		TEXAS		79830		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
11. FATHER'S NAME PRIOR TO FIRST MARRIAGE				12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE			
BERT HORN				Sally Jane Pancake			
13. PLACE OF DEATH (CHECK ONLY ONE)							
IF DEATH OCCURRED IN A HOSPITAL:				IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL:			
<input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				<input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input checked="" type="checkbox"/> Other (Specify)			
14. COUNTY OF DEATH		15. CITY/TOWN, ZIP CODE (if outside city limits, give precinct no)			16. FACILITY NAME (if not institution, give street address)		
BREWSTER		ALPINE, 79830			Disney Medical Center		
17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED				18. MAILING ADDRESS OF INFORMANT (Street and Number, City, State, Zip Code)			
Michael Mouse - Husband				123 Disney Street Alpine, TX 79830			

**Item 19:** If other is selected, you must specify

**Item 20:** If burying at home, name is needed but not a license number

**Item 22 – 25:** Put the name of the place that is handling the body

**Item 33:** No blanks, unknown is acceptable

**Item 36:** Mandatory Field. If Accident, suicide, or homicide is marked, then 40A-41 must be completed

19. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from state <input checked="" type="checkbox"/> Other (Specify)		20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH <b>Goofy Bacon, BY ELECTRONIC SIGNATURE</b>		21. Section <input checked="" type="checkbox"/> Unknown Block _____ Room _____ Space _____	
22. PLACE OF DISPOSITION (Name of Cemetery, crematory, other place) <b>Sammy Crematory</b>		23. LOCATION (City/Town, and State) <b>ODESSA, TX</b>			
24. NAME OF FUNERAL FACILITY <b>Apples Funeral Home</b>		25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City State, Zip Code) <b>999 Tree Ave Alpine, TX 79830</b>			
26. CERTIFIER (Check only one) <input checked="" type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/Justice of the Peace - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
27. SIGNATURE OF CERTIFIER 		28. DATE CERTIFIED (mm-dd-yyyy) <b>11-02-2015</b>		29. LICENSE NUMBER 	
30. TIME OF DEATH (Actual or presumed) <b>01:15 AM</b>					
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) <b>Nancy Escovan, M.D., 26666 I-35 Alpine, TX 79830</b>				32. TITLE OF CERTIFIER <b>M.D.</b>	
33. PART 1. ENTER THE CHAIN OF EVENTS - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE DEATH. DO NOT ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON EACH LINE.					
CAUSE OF DEATH IMMEDIATE CAUSE (First disease or condition resulting in death)		<b>UNKNOWN</b>			
Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated, the events resulting in death) LAST		<b>Multiple Acute Myocardial Infarctions</b>			
Due to (or as a consequence of):					
		<b>Coronary Artery Disease</b>			
Due to (or as a consequence of):					
PART 2. ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1.		<b>Atrial Fibrillation, Urinary Tract Infection</b>			
34. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No			
36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		38. IF FEMALE: <input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to one year before death <input type="checkbox"/> Unknown if pregnant within the past year	
39. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)					
40a. DATE OF INJURY (mm-dd-yyyy)		40b. TIME OF		40c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
40d. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area)				40f. COUNTY OF INJURY	
41. DESCRIBE HOW INJURY OCCURRED					
42a. REGISTRAR FILE NO. <b>01-58-2015</b>		42b. DATE RECEIVED BY LOCAL REGISTRAR <b>NOVEMBER 4, 2015</b>		42c. REGISTRAR <b>JANE DOE</b>	

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine up to \$10,000.

VS-112 REV 1/2006

# Query Letters: and how to prevent them

- Rare Causes– Specify? ie) West Nile, Jacobsen's
- Ill-defined – ie) cardiac arrest. **BE MORE SPECIFIC**
- Edits From CHS – illogical deaths **DOUBLE CHECK YOUR WORK**
- Ill-eligible – not legible. Easy Solution **JUST USE TER**

**33. PART 1. Enter The Chain of Events**

31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) \_\_\_\_\_ 32. TITLE OF CERTIFIER \_\_\_\_\_

33. PART 1. ENTER THE CHAIN OF EVENTS - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE DEATH. DO NOT ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON EACH LINE

CAUSE OF DEATH	IMMEDIATE CAUSE (Final disease or condition -----> resulting in death) <b>A</b>	Due to (or as a consequence of):	Approximate interval Onset to death
	Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated, the events resulting in death) LAST <b>B</b>	Due to (or as a consequence of):	
	<b>C</b>	Due to (or as a consequence of):	
	<b>D</b>	Due to (or as a consequence of):	

PART 2. ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I.

34. WAS AN AUTOPSY PERFORMED?  
 Yes  No

35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  
 Yes  No

36. MANNER OF DEATH  
 Natural

37. DID TOBACCO USE CONTRIBUTE TO DEATH?

38. IF FEMALE:

39. IF TRANSPORTATION INJURY, SPECIFY:  
 Driver/Operator



**LINE A:**  
immediate cause

**LINE B:**  
chain of events

WARNING The penalty for knowingly making a false statement in this form is a fine up to \$10,000. (Health and Safety Code, Sec. 195, 1989)

# SAMPLE "RARE DISEASES" QUERY LETTER

<input checked="" type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.				
<input type="checkbox"/> Medical Examiner/Justice of the Peace - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
27. SIGNATURE OF CERTIFIER:		28. DATE CERTIFIED (mm-dd-yyyy)	29. LICENSE NUMBER	30. TIME OF DEATH (Actual or presumed)
 BY ELECTRONIC SIGNATURE		JULY 10, 2013		11:45 AM
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code)				32. TITLE OF CERTIFIER
				DO
CAUSE OF DEATH	33. PART 1. ENTER THE <u>CHAIN OF EVENTS</u> - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE DEATH. <u>DO NOT</u> ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON A EACH.			Approximate interval Onset to death
	IMMEDIATE CAUSE (Final disease or condition -----> resulting in death)	a. WEST NILE ENCEPHALITIS	Due to (or as a consequence of):	2 WEEKS
	Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated, the events resulting in death) LAST	b. PNEUMONIA	Due to (or as a consequence of):	2 DAYS
		c.	Due to (or as a consequence of):	
PART 2. ENTER OTHER <u>SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</u> BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1.			34. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
36. MANNER OF DEATH	37. DID TOBACCO USE CONTRIBUTE TO DEATH?	38. IF FEMALE:		39. IF TRANSPORTATION INJURY, SPECIFY:
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death		<input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian

Dear Dr. [REDACTED],

Date 07/19/2013

Some Infectious diseases or external conditions are so scarce in the United States that they are rarely the cause of death. They are generally recognized as a threat to the public health, and are automatically verified with the certifier to avoid undue concern. Please verify the cause of death on the attached certificate based on your judgment and knowledge of the facts of this case. If this case has not been officially reported, an epidemiologist from your local or state health department may contact you to obtain more information. If there are any changes to be made, please log into our TER Death Registration website at <https://ter2.dshs.state.tx.us/edeath/> to complete An Amendment to Medical Certification of Certificate of Death. If there are not any changes to be made, sign and return the attached letter in the enclosed return envelope. Your attention and prompt reply will be appreciated. If you have any questions, please contact Nosology at (512) 776-7359.

1. is the stated condition West Nile Encephalitis Correctly reported?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. If yes, how was the stated disease confirmed \_\_\_\_\_

(laboratory test, history, clinical evidence, and/or others. If applicable, please state name of laboratory test, and/or source of evidence)

3. If no, please complete the enclosed medical ammendment to remove the stated condition from the death certificate.

4. Was the condition active or current? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Was the condition cured, old, or healed Yes \_\_\_\_\_ No \_\_\_\_\_

SIGNATURE OF CERTIFIER \_\_\_\_\_ DATE \_\_\_\_\_

# Medical Amendment

## ► Things to check for:

- ❑ Name and Place of Death must match original certificate exactly.
- ❑ Common mistakes:
  - Item 31 – Printed Name & Full Address
  - Place of Death – List City or Town and County

Everything should match the original certificate except for what is being changed.

**Name and Place of Death:** Must match original death certificate

**Mandatory Items:** Item 26 – 39

**Item 26:** Certifying Physician and full address in a separate box

**Item 30:** If a coroner, surgeon or homicide is selected on the 40A-41 must be completed

**Item 42A-42C:** mandatory information

# What do you see wrong?

### AMENDMENT TO MEDICAL CERTIFICATION OF CERTIFICATE OF DEATH

STATE OF TEXAS		STATE FILE NUMBER 555555	
ENTER NAME OF DECEASED AND PLACE OF DEATH EXACTLY AS SHOWN ON ORIGINAL DEATH CERTIFICATE			
NAME OF DECEASED Ruby Slippers		DATE OF DEATH 8/31/2015	
PLACE OF DEATH (City or Town and County) The Colony Apartments at The Colony		IS THE DATE OF DEATH BEING CORRECTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. CERTIFIER (Check only one): <input checked="" type="checkbox"/> Certifying Physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/Justice of the Peace - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.			
27. SIGNATURE OF CERTIFIER <i>[Signature]</i>		28. DATE CERTIFIED (mm/dd/yyyy) 8-31-2015	29. LICENSE NUMBER 11111111
30. TIME OF DEATH (Actual or presumed) 09:55 AM		31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) 16666 Southwest Road Suite 175 Texas 77479	
32. TITLE OF CERTIFIER M.D.		33. PART 1. ENTER THE CAUSE OF DEATH - DISEASE, INJURY, OR COMPLICATIONS THAT DIRECTLY CAUSED THE DEATH. DO NOT ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON EACH LINE.	
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <u>CARDIAC ARRHYTHMIA</u> Due to (or as a consequence of):		Approximate Interval: Onset to death <u>Unknown</u>	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST. b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____			
PART 2. ENTER OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1.		34. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could Not Be Determined		37. DID TOBACCO CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		38. IF FEMALE: <input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	
		39. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) <u>NONE</u>	
40a. DATE OF INJURY (mm/dd/yyyy) <u>NONE</u>	40b. TIME OF INJURY <u>NONE</u>	40c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	40d. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area)
40e. LOCATION (Street and Number, City, State, Zip Code)			40f. COUNTY OF INJURY <u>NONE</u>
41. DESCRIBE HOW INJURY OCCURRED <u>NONE</u>			
42a. REGISTRAR FILE NO.	42b. DATE RECEIVED BY LOCAL REGISTRAR	42c. SIGNATURE OF LOCAL REGISTRAR	

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine of up to \$10,000. (Health and Safety Code, Sec. 195, 1989)

S-174 REV. 11/2009

# Fetal Death Certificates

## ▶ Things to check for:

- ❑ Back of Form

- ❖ Something needs to be marked in each box
- ❖ Cannot be left blank

- ❑ Dates

- ❖ All dates must flow correctly

- ❑ Most Common Rejection

- ❖ 17B or 18B blank
- ❖ No Alterations

**Item 1:** If name unknown, put case number

**Item 4:** Sex must be spelled out

Item 17B or 18B is left blank

Mandatory Items: 1-8B and 17A-25

No mistakes, cross-outs, or edits.

STATE OF TEXAS		CERTIFICATE OF FETAL DEATH		STATE FILE NUMBER
1. Name (Optional - at the discretion of the parents) <b>Megan Sally Johnson</b>		2. Date of Delivery (mm/dd/yyyy) <b>8/13/2015</b>	3. Time of Delivery <b>12:03 PM</b>	4. Sex <b>F Female</b>
5. Place of Delivery - County <b>Travis</b>	6a. City or Town (if outside city limits, give precinct no.) <b>Whooville</b>	6b. Zip Code <b>7771</b>	6c. Purity - Single, Twin, Triplet, etc. <b>single</b>	7b. If Plural, Delivered 1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , etc.
8a. Place of Delivery <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Licensed Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Delivery (Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No) <input type="checkbox"/> Other (Specify):		8b. Name of Hospital or Birthing Center (if not institution, give street address) <b>Whooville Regional Hospital</b> Facility NPI:		
9. Mother's Current Legal Name <b>Maple Syrup Johnson</b>			10. Mother's Date of Birth <b>10/25/96</b>	
11. Mother's Name Prior to First Marriage First Middle Last <b>Maple Syrup Pancakeston</b>		12. Birthplace (State, Territory or Foreign Country) <b>Longview</b>		
13a. Mother's Residence - State <b>TX</b>		13b. County <b>Travis</b>	13c. City, Town, or Location <b>Whooville</b>	
13d. Street Address or Rural Location <b>1234 Bacon Lane</b>		13e. Apt. No.	13f. Zip Code <b>77771</b>	13g. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14. Father's Name First Middle Last Suffix <b>Squirrel Jay Johnson</b>		15. Father's Date of Birth <b>2-14-95</b>		16. Birthplace (State, Territory or Foreign Country)
17a. Attendant's Name and Mailing Address <b>Ima Midwife 444 Burger Lane Dallas, TX 77777</b> NPI: <b>198842211</b>		17b. Certifier - To the best of my knowledge, the fetus was delivered at the time, date, and place as shown and fetal death was due to the cause(s) as stated. <b>[Signature] MD.</b> <b>10/14/15</b> Date Signed		
17c. <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM <input type="checkbox"/> Midwife <input type="checkbox"/> Other (Specify):		18. <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Medical Examiner/Justice of the Peace		
19. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		20. Signature and License Number of Funeral Director or Person Acting as Such <b>Tom Baker 1139441</b>		21. Section <input checked="" type="checkbox"/> Unknown Block Lot Space
22. Place of Disposition (Name of cemetery, crematory, other place) <b>Rainbow Hill Crematory,</b>		23. Location (City/Town and State) <b>Longview, TX 75601</b>		
24. Name of Funeral Facility <b>Star Power Funeral Homes</b>		25. Complete Address of Funeral Facility (Street and Number, City, State, Zip Code) <b>5555 Sally Jackson Trail Longview, TX 75601</b>		

# Back of Fetal Death Certificate

**CONFIDENTIAL INFORMATION FOR MEDICAL AND PUBLIC HEALTH USE - THE FOLLOWING INFORMATION WILL NOT BE SHOWN ON CERTIFIED COPIES**

<p>34. Mother's Education (Check the box that best describes the highest degree or level of school completed at the time of delivery)</p> <p><input checked="" type="checkbox"/> 9th grade or less</p> <p><input type="checkbox"/> 9th - 12th grade, no diploma</p> <p><input type="checkbox"/> High school graduate or GED completed</p> <p><input type="checkbox"/> Some college credit, but no degree</p> <p><input type="checkbox"/> Associate degree (e.g., AA, AS)</p> <p><input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)</p> <p><input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MEd, MSW, MBA)</p> <p><input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)</p>	<p>35. Mother of Hispanic Origin? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if decedent is not Spanish/Hispanic/Latina)</p> <p><input checked="" type="checkbox"/> No, not Spanish, Hispanic/Latina</p> <p><input type="checkbox"/> Yes, Mexican, Mexican American, Chicana</p> <p><input type="checkbox"/> Yes, Puerto Rican</p> <p><input type="checkbox"/> Yes, Cuban</p> <p><input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____</p>	<p>36. Mother's Race (Check one or more races to indicate what the mother considers herself to be)</p> <p><input type="checkbox"/> White</p> <p><input checked="" type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____</p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian (Specify) _____</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Other Pacific Islander (Specify) _____</p>																
<p><b>PREGNANCY HISTORY</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 33%;">LIVE BIRTHS</th> <th style="width: 33%;">OTHER PREGNANCY OUTCOMES</th> <th style="width: 33%;">Miscarriages or Stillbirths</th> </tr> <tr> <td> <p>37a. Now Living</p> <p>Number _____</p> <p><input checked="" type="checkbox"/> None</p> </td> <td> <p>37b. Now Dead</p> <p>Number _____</p> <p><input checked="" type="checkbox"/> None</p> </td> <td> <p>37c. Date Last Other Pregnancy Ended (mm/yyyy)</p> <p>_____</p> </td> </tr> </table>		LIVE BIRTHS	OTHER PREGNANCY OUTCOMES	Miscarriages or Stillbirths	<p>37a. Now Living</p> <p>Number _____</p> <p><input checked="" type="checkbox"/> None</p>	<p>37b. Now Dead</p> <p>Number _____</p> <p><input checked="" type="checkbox"/> None</p>	<p>37c. Date Last Other Pregnancy Ended (mm/yyyy)</p> <p>_____</p>	<p>41. Source of prenatal care</p> <p><input type="checkbox"/> Hospital Clinic    <input checked="" type="checkbox"/> Public Health Clinic</p> <p><input type="checkbox"/> Private Physician    <input type="checkbox"/> Mobile</p> <p><input type="checkbox"/> None    <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>42. Mother's Weight at Delivery _____ (pounds)</p> <p>43a. Date of First Visit (mm/dd/yyyy) _____</p> <p>43b. Date of Last Visit (mm/dd/yyyy) _____</p> <p>43c. Number of Prenatal Visits _____</p>									
LIVE BIRTHS	OTHER PREGNANCY OUTCOMES	Miscarriages or Stillbirths																
<p>37a. Now Living</p> <p>Number _____</p> <p><input checked="" type="checkbox"/> None</p>	<p>37b. Now Dead</p> <p>Number _____</p> <p><input checked="" type="checkbox"/> None</p>	<p>37c. Date Last Other Pregnancy Ended (mm/yyyy)</p> <p>_____</p>																
<p>38. Cigarette Smoking Before and During Pregnancy (For each time period, enter the number of cigarettes or packs of cigarettes smoked. IF NONE, ENTER "0".)</p> <p>Average number of cigarettes or packs of cigarettes smoked per day</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 33%;"># of cigarettes</th> <th style="width: 33%;">OR</th> <th style="width: 33%;"># of packs</th> </tr> <tr> <td>Three months before pregnancy: 0</td> <td>OR</td> <td>0</td> </tr> <tr> <td>First three months of pregnancy: 0</td> <td>OR</td> <td>0</td> </tr> <tr> <td>Second three months of pregnancy: 0</td> <td>OR</td> <td>0</td> </tr> <tr> <td>Third trimester of pregnancy: 0</td> <td>OR</td> <td>0</td> </tr> </table>		# of cigarettes	OR	# of packs	Three months before pregnancy: 0	OR	0	First three months of pregnancy: 0	OR	0	Second three months of pregnancy: 0	OR	0	Third trimester of pregnancy: 0	OR	0	<p>44. Did mother get WIC food for herself during this pregnancy? <input type="checkbox"/> Yes    <input checked="" type="checkbox"/> No</p> <p>45. Mother Married? (at delivery, conception, or anytime between) <input type="checkbox"/> Yes    <input checked="" type="checkbox"/> No</p> <p>47. Mother transferred for maternal medical or fetal indications for this delivery? <input type="checkbox"/> Yes    <input checked="" type="checkbox"/> No</p> <p>If Yes, enter the name of facility mother transferred from: _____</p>	
# of cigarettes	OR	# of packs																
Three months before pregnancy: 0	OR	0																
First three months of pregnancy: 0	OR	0																
Second three months of pregnancy: 0	OR	0																
Third trimester of pregnancy: 0	OR	0																
<p>48. Maternal Medical History (Check all that apply)</p> <p><input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy)</p> <p><input type="checkbox"/> Gestational (Diagnosis in this pregnancy)</p> <p>Hypertension</p> <p><input type="checkbox"/> Prepregnancy (Chronic)</p> <p><input type="checkbox"/> Gestational (PIH, preeclampsia)</p> <p><input type="checkbox"/> Eclampsia</p> <p><input type="checkbox"/> Previous preterm birth</p> <p><input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)</p> <p><input type="checkbox"/> Pregnancy resulted from infertility treatment - If yes, check all that apply:</p> <p><input type="checkbox"/> Fertility-enhancing drugs, artificial insemination, or intravaginal insemination</p> <p><input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))</p> <p><input type="checkbox"/> Mother had previous cesarean delivery if yes, how many _____</p> <p><input type="checkbox"/> Antiretrovirals administered during pregnancy or at delivery</p> <p><input checked="" type="checkbox"/> None of the above</p>		<p>49. Maternal History (Check all that apply)</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Listeria</p> <p><input type="checkbox"/> Group B Streptococcus</p> <p><input type="checkbox"/> Cytomegalovirus</p> <p><input type="checkbox"/> Parvovirus</p> <p><input type="checkbox"/> Toxoplasmosis</p> <p><input checked="" type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Other (Specify) _____</p> <p style="text-align: center; font-size: 2em;">NONE ⊕</p>																
<p>50a. HIV Test Done Prenatally <input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No</p>		<p>50b. HIV Test Done at Delivery <input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No</p>																
<p>52. Maternal Morbidity - Complications</p>		<p>53. Congenital Anomalies Of The Newborn</p>																

Items 26A - 33C

is

MANDATORY

All fields must have something marked.

# Marriage License Applications

## ► Things to check for:

### □ Paper Format

- ❖ (VS 180 REV 6-2015)
- ❖ Margins
  - ¾" Left Side Margin
  - ¾" from Top Edge of Paper to first line

### □ Absent Applicant

- ❖ Absent Applicant Application **MUST** be attached or it will be rejected

### □ Dates

- ❖ Sworn Date and Marriage Date **MUST** be within 90 days of each other

### □ Mandatory Information

- ❖ County
- ❖ First and Last Name (both parties)
- ❖ Signature of both parties

### □ Duplicate Copies

- ❖ Duplicates NOT ACCEPTED

# MANDATORY FIELDS



R109421  
07/17/2015 CLAY ROAD  
\$12.00 MARR TWO

## APPLICATION FOR MARRIAGE LICENSE, Harris COUNTY, TEXAS

The form and content of this application is prescribed by section 2.004 of the Texas Family Code.

**WARNING: IT IS A CRIMINAL OFFENSE TO FURNISH FALSE INFORMATION ON THIS DOCUMENT. THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT ON THIS FORM FOR SIGNING IS FORTH WITH A FINE OF IMPRISONMENT AND A FINE OF UP TO \$2000. (HEALTH AND SAFETY CODE, CHAPTER 495, SEC. 195.003)**

Applicant One	First Name <b>Tom</b>	Middle Name <b>John</b>	Current Last Name <b>Smith</b>	Suffix III
	Woman's Maiden Name (If Applicant)		Telephone Number <b>888-555-5555</b>	
	Street Address <b>111 Apple Street</b>	City <b>Houston</b>	State <b>TX</b>	Zip <b>77064</b>
	Date of Birth <b>05/18/1985</b>	Place of Birth (including city, county and state) <b>Hammond Louisiana</b>	Social Security Number <b>456-65-6578</b>	

First and Last Name

I have not been divorced within the last 30 days.  TRUE  FALSE  
 I am not presently married.  TRUE  FALSE  
 I am not presently delinquent in the payment of court ordered child support.  
 TRUE  FALSE  
 The other applicant is not presently married.  TRUE  FALSE

I am not related to the other applicant as:  TRUE  FALSE

- an ancestor or descendant, by blood or adoption;
- a brother or sister, of the whole or half blood or by adoption;
- a parent's brother or sister, of the whole or half blood or by adoption;
- a son or daughter of a brother or sister, of the whole or half blood or by adoption;
- a current or former stepchild or stepparent; or
- a son or daughter of a parent's brother or sister, of the whole or half blood or by adoption;

Signatures of both parties

I wish to make a voluntary contribution of \$5.00 to promote healthy early childhood by supporting the Texas Home Visitation Program administered by the Office of Early Childhood Coordination of Health and Human Services [Texas Family Code 2.004(13)].

I solemnly swear (or affirm) that the information I have given in this application is correct. *[Signature]*  
 Applicant's Signature and Date Signed 07/14/2015

Applicant Two	First Name <b>Sally</b>	Middle Name <b>Megan</b>	Current Last Name <b>Apple</b>	Suffix
	Woman's Maiden Name (If Applicant) <b>Johnson</b>		Telephone Number <b>(832) 331-7648</b>	
	Street Address <b>111 Apple Street</b>	City <b>Houston</b>	State <b>TX</b>	Zip <b>77064</b>
	Date of Birth <b>08/20/1989</b>	Place of Birth (including city, county and state) <b>Galveston, Texas</b>	Social Security Number <b>456-65-6541</b>	

County/Place of Marriage

I have not been divorced within the last 30 days.  TRUE  FALSE  
 I am not presently married.  TRUE  FALSE  
 I am not presently delinquent in the payment of court ordered child support.  
 TRUE  FALSE  
 The other applicant is not presently married.  TRUE  FALSE

I am not related to the other applicant as:  TRUE  FALSE

- an ancestor or descendant, by blood or adoption;
- a brother or sister, of the whole or half blood or by adoption;
- a parent's brother or sister, of the whole or half blood or by adoption;
- a son or daughter of a brother or sister, of the whole or half blood or by adoption;
- a current or former stepchild or stepparent; or
- a son or daughter of a parent's brother or sister, of the whole or half blood or by adoption;

I wish to make a voluntary contribution of \$5.00 to promote healthy early childhood by supporting the Texas Home Visitation Program administered by the Office of Early Childhood Coordination of Health and Human Services [Texas Family Code 2.004(13)].

I solemnly swear (or affirm) that the information I have given in this application is correct. *[Signature]*  
 Applicant's Signature and Date Signed 07/14/2015

Mail Executed License To (Street/P.O. Box, City, State, Zip)

For County Clerk Office Use Only  
 Subscribed and sworn to before me, or I certified that the applicant did not appear personally but the prerequisites for the license have been fulfilled by §2.007 of the Texas Family Code on **Friday, July 17, 2015** at **8:35:23** am/gg

By *Stan Stanart* County Clerk, Harris County, Texas. Ceremony performed by *DONALD DUCK*  
 Deputy *Martha Beatriz Mayes* Date of Marriage **7/20/15** County Place of Marriage **Harris**  
 Applicant One Identification Type (ID & Age) **TXDL J1111** 30 License Number  
 Applicant Two Identification Type (ID & Age) **TXDL 22222** 25 Volume Page

Sworn in Date AND Marriage Date **MUST BE WITHIN 90 days**

# Suits

## ► Things to check for:

### □ Paper Format

- ❖ OLD Form (VS 165 REV 1/2006)
  - If using this form: You cannot put Pro Se for Attorney unless Item 20 is marked.
  - If using Pro Se, you must fill out Section 2 as well.
- ❖ NEW/UPDATED Form (VS 165 REV 7/2015)
- ❖ Must complete Section 1, 2, and 3
- ❖ Double sided print

### □ Mandatory Fields

- ❖ Section 1
  - County
  - Court No.
  - Cause No.
  - Date of Order
  - Type of Order
  - Attorney's First and Last Name
- ❖ Section 2
  - Petitioner's First and Last Name
  - Respondent's First and Last Name
- ❖ Section 3
  - Children's First and Last Name

# MANDATORY FIELDS

## INFORMATION ON SUIT AFFECTING THE FAMILY RELATIONSHIP (EXCLUDING ADOPTIONS)

### SECTION I GENERAL INFORMATION (REQUIRED)

### STATE FILE NUMBER

1a. COUNTY Travis 1b. COURT NO. 99th

1c. CAUSE NO. dv-11-2948 1d. DATE OF ORDER (mm/dd/yyyy) 11/25/2014

### 2. TYPE OF ORDER (CHECK ALL THAT APPLY):

DIVORCE/ANNULMENT WITH CHILDREN (Sec. 1,2 AND 3)

DIVORCE/ANNULMENT WITHOUT CHILDREN (Sec 1 AND 2)

ESTABLISHMENT OF COURT OF CONTINUING JURISDICTION (Sec 1 AND 3)  
(Court Order Establishing Paternity, Conservatorship, Child Support or Termination of Parental Rights)

CHANGE IN THE NAME OF THE CHILD (Sec 1 AND 3)  
(PROVIDE PRIOR AND NEW NAME OF CHILD IN SECTION 3)

TRANSFER OF COURT OR CONTINUING JURISDICTION (Sec 1,3 AND INFORMATION BELOW)

TRANSFER TO: COUNTY \_\_\_\_\_ COURT NO. \_\_\_\_\_ STATE COURT ID# \_\_\_\_\_

3a. NAME OF ATTORNEY FOR PETITIONER

**Paul Paulston**

3b. TELEPHONE NUMBER (including area code)

**512-444-5555**

3c. CURRENT MAILING ADDRESS (STREET AND NUMBER OR P.O BOX, CITY, STATE, ZIP)

**1111 Apple Street Austin, TX 78748**

# MANDATORY FIELDS

## SECTION 2 (IF APPLICABLE) REPORT OF DIVORCE OR ANNULMENT OF MARRIAGE

PETITIONER		
4. NAME (FIRST MIDDLE LAST SUFFIX) <b>Joshua Sam Smith</b>		5. MAIDEN LAST NAME (NAME BEFORE 1 <sup>ST</sup> MARRIAGE)
6. PLACE OF BIRTH (CITY AND STATE OR FOREIGN COUNTRY) <b>Seattle, Washington</b>	7. RACE <b>Cau</b>	8. DATE OF BIRTH (mm/dd/yyyy) <b>03/19/1986</b>
9. USUAL RESIDENCE <b>123 Kat Lane</b>	STREET NAME & NUMBER <b>Austin, TX 78748</b>	CITY STATE ZIP
RESPONDENT		
10. NAME (FIRST MIDDLE LAST SUFFIX) <b>Samantha Judy Smith</b>		11. MAIDEN LAST NAME (NAME BEFORE 1 <sup>ST</sup> MARRIAGE) <b>Farmerton</b>
12. PLACE OF BIRTH (CITY AND STATE OR FOREIGN COUNTRY) <b>Denver, Colorado</b>	13. RACE <b>Cau</b>	14. DATE OF BIRTH (mm/dd/yyyy) <b>12/20/1989</b>
15. USUAL RESIDENCE (STREET AND NUMBER CITY, STATE, ZIP) <b>123 Kat Lane</b>	<b>Austin, TX 78748</b>	
16. NUMBER OF MINOR CHILDREN <b>2</b>	17. DATE OF MARRIAGE (mm/dd/yyyy) <b>12/27/2006</b>	18. PLACE OF MARRIAGE (CITY AND STATE OR FOREIGN COUNTRY) <b>Austin Texas</b>

# MANDATORY FIELDS

SECTION 3 (IF APPLICABLE) CHILDREN AFFECTED BY THIS SUIT			
CHILD 1	19a. CHILD CURRENT NAME (FIRST MIDDLE LAST SUFFIX) <b>Wesley Snipes Smith</b>		
	19b. DATE OF BIRTH (mm/dd/yyyy) <b>03/24/2007</b>	19c. SEX <b>M</b>	19d. BIRTHPLACE (CITY, COUNTY AND STATE) <b>Austin Texas</b>
	19e. PRIOR NAME OF CHILD (FIRST MIDDLE LAST SUFFIX) – IF APPLICABLE		
CHILD 2	20a. CHILD CURRENT NAME (FIRST MIDDLE LAST SUFFIX) <b>Sally Snipes Smith</b>		
	20b. DATE OF BIRTH (mm/dd/yyyy) <b>01/27/2009</b>	20c. SEX <b>F</b>	20d. BIRTHPLACE (CITY, COUNTY AND STATE) <b>Austin, Texas</b>
	20e. PRIOR NAME OF CHILD (FIRST MIDDLE LAST SUFFIX) – IF APPLICABLE		
CHILD 3	21a. CHILD CURRENT NAME (FIRST MIDDLE LAST SUFFIX)		
	21b. DATE OF BIRTH (mm/dd/yyyy)	21c. SEX	21d. BIRTHPLACE (CITY, COUNTY AND STATE)
	21e. PRIOR NAME OF CHILD (FIRST MIDDLE LAST SUFFIX) – IF APPLICABLE		

ADDITIONAL CHILDREN LISTED ON BACK OF THE FORM.

I CERTIFY THAT THE ABOVE ORDER WAS GRANTED ON THE DATE AND PLACE AS STATED.

**JUDY BLOOM**

SIGNATURE OF THE CLERK OF THE COURT

WARNING: This is a governmental document. Texas Penal Code, Section 37.10, specifies penalties for making false entries or providing false information in this document. VS-165 REV 11/2015