Vital Event Data Request Form

Instructions

1. Use the checkbox(es) listed above to select certificate(s) from which you are requesting data
    - A certificate's electronic fields will *not* be accessible until it is selected above
    - Unchecking a selected certificate will deactivate access to the corresponding form fields and deselect any corresponding checkboxes. *Any justifications you have provided will not be deleted by this action*.
2. Use the links on this page or the bookmark bar to navigate to a certificate.
3. On a certificate's checklist, select the data items you are requesting.
    - Provide a brief justification for each data item requested
        - Required justification fields will be highlighted with a red border
    - Use the "Validate Form" button at the bottom of any page to check for missing criteria
        - If any criteria is missing, a pop-up alert will indicate the relevant page(s)
4. When you have finished making your selections and justifications, save and submit this file along with the rest of your application
5. To start over, use the "Reset Form" button to clear *all* selection and justification fields

Last updated: November 6, 2024

Checklist for Birth Certificate Data
1999-2004

Instructions:

1. Since these data are confidential, all requested certificate items need to have brief justifications according to your project aims.
2. If a certificate item is used for linkage, then state how and whether it will be removed from the resulting linked analysis file. If the certificate item will be retained in the linked analysis file, please also provide a brief justification according to your project aims.
3. For certain sensitive data elements, such as certificate number or residence address, consider alternative means of accomplishing your project aims while using less sensitive data. Examples include creating your own unique identifier instead of requesting the certificate number, and requesting geocoded census tracts instead of residence address.

I. Birth Certificate Items Available Electronically

✓	Item Number	Item Descriptor	Justification
		Newborn	
☐		Birth Number (Certificate Number)	
☐		Child's Birth State	
☐	1.	Newborn Name: First	
☐		Newborn Name: Middle	
☐		Newborn Name: Last	
☐		Newborn Name: Suffix	
☐	2.	Date of Birth	
☐	3.	Sex	
☐	4a.	Place of Birth - County	
☐	4b.	Place of Birth - City or Town	
☐	5.	Time of Birth	
☐	6a.	Plurality - Single, Twin, etc.	
☐	6b.	If Plural Birth, Born, 1st, 2nd, 3rd, etc.	
☐	7a.	Place of Birth: Clinic/Doctor's Office Licensed Birthing Center Hospital Residence	
☐		Place of Birth - Other (Specify) – *includes residential addresses for home births*	
☐	7b.	Name of Hospital or Birthing Center *(hospital codes)*	
		Attendant/Certifier	
☐	8b.	Attendant Type: MD, DO, CNM, Midwife	
☐		Attendant Type Other (Specify):	
		Mother	
☐	10.	Mother Name: First	
☐		Mother Name: Middle	
☐		Mother Name: Maiden Surname	
☐		Mother Name: Suffix	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	11	Date of Birth (of mother)	
☐	12	Mother's Birthplace (State or Foreign Country)	
☐	13a.	Mother's Residence State	
☐	13b.	Mother's Residence County	
☐	13c.	Mother's Residence City or Town	
☐	13d.	Mother's Residence Street Address or Rural Location	
☐	13e.	Inside City Limits (mother's residence)	
☐	14.	Mother's Mailing Address (if same as residence, enter zip code only)	
		Father	
☐	15.	Father Name: First	
☐		Father Name: Middle	
☐		Father Name: Last	
☐		Father Name: Suffix	
☐	16.	Date of Birth (of father)	
☐	17.	Father's Birthplace (state or foreign country)	

Items 19a through 38g are confidential information for medical and public health use.
Tex. Health and Safety Code, Sec.192.002(b)

✓	Item Number	Item Descriptor	Justification
☐	19a.	Mother Married?	
☐	21.	Father's Mailing Address	
☐	22a.	Race of Mother	
☐	22b.	Race of Father	
	23.	Hispanic Origin	
☐	23a.	If Mother Hispanic (Yes/No)	
☐		If Mother Hispanic Specify (Mexican, Cuban, Puerto Rican, etc.)	
☐	23b.	If Father Hispanic (Yes/No)	
☐		If Father Hispanic Specify (Mexican, Cuban, Puerto Rican, etc.)	
	24.	Education - Highest Grade Completed	
☐	24a.	Mother	
☐	24b.	Father	
	25a-b.	Usual Occupation	
☐	25a.	Mother	
☐	25b.	Father	
	25c-d.	Type of Business or Industry	
☐	25c.	Mother	
☐	25d.	Father	
		Pregnancy History	
☐	26a.	Live Births Now Living	
☐	26b.	Live Births Now Dead	
☐	26c.	Date of Last Live Birth	
☐	26d.	Other Pregnancies	
☐	26e.	Date Last Other Pregnancy Ended	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
	27.	Source of Prenatal Care	
☐		Hospital Clinic	
☐		Public Health Clinic	
☐		Private Physician	
☐		Midwife	
☐		None	
☐		Unknown	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐	28.	Mother's Medicaid Number	
☐	29	Hepatitis B Immunization Given	
	30.	Birthweight	
☐		Grams	
☐		LB	
☐		OZ	
☐	31.	Date Last Normal Menses Began	
☐	32.	Clinical Estimate of Gestation (Weeks)	
☐	33.	Prenatal Care Began During 1st, 2nd, 3d, etc. month	
☐	34.	Number of Prenatal Visits	
☐	35a.	HIV Test Done Prenatally	
☐	35b.	HIV Test Done at Delivery	
☐	36.	Serologic Test Done at Delivery	
☐	37a.	Mother Transferred Prior to Delivery (Yes/No)	
☐	37a.	Mother Transferred Prior to Delivery (specify facility):	
☐	37b.	Infant Transferred After Delivery (Yes/No):	
☐	37b.	Infant Transferred After Delivery (specify facility):	
	38a.	Medical Risk Factors for this Pregnancy	
☐		Anemia	
☐		Cardiac Disease	
☐		Acute or Chronic Lung Disease	
☐		Diabetes	
☐		Hydramnios/Oligohydramnios	
☐		Hemoglobinopathy	
☐		Hypertension, Chronic	
☐		Hypertension, Pregnancy-Associated	
☐		Eclampsia	
☐		Incompetent Cervix	
☐		Previous Infant 4000 + Grams	
☐		Previous Preterm or Small - for - Gestational-Age Infant	
☐		Preterm Labor	
☐		Renal Disease	
☐		Blood Group Isoimmunization	
☐		Preterm Rupture of Membranes (<37 weeks)	
☐		STD *(Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS)*	
☐		Zidovudine Administered During Pregnancy *(Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS)*	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→38a.	None	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐		Unknown	
	38b.	Other Risk Factors for this Pregnancy	
☐		Tobacco Use During Pregnancy	
☐		Average Number of Cigarettes Per Day	
☐		Alcohol Use During Pregnancy	
☐		Average Number of Drinks Per Week	
☐		Weight Gained During Pregnancy	
	38c.	Obstetric Procedures	
☐		Amniocentesis	
☐		Electronic Fetal Monitoring	
☐		Induction of Labor	
☐		Augmentation of Labor	
☐		Tocolysis	
☐		Ultrasound	
☐		None	
☐		Other (Yes/No)	
☐		Other (Specify):	
	38d.	Complications of Labor and/or Delivery	
☐		Febrile > (100 degrees F or 38 degrees C.)	
☐		Meconium, Moderate/Heavy	
☐		Premature Rupture of Membrane (>12 hours)	
☐		Abruptio Placenta	
☐		Other Excessive Bleeding	
☐		Seizures During Labor	
☐		Precipitous Labor (< 3 hours)	
☐		Prolonged Labor (> 20 hours)	
☐		Dysfunctional Labor	
☐		Breech/Malpresentation	
☐		Cephalopelvic Disproportion	
☐		Cord Prolapse	
☐		None	
☐		Other (Yes/No)	
☐		Other (Specify):	
	38e.	Method of Delivery	
☐		Vaginal	
☐		Vaginal Birth After Previous C-Section	
☐		Primary C-Section	
☐		Repeat C-Section	
☐		Forceps	
☐		Vacuum	
	38f.	Abnormal Conditions of the Newborn	
☐		Anemia	
☐		Fetal Alcohol Syndrome	
☐		Hyaline Membrane Disease/RDS	
☐		Meconium Aspiration Syndrome	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→38f.	Assisted Ventilation < 30 Minutes	
☐		Assisted Ventilation > 30 Minutes	
☐		Seizures	
☐		Sepsis	
☐		UABG pH < 7.2	
☐		None	
☐		Other (Yes/No)	
☐		Other (Specify):	
	38g.	Congenital Anomalies of Child	
☐		Anencephalus	
☐		Spina Bifida / Meningocele	
☐		Hydrocephalus	
☐		Microcephalus	
☐		Other Central Nervous System Anomalies (Yes/No)	
☐		Other Central Nervous System Anomalies (Specify)	
☐		Heart Malformations	
☐		Other Circulatory/Respiratory Anomalies (Yes/No)	
☐		Other Circulatory/Respiratory Anomalies (Specify)	
☐		Rectal Atresia / Stenosis	
☐		Tracheo-Esophageal Fistula / Esophageal Atresia	
☐		Omphalocele / Gastroschisis	
☐		Other Gastrointestinal Anomalies (Yes/No)	
☐		Other Gastrointestinal Anomalies (Specify)	
☐		Malformed Genitals	
☐		Renal Agenesis	
☐		Other Urogenital Anomalies (Yes/No)	
☐		Other Urogenital Anomalies (Specify)	
☐		Cleft Lip / Palate	
☐		Polydactyly / Syndactyly	
☐		Club Foot	
☐		Diaphragmatic Hernia	
☐		Other Musculoskeletal / Integumental Anomalies (Yes/No)	
☐		Other Musculoskeletal / Integumental Anomalies (Specify)	
☐		Down's Syndrome	
☐		Other Chromosomal Anomalies (Yes/No)	
☐		Other Chromosomal Anomalies (Specify):	
☐		None	
☐		Other Congenital Anomalies of Child (Yes/No)	
☐		Other Congenital Anomalies of Child (Specify)	

II. Variables Calculated Based on the Certificate Information

☐		Father's Age	
☐		Mother's Age	
☐		Mother's Combined Race / Ethnicity Field	
☐		Mother's Residence Zip Code	
☐		Birth Weight Group	
☐		Birth Weight Calculated in Grams	

Validate Form Reset Form ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐		Calculated Weeks of Gestation	
☐		Longitude - Decimal Degrees (based on mother's street address)	
☐		Latitude - Decimal Degrees (based on mother's street address)	
☐		GIS Match Code	
☐		GIS Location Code	
☐		Geocoding Accuracy	
☐		1990 Census Tract (based on mother's street address)	
☐		2000 Census Tract (based on mother's street address)	

III. Variables Available Electronically for Previous Revisions

✓	Item Number	Item Descriptor	
☐		Was Rh Shot Given to Infant? (for 1980-1993)	
☐		Was Rh Shot Given to Mother? (For 1980-1993)	
☐		Was Immune Globulin Given to Mother? (For 1980-1993)	
☐		Calculated Race-Sex Codes (8 groups) – for 1964-1996	
☐		Serologic Test Done During Pregnancy (for 1988-1993)	
☐		Birth Length in Inches (for 1994-2003)	
☐		Congenital Anomalies of Child (Yes or No) (available prior to 2004)	

Last updated: March 20, 2018

Validate Form Reset Form ↑ Back To Start

Checklist for Birth Certificate Data
2005 and beyond

Instructions:

1. Since these data are confidential, all requested certificate items need to have brief justifications according to your project aims.
2. If a certificate item is used for linkage, then state how and whether it will be removed from the resulting linked analysis file. If the certificate item will be retained in the linked analysis file, please also provide a brief justification according to your project aims.
3. For certain sensitive data elements, such as certificate number or residence address, consider alternative means of accomplishing your project aims while using less sensitive data. Examples include creating your own unique identifier instead of requesting the certificate number, and requesting geocoded census tracts instead of residence address.

I. Birth Certificate Items Available Electronically

✓	Item Number	Item Descriptor	Justification
☐		Random Unique ID (unrelated to certificate number)	
☐		Birth Number (Certificate Number)	
☐		Child's Birth State	
	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	
☐ ☐	5.	Time of Birth AM/PM	
☐	6a.	Plurality - Single, Twin, Triplet, etc.	
☐	6b.	If Plural Birth, Born, 1st, 2nd, 3rd, etc.	
☐ ☐	7a.	Place of Birth: Clinic/Doctor's Office Licensed Birthing Center Hospital Home Birth (Planned to deliver at home? Yes/No) Other: Other (Specify) - *includes residential addresses for home births*	
☐	7b.	Name of Hospital or Birthing Center *(street address for not institution)*	
☐ ☐	8b.	Attendant Type: MD, DO, CNM, Midwife, Other Other (Specify):	
	10.	Mother's Name Prior to First Marriage	
☐		First	
☐		Middle	
☐		Last	
☐		Suffix	
☐	11	Date of Birth (mm/dd/yyyy)	
☐	12	Birthplace (state, territory, or foreign country)	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	13a.	Residence State	
☐	13b.	County	
☐	13c.	City, Town or Location	
☐	13d.	Street Address or Rural Location	
☐		Mother's residence apartment number	
☐	13e.	Zip Code	
☐	13f.	Inside City Limits (Yes/No)	
☐	14.	Mother's Mailing Address	
☐		Mother's Mailing Apartment Number	
☐		Mother's Mailing City	
☐		Mother's Mailing State	
☐		Mother's Mailing Zip Code	
☐		Same as Residence, or:	
	15.	Father Name	
☐		First	
☐		Middle	
☐		Last	
☐		Suffix	
☐	16.	Date of Birth (mm/dd/yyyy)	
☐	17.	Birthplace (state, territory or foreign country)	

Items 19 through 65 are confidential information for medical and public health use.
Tex. Health and Safety Code, Sec.192.002(b)

✓	Item Number	Item Descriptor	Justification
	19.	Mother's Current Legal Name	
☐		First	
☐		Middle	
☐		Last	
☐	22.	Mother Married (Yes/No)	
☐		Father's Mailing Address	
☐		Father's Mailing Apartment Number	
☐	26	Father's Mailing City	
☐		Father's Mailing State	
☐		Father's Mailing Zip Code	
☐		Same as Mother	
☐	27.	Mother's Education	
		8th Grade or Less	
		9th - 12th Grade, No Diploma	
		High School Graduate or GED	
		Some College Credit, but No Degree	
		Associate Degree (e.g., AA, AS)	
		Bachelor's Degree (e.g., BA, AB, BS)	
		Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)	
		Doctorate (e.g., PhD. EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)	
	28.	Mother of Hispanic Origin?	
☐		No, Not Spanish, Hispanic/Latina	
☐		Yes, Mexican, Mexican American, Chicana	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→28.	Yes, Puerto Rican	
☐		Yes, Cuban	
☐		Yes, Other Spanish, Hispanic/Latina	
☐		Yes, Other Spanish, Hispanic/Latina (Specify)	
☐		Mother of Hispanic Origin: Unknown	
	29.	Mother's Race	
☐		White	
☐		Black or African American	
☐		American Indian or Alaska Native	
☐		American Indian or Alaska Native (Name of the enrolled or principal tribe)	
☐		Asian Indian	
☐		Chinese	
☐		Filipino	
☐		Japanese	
☐		Korean	
☐		Vietnamese	
☐		Other Asian	
☐		Other Asian (Specify)	
☐		Native Hawaiian	
☐		Guamanian or Chamorro	
☐		Samoan	
☐		Other Pacific Islander	
☐		Other Pacific Islander (Specify)	
☐		Other	
☐		Other (Specify)	
☐		Mother's Race: Unknown	
☐	30.	Father's Education	
		8th Grade or Less	
		9th - 12th Grade, No Diploma	
		High School Graduate or GED	
		Some College Credit, but No Degree	
		Associate Degree (e.g., AA, AS)	
		Bachelor's Degree (e.g., BA, AB, BS)	
		Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)	
		Doctorate (e.g., PhD. EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)	
	31.	Father of Hispanic Origin?	
☐		No, not Spanish, Hispanic/Latino	
☐		Yes, Mexican, Mexican American, Chicana	
☐		Yes, Puerto Rican	
☐		Yes, Cuban	
☐		Yes, Other Spanish, Hispanic/Latino	
☐		Yes, Other Spanish, Hispanic/Latino (Specify)	
☐		Father of Hispanic Origin: Unknown	
	32.	Father's Race	
☐		White	
☐		Black or African American	
☐		American Indian or Alaska Native	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→32.	American Indian or Alaska Native (Name of the enrolled or principal tribe)	
☐		Asian Indian	
☐		Chinese	
☐		Filipino	
☐		Japanese	
☐		Korean	
☐		Vietnamese	
☐		Other Asian	
☐		Other Asian (Specify)	
☐		Native Hawaiian	
☐		Guamanian or Chamorro	
☐		Samoan	
☐		Other Pacific Islander	
☐		Other Pacific Islander (Specify)	
☐		Other	
☐		Other (Specify)	
☐		Father's Race: Unknown	
	33.	Mother	
☐		Usual Occupation	
	34.	Father	
☐		Usual Occupation	
	35.	Mother	
☐		Type of Business/Industry	
	36.	Father	
☐		Type of Business/Industry	
		Pregnancy History	
		PREVIOUS LIVE BIRTHS (Do not include this child)	
☐	37a.	Now Living	
		Number	
		None	
☐	37b.	Now Dead	
		Number	
		None	
☐	37c.	Date of Last Live Birth (mm/yyyy)	
☐	37d.	OTHER PREGNANCY OUTCOMES	
		Number	
		None	
☐	37e.	Date Last Other Pregnancy Ended (mm/yyyy)	
	38.	SOURCE OF PRENATAL CARE (check all that apply)	
☐		Hospital Clinic	
☐		Public Health Clinic	
☐		Private Physician	
☐		Midwife	
☐		None	
☐		Unknown	
☐		Other	
☐		Other (Specify)	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	39.	Mother's Medicaid Number	
☐	40.	Mother's Prepregnancy Weight (pounds)	
☐	41.	Mother's Weight at Delivery (pounds)	
☐	42.	Mother's Height (feet/inches)	
☐	43.	Date Last Normal Menses Began (mm/dd/yyyy)	
		PRENATAL CARE	
☐		No Prenatal Care	
☐	44a.	Date of First Visit (mm/dd/yyyy)	
☐	44b.	Date of Last Visit (mm/dd/yyyy)	
☐	44c.	Number of Prenatal Visits	
	45.	Cigarette Smoking Before and During Pregnancy Average Number of Cigarettes or Packs of Cigarettes Smoked per Day	
		Three Months Before Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
		First Three Months of Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
		Second Three Months of Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
		Third Trimester of Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
☐	46.	Principal Source of Payment for this Delivery	
		Private Insurance	
		Medicaid	
		Self-pay	
☐		Other (Specify)	
☐	47.	Did Mother get WIC Food for Herself During this Pregnancy? (Yes/No)	
☐ ☐	48.	Mother Transferred for Maternal Medical or Fetus Indications for this Delivery? (Yes/No) If Yes, Enter the Name of Facility Mother Transferred From:	
	49.	Risk Factors in this Pregnancy (check all that apply)	
		Diabetes	
☐		Prepregnancy (diagnosis prior to this pregnancy)	
☐		Gestational (diagnosis in this pregnancy)	
		Hypertension	
☐		Prepregnancy (chronic)	
☐		Gestational (PIH preeclampsia)	
☐		Eclampsia	
☐		Previous Preterm Birth	
☐		Other Previous Poor Pregnancy Outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted growth)	
☐		Pregnancy Resulted from Infertility Treatment	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→49.	Fertility-enhancing Drugs, Artificial Insemination, or Intrauterine Insemination	
☐		Assisted Reproductive Technology (e.g. IVF, GIFT)	
☐		Mother had Previous Cesarean Delivery	
☐		If yes, how many	
☐		Antiretrovirals Administered During Pregnancy or at Delivery *(*Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS*)*	
☐		None of the Above	
	50.	Infections Present and/or Treated During this Pregnancy *(*Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS*)*	
☐		Gonorrhea	
☐		Syphilis	
☐		Chlamydia	
☐		Hepatitis B	
☐		Hepatitis C	
☐		None of the Above	
☐	51a.	HIV Test Done Prenatally (Yes/No) - *available for 2011 onwards*	
☐		First Trimester	
☐		Second Trimester	
☐		Third Trimester	
☐		Unknown	
☐		None	
☐	51b.	HIV Test Done at Delivery (Yes/No)	
☐		Infant Tested for HIV at Birth (Yes/No) - *available for 2011 onwards*	
	52.	Obstetric Procedures	
☐		Cervical Cerclage	
☐		Tocolysis	
		External Cephalic Version:	
☐		Successful	
☐		Failed	
☐		None of the Above	
	53.	Onset of Labor	
☐		Premature Rupture of the Membranes (prolonged ≥ 12 hrs.)	
☐		Precipitous Labor (< 3 hrs.)	
☐		Prolonged Labor (≥ 20 hrs.)	
☐		None of the Above	
	54.	Characteristics of Labor and Delivery	
☐		Induction of Labor	
☐		Augmentation of Labor	
☐		Non-Vertex of Labor	
☐		Steroids (glucocorticoids) for Fetal Lung Maturation Received by the Mother Prior to Delivery	
☐		Antibiotics Received by the Mother During Labor	
☐		Chorioamnionitis or Maternal Temperature ≥38°C (100.4°F)	
☐		Moderate/Heavy Meconium Staining of the Amniotic Fluid	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→54.	Fetal Intolerance of Labor Such That One or More of the Following Actions was Taken: In-Utero Resuscitative Measures, Further Fetal Assessment or Operative Delivery	
☐		Epidural or Spinal Anesthesia During Labor	
☐		None of the Above	
	55.	Method of Delivery	
☐	55a.	Was Delivery with Forceps Attempted but Unsuccessful? (Yes/No)	
☐	55b.	Was Delivery with Vacuum Extraction Attempted but Unsuccessful? (Yes/No)	
☐	55c.	Fetal Presentation at Birth	
		Cephalic	
		Breech	
		Other	
☐	55d.	Final Route and Method of Delivery (check one)	
		Vaginal/Spontaneous	
		Vaginal/Forceps	
		Vaginal/Vacuum	
☐		Cesarean If Cesarean, was a Trial of Labor Attempted: (Yes/No)	
	56.	Maternal Morbidity - Complications Associated with Labor and Delivery (Check All That Apply)	
☐		Maternal Transfusion	
☐		Third or Fourth Degree Perineal Laceration	
☐		Ruptured Uterus	
☐		Unplanned Hysterectomy	
☐		Admission to Intensive Care Unit	
☐		Unplanned Operating Room Procedure Following Delivery	
☐		None of the Above	
		Newborn Information	
☐	57.	Hepatitis B Immunization Given? (Yes/No)	
	58.	Birthweight (G or LB. OZ.)	
☐		G	
☐		LB	
☐		OZ	
☐	59.	Obstetric Estimate of Gestation (completed weeks)	
☐	60a.	Apgar Score at 5 Minutes	
☐	60b.	If 5 Minute Score is Less Than 6, Apgar Score at 10 Minutes	
☐	61.	Is the Infant Living at the Time of the Report? (Yes/No)	
☐	62.	Is the Infant Being Breastfed at the Time of Discharge?	
		Yes	
		No	
		Infant Transferred, Status Unknown	
	63.	Abnormal Conditions of the Newborn (check all that apply)	
☐		Assisted Ventilation Required Immediately Following Delivery	
☐		Assisted Ventilation Required for More Than 6 Hours	
☐		NICU Admission	
☐		Newborn Given Surfactant Replacement Therapy	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→63.	Antibiotics Received by the Newborn for Suspected Neonatal Sepsis	
☐		Seizure or Serious Neurologic Dysfunction	
☐		Significant Birth Injury (Skeletal Fracture(s), Peripheral Nerve Injury, and/or Soft Tissue/Solid Organ Hemorrhage Which Requires Intervention)	
☐		None of the Above	
	64.	Congenital Anomalies of the Newborn (check all that apply)	
☐		Anencephaly	
☐		Meningomyelocele/Spina Bifida	
☐		Cyanotic Congenital Heart Disease	
☐		Congenital Diaphragmatic Hernia	
☐		Omphalocele	
☐		Gastroschisis	
☐		Limb Reduction Defect (excluding congenital amputation and dwarfing syndromes)	
☐		Cleft Lip With or Without Cleft Palate	
☐		Cleft Palate Alone	
☐		Down Syndrome	
☐		Karyotype Confirmed	
☐		Karyotype Pending	
☐		Suspected Chromosomal Disorder	
☐		Karyotype Confirmed	
☐		Karyotype Pending	
☐		Hypospadias	
☐		None of the Anomalies Listed Above	
☐	65.	Was Infant Transferred Within 24 Hours of Delivery? (Yes/No)	
☐		If Yes, Name of Facility Infant Transferred to:	

II. Variables Calculated Based on the Certificate Information

✓	Item Number	Item Descriptor	Justification
☐		Father's Age	
☐		Mother's Age	
☐		Mother's Combined Race / Ethnicity	
☐		Mother's Bridged Race Code *(determined by NCHS)*	
☐		Father's Bridged Race Code *(determined by NCHS)*	
☐		Birth Weight Group	
☐		Birth Weight Calculated in Grams	
☐		Birth Weight Priority (2005-2017)	
☐		Calculated Gestation or Length of Pregnancy	
☐		Month Prenatal Care Began	
☐		Number of Live Births at this Delivery (2005-2018)	
☐		Longitude *(based on mother's street address)*	
☐		Latitude *(based on mother's street address)*	
☐		GIS Match Code	
☐		GIS Location Code	
☐		Geocoding Accuracy	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐		GIS Mother's Residence County Name (from 2014 data on)	
☐		GIS Mother's Residence County FIPS Code (from 2014 data on)	
☐		Zip Code Tabulation Area (ZCTA) (from 2013 data on)	
☐		1990 Census Tract *(based on mother's street address)*	
☐		2000 Census Tract *(based on mother's street address)*	
☐		2010 Census Tract (*based on mother's street address) - from 2010 data*	
☐		2020 Census Tract (based on mother's street address) – from 2020 data	

Last updated: December 7, 2023

Validate Form Reset Form ↑ Back To Start

Checklist for Death Certificate Data
1990-2005

Instructions:

1. Since these data are confidential, all requested certificate items need to have brief justifications according to your project aims.
2. If a certificate item is used for linkage, then state how and whether it will be removed from the resulting linked analysis file. If the certificate item will be retained in the linked analysis file, please also provide a brief justification according to your project aims.
3. For certain sensitive data elements, such as certificate number or residence address, consider alternative means of accomplishing your project aims while using less sensitive data. Examples include creating your own unique identifier instead of requesting the certificate number, and requesting geocoded census tracts instead of residence address.

I. Death Certificate Items

✓	Item Number	Item Descriptor	Justification
☐		State File Number (Death Certificate Number)	
☐		State of Death	
☐	1a.	Name of Deceased: First	
☐	1b.	Name of Deceased: Middle	
☐	1c.	Name of Deceased: Last	
☐	1d.	Name of Deceased: Maiden	
☐	1e.	Name of Deceased: Suffix	
☐	2.	Sex	
☐	3.	Date of Death	
☐	4.	Date of Birth	
☐	5.	Age in years	
		If Under One Year – in months and days	
		If Under One Day – in hours and minutes	
☐		Age – kind of units (years, months, weeks, days, hours, minutes)	
☐	6.	Birth Place (State or Foreign Country)	
☐	8.	Race	
☐	9a.	Was the Decedent of Hispanic Origin? (Yes/No)	
☐	9b.	If Yes, Specify (Mexican, Cuban, Puerto Rican, etc.)	
☐	10.	Was Decedent Ever in U.S. Armed Forces?	
☐	11.	Education (Specify Highest Grade Completed) of decedent	
☐	12.	Marital Status of decedent	
☐	13.	Surviving Spouse: First Name	
☐		Surviving Spouse: Middle Name	
☐		Surviving Spouse: Last Name	
☐		Surviving Spouse (If wife, give maiden name)	
☐		Surviving Spouse : Suffix	
☐	14a.	Decedent's Usual Occupation	
☐	14b.	Kind of Business or Industry	
☐	15a.	Residence Street Address	
☐	15b.	Residence City or Town	
☐	15c.	Residence County	

Validate Form Reset Form ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	15d.	Residence State	
☐	15e	Residence Zip Code	
☐	15f.	Residence Inside City Limits	
☐	16.	Father's First Name	
☐		Father's Middle Name	
☐		Father's Last Name	
☐		Father's Name: Suffix	
☐	17.	Mother's First Name	
☐		Mother's Middle Name	
☐		Mother's Maiden Name	
☐		Mother's Name: Suffix	
☐	18.	Place of Death (institution type)	
☐	19.	County of Death	
☐	20.	City or Town of Death (If outside city limits, give precinct number	
☐	21.	Name of Hospital or Institution (If not in institution, show street address)	
☐	24.	Method of Disposition	
☐	30.	Certifier - type of attendant	
☐	33.	Time of Death	
☐	35. Part 1 a - d.	Multiple and Underlying Causes of Death – ICD Codes	
☐	35. Part 1	Underlying (primary) Cause of Death only – ICD Codes	
☐	36a.	Autopsy? (Yes/No)	
☐	36b.	Autopsy Findings Available Prior to Completion of Cause of Death?	
☐	37.	Did Tobacco Use Contribute to Death?	
☐	38.	Did Alcohol Use Contribute to Death?	
☐		Was Decedent Pregnant At Time of Death	
☐		Was Decedent Pregnant Within Last 12 Months	
☐	40.	Manner of Death	
☐	41a.	Date of Injury	
☐	41b.	Time of Injury: hour	
☐		Time of Injury: am/pm	
☐		Time of Injury: minutes	
☐	41c.	Injury at Work	
☐	41d.	Place of Injury - At Home, Farm, Street, Factory, Office, etc. (Specify)	
☐	41e.	Location of Injury (Street and Number, City or Town, State)	

Validate Form | Reset Form | ↑ Back To Start

II. Other Variables Calculated Based on the Death Certificate Items

✓	Item Number	Item Descriptor	Justification*
☐		Alias name of decedent	
☐		Age Group	
☐		CDC 61 selected causes of infant death (ICD-9) for 1979-1998	
☐		CDC 130 selected causes of infant death (ICD-10) from 1999	
☐		CDC 72 selected causes of death (ICD-9) for 1979-1998	
☐		CDC 113 selected causes of death (ICD-10) from 1999	
☐		Decedent race/ethnicity	
☐		Race/sex derived code of decedent (for 1964-1996)	
☐		Longitude- decimal degrees (based on decedent's street address)	
☐		Latitude- decimal degrees (based on decedent's street address)	
☐		GIS Match code	
☐		GIS Location code	
☐		Geocoding accuracy	
☐		1990 census tract (based on decedent's street address)	
☐		2000 census tract (based on decedent's street address)	

Last updated: March 20, 2018

Checklist for Death Certificate Data - Draft
2006 and beyond

Instructions:

1. Since these data are confidential, all requested certificate items need to have brief justifications according to your project aims.
2. If a certificate item is used for linkage, then state how and whether it will be removed from the resulting linked analysis file. If the certificate item will be retained in the linked analysis file, please also provide a brief justification according to your project aims.
3. For certain sensitive data elements, such as certificate number or residence address, consider alternative means of accomplishing your project aims while using less sensitive data. Examples include creating your own unique identifier instead of requesting the certificate number, and requesting geocoded census tracts instead of residence address.

I. Death Certificate Items

✓	Item Number	Item Descriptor	Justification
☐		Random Unique ID (unrelated to certificate number)	
☐	n/a	State File Number (Certificate Number)	
☐	n/a	State of Death	
☐	1.	Legal Name of Deceased: First	
☐		Middle	
☐		Last	
☐		Maiden	
☐		Suffix	
☐		Deceased AKA's if any: First	
☐		Middle	
☐		Last	
☐		Suffix	
☐	2.	Date of Death	
☐		Date of Death Type (Actual, Presumed, Estimated, Found)	
☐	3.	Sex	
☐	4.	Date of Birth	
☐	5.	Age - Last Birthday	
☐		Age – kind of units (years, months, weeks, days, hours, minutes)	
☐	6.	Birthplace - City	
☐		State or Foreign Country	
☐	8.	Marital Status at Time of Death	
☐	9.	Surviving Spouse (If wife, give name prior to first marriage): First	
☐		Middle	
☐		Last	
☐		Suffix	
☐	10a.	Residence Street Address	
☐	10b.	Apt No	
☐	10c.	City or Town of Residence	
☐	10d.	County of Residence	
☐	10e.	State of Residence	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐ ☐	10f.	Zip Code Zip Code Extension	
☐	10g.	Inside City Limits?	
☐ ☐ ☐ ☐	11.	Father's Name: First Middle Last Suffix	
☐ ☐ ☐ ☐	12.	Mother's Name Prior to First Marriage: First Middle Last Suffix	
☐ ☐	13.	Place of Death: If Death Occurred in a Hospital: Inpatient If Death Occurred in a Hospital: ER/Outpatient If Death Occurred in a Hospital: DOA If Death Occurred Somewhere Other Than a Hospital: Hospice Facility If Death Occurred Somewhere Other Than a Hospital: Nursing Home (*Includes LTC)* If Death Occurred Somewhere Other Than a Hospital: Decedent's Home Other Other (Specify)	
☐	14.	County of Death	
☐ ☐ ☐ ☐	15.	City/Town of Death (If outside city limits give precinct no) Street Address Zip Code Zip Code Extension	
☐	16.	Facility Name (If not institution give street address)	
☐ ☐	17.	Informant's Name & Relationship to Deceased	
☐ ☐ ☐ ☐ ☐ ☐	18.	Mailing Address of Informant: Street Number City State Zip Code Zip Code Extension	
☐ ☐	19.	Method of Disposition: Burial Cremation Donation Entombment Removal From State Other Other (Specify)	
☐	20.	License Number of Funeral Director or Person Acting As Such	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐ ☐ ☐ ☐ ☐	21.	Section Block Lot Space Unknown	
☐	22.	Place of Disposition (Name of cemetery, crematory, other place)	
☐ ☐	23.	Location of Disposition: City, Town State	
☐	24.	Name of Funeral Facility	
☐ ☐ ☐ ☐ ☐	25.	Complete Address of Funeral Facility: Street Number City State Zip Code Zip Code Extension	
☐	26.	Certifier: Certifying Physician Medical Examiner Justice of the Peace	
☐	28.	Date Certified (Mo/Day/Yr)	
☐	29.	Certifier‘s License Number	
☐ ☐	30.	Time of Death Time of Death Type (Actual, Presumed, Estimated, Found)	
☐ ☐ ☐ ☐ ☐	31.	Certifier’s Address: Street and Number City State Zip Code Zip Code Extension	
☐	32.	Title of Certifier	
	33.	Chain of Events –Diseases, Injuries or Complications – That Directly Caused the Death: *(if you want to order ICD-10 codes, check with the Section II of this checklist):*	
☐ ☐	33. Part 1a.	Cause of Death A (Immediate Cause) – *certifier’s text* Approximate Interval: Onset to death	
☐ ☐	33. Part 1b.	Cause of Death B - *certifier’s text* Approximate Interval: Onset to death	
☐ ☐	33. Part 1c.	Cause of Death C - *certifier’s text* Approximate Interval: Onset to death	
☐ ☐	33. Part 1d.	Cause of Death D - *certifier’s text* Approximate Interval: Onset to death	
☐	33. Part 2.	Other Significant Conditions Contributing to Death but not Resulting in the Underlying Cause Given in Part 1.	
☐	34.	Was an Autopsy Performed?	
☐	35.	Were Autopsy Findings Available to Complete the Cause of Death?	
☐	36.	Manner of Death	
☐	37.	Did Tobacco Contribute to Death?	

Validate Form Reset Form ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	38.	If Female: Not pregnant within past year Pregnant at time of death Not pregnant, but pregnant within 42 days of death Not pregnant, but pregnant 43 days to 1 year before death Unknown if pregnant within the past year	
☐ ☐	39.	If Transportation Injury, Specify: Driver/Operator Passenger Pedestrian Other Other (Specify)	
☐	40a.	Date of Injury (Mo/Day/Yr)	
☐	40b.	Time of Injury	
☐	40c.	Injury at Work?	
☐	40d.	Place of Injury (e.g. Decedent's home; construction site, restaurant, wooded area)	
☐ ☐ ☐ ☐ ☐	40e.	Location: Street Number City State Zip Code	
☐	40f.	County of Injury	
☐	41.	Describe How Injury Occurred	
☐	43.	Decedent's Education	
	44.	Decedent of Hispanic Origin?	
☐		No, Not Spanish, Hispanic/Latino	
☐		Yes, Mexican, Mexican American, Chicano	
☐		Yes, Puerto Rican	
☐		Yes, Cuban	
☐		Yes, Other Spanish/Hispanic/Latino	
☐		Specify	
	45.	Decedent's Race *(2006 revision allows informants to select one or more races to indicate what the decedent considered himself or herself to be):*	
☐		White	
☐		Black or African American	
☐ ☐		American Indian or Alaska Native Name of the enrolled or principal tribe	
☐		Asian Indian	
☐		Chinese	
☐		Filipino	
☐		Japanese	
☐		Korean	
☐		Vietnamese	
☐		Other Asian	
☐		Other Asian (Specify)	
☐		Native Hawaiian	

Validate Form Reset Form ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→45.	Guamanian or Chamorro	
☐		Samoan	
☐		Other Pacific Islander	
☐		Other Pacific Islander (Specify)	
☐		Other	
☐		Other (Specify)	
☐	46.	Ever in U.S. Armed Forces?	
☐	47.	Ever a Peace Officer in This State?	
☐	48.	Decedent's Usual Occupation (Indicate type of work done during most of working life).	
☐	49.	Decedent's Type of Business/Industry	
☐ ☐ ☐ ☐ ☐	n/a	If Deceased Served in U.S. Armed Forces, Fill Out the Following: Is the deceased reported to have been in such service? Name of organization in which service was rendered? Serial number of discharge papers or adjusted service certificate? Name of next of kin or of next friend? Post Office Address?	
		II. Other Variables Calculated Based on the Death Certificate Items	
✓	**Item Number**	**Item Descriptor**	
☐		Record Type *(Identified, Un-indentified, Out of State, Catastrophic)*	
☐		Age Group	
☐		Additional Funeral Home	
☐		Causes of Death (multiple, including underlying) – *ICD-10 codes*	
☐		Underlying Cause of Death – *ICD-10 codes*	
☐		CDC 113 Selected Causes of Death (ICD-10)	
☐		CDC 130 Selected Causes of Infant Death (ICD-10)	
☐		CDC 52 Rankable Causes of Death (ICD-10)	
☐		Was Death a Result of an Injury?	
☐		Decedent's Bridged Race Code *(determined by NCHS)*	
☐		Decedent's Race/Ethnicity *(based on the TSDC method)*	
☐		Decedent's Spanish/Hispanic/Latino Origin Unknown	
☐		Decedent's Race: Unknown	
☐		Longitude *(based on decedent's street address)*	
☐		Latitude *(based on decedent's street address)*	
☐		GIS Match code	
☐		GIS Location code	
☐		Geocoding accuracy	
☐		1990 census tract *(based on decedent's street address)*	
☐		2000 census tract *(based on decedent's street address)*	
☐		2010 census tract *(based on decedent's street address)*	
☐		2020 census tract *(based on decedent's street address)* - 2020 forward	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐		Zip code tabulation areas (ZCTAs) - from 2013 data	
☐		GIS Residence County Name - from 2014 data	
☐		GIS Residence County FIPS - from 2014 data	
☐		NIOSH Industry Code – 2020 forward	
☐		NIOSH Occupation Code – 2020 forward	
☐		Covid-19 Flag – 2020 forward	

Last updated: December 7, 2023

Validate Form Reset Form ↑ Back To Start

Checklist for Fetal Death Certificate Data
Prior to 2006

Instructions:

1. Since these data are confidential, all requested certificate items need to have brief justifications according to your project aims.
2. If a certificate item is used for linkage, then state how and whether it will be removed from the resulting linked analysis file. If the certificate item will be retained in the linked analysis file, please also provide a brief justification according to your project aims.
3. For certain sensitive data elements, such as certificate number or residence address, consider alternative means of accomplishing your project aims while using less sensitive data. Examples include creating your own unique identifier instead of requesting the certificate number, and requesting geocoded census tracts instead of residence address.

I. Fetal Death Certificate Items

✓	Item Number	Item Descriptor	Justification
☐		STATE FILE NUMBER (Certificate Number)	
☐		State of Death	
☐	1.	Fetus Name: First	
☐		Fetus Name: Middle	
☐		Fetus Name: Last	
☐		Fetal Name: Suffix	
☐	2.	Date of Delivery	
☐	3.	Sex	
☐	4a.	Place of Delivery - County	
☐	4b.	Place of Delivery - City or Town	
☐	5.	Time of Delivery	
☐	6a.	Plurality - Single, Twin, etc.	
☐	6b.	If Plural Birth, Born, 1st, 2nd, 3rd, etc.	
☐	7a.	Place of Birth - Clinic/Doctor's Office	
		Licensed Birthing Center	
		Hospital	
		Residence	
		Other	
☐	7b.	Name of Hospital or Birthing Center	
☐	8.	Mother Name: First	
☐		Mother Name: Middle	
☐		Mother Name: Maiden Surname	
☐		Mother Name: Suffix	
☐	9.	Date of Birth (of mother)	
☐	10.	Mother’s Birthplace (state or foreign country)	
☐	11a.	Mother’s Residence State	
☐	11b.	Mother’s Residence County	
☐	11c.	Mother’s Residence City or Town	
☐	11d.	Mother’s Residence Street Address or Rural Location	
☐	11e.	Inside City Limits (mother’s residence)	
☐	12.	Mother's Mailing Address (if same as residence, enter zip code only)	
☐	14.	Father Name: First	
☐		Father Name: Middle	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→14.	Father Name: Last	
☐		Father Name: Suffix	
☐	15.	Date of Birth (of father)	
☐	16.	Father's Birthplace (state or foreign country)	
☐	17b.	Attendant Type	
		MD	
		DO	
		CNM	
		Midwife	
		Other	
☐	19.	Method of Disposition	
		Burial	
		Cremation	
		Removal from state	
		Donation	
		Other:	
☐	23.	Date of Disposition	
☐	25. Part1	Underlying Cause of Death *(ICD codes)*	
☐	26.	Fetus Died Before Labor, During Labor or Delivery, Unknown	
☐	27a.	Was an Autopsy Performed?	
☐	27b.	Were Autopsy Findings Available Prior to Completion of Cause of Death?	
		Items 29 through 44f are confidential information for medical and health use only.	
☐	29a.	Race of Mother	
☐	29b.	Race of Father	
	30.	Hispanic Origin	
☐	30a.	If Mother Hispanic (Yes/No)	
☐	30a.	If Mother Hispanic Specify (Mexican, Cuban, Puerto Rican, etc.)	
☐	30b.	If Father Hispanic (Yes/No)	
☐	30b.	If Father Hispanic Specify (Mexican, Cuban, Puerto Rican, etc.)	
	31.	Education - Highest Grade Completed	
☐	31a.	Mother	
☐	31b.	Father	
	32a-b.	Usual Occupation	
☐	32a.	Mother	
☐	32b.	Father	
	32c-d.	Type of Business or Industry	
☐	32c.	Mother	
☐	32d.	Father	
☐	33a.	Live Births Now Living	
☐	33b.	Live Births Now Dead	
☐	33c.	Date of Last Live Birth	
☐	33d.	Other Pregnancies	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	33e.	Date Last Other Pregnancy Ended	
	34.	Source of Prenatal Care	
☐		Hospital Clinic	
☐		Public Health Clinic	
☐		Private Physician	
☐		Midwife	
☐		None	
☐		Unknown	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐	35.	Mother Married (Yes/No)	
	36.	Weight of Fetus	
☐		Grams	
☐		LB	
☐		OZ	
☐	37.	Date Last Normal Menses Began	
☐	38.	Clinical Estimate of Gestation (weeks)	
☐	39a.	Mother Transferred Prior to Delivery (Yes/No)	
☐	39a.	Mother Transferred Prior to Delivery (specify facility):	
☐	40.	Prenatal Care Began During 1st, 2nd, 3rd, etc. month. Specify:	
☐	41.	Number of Prenatal Visits	
☐	42a.	HIV Test Done Prenatally	
☐	42b.	HIV Test Done at Delivery	
☐	43.	Serologic Test Done at Delivery	
☐	44a.	Medical Risk Factors for this Pregnancy	
		Anemia	
		Cardiac Disease	
		Acute or Chronic Lung Disease	
		Diabetes	
		Hydramnios/Oligohydramnios	
		Hemoglobinopathy	
		Hypertension, Chronic	
		Hypertension, Pregnancy-Associated	
		Eclampsia	
		Incompetent Cervix	
		Previous Infant 4000 + Grams	
		Previous Preterm or Small - for - Gestational-Age Infant	
		Preterm Labor	
		Renal Disease	
		Blood Group Isoimmunization	
		Preterm Rupture of Membranes (<37 weeks)	
		STD *(Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS. These data elements should normally be left unchecked)*	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
	→44a.	Zidovudine Administered During Pregnancy *(Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS. These data elements should normally be left unchecked)*	
		None	
		Other (Yes/No)	
		Other (Specify):	
		Unknown	
	44b.	Other Risk Factors for this Pregnancy	
☐		Tobacco Use During Pregnancy	
☐		Average Number of Cigarettes Per Day	
☐		Alcohol Use During Pregnancy	
☐		Average Number of Drinks Per Week	
☐		Weight Gained During Pregnancy	
☐	44c.	Obstetric Procedures	
		Amniocentesis	
		Electronic Fetal Monitoring	
		Induction of Labor	
		Augmentation of Labor	
		Tocolysis	
		Ultrasound	
		None	
		Other (Yes/No)	
		Other (Specify):	
☐	44d.	Complications of Labor and/or Delivery	
		Febrile > (100 degrees F or 38 degrees C.)	
		Meconium, Moderate/Heavy	
		Premature Rupture of Membrane (>12 hours)	
		Abruptio Placenta	
		Placenta Previa	
		Other Excessive Bleeding	
		Seizures During Labor	
		Precipitous Labor (< 3 hours)	
		Prolonged Labor (> 20 hours)	
		Dysfunctional Labor	
		Breech/Malpresentation	
		Cephalopelvic Disproportion	
		Cord Prolapse	
		None	
		Other (Yes/No)	
		Other (Specify):	
☐	44e.	Method of Delivery	
		Vaginal	
		Vaginal Birth After Previous C-Section	
		Primary C-Section	
		Repeat C-Section	
		Forceps	
		Vacuum	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	44f.	Congenital Anomalies of Fetus	
		Anencephalus	
		Spina Bifida / Meningocele	
		Hydrocephalus	
		Microcephalus	
		Other Central Nervous System Anomalies (Yes/No)	
		Other Central Nervous System Anomalies (Specify)	
		Heart Malformations	
		Other Circulatory/Respiratory Anomalies (Yes/No)	
		Other Circulatory/Respiratory Anomalies (Specify)	
		Rectal Atresia / Stenosis	
		Tracheo-Esophageal Fistula / Esophageal Atresia	
		Omphalocele / Gastroschisis	
		Other Gastrointestinal Anomalies (Yes/No)	
		Other Gastrointestinal Anomalies (Specify)	
		Malformed Genitalia	
		Renal Agenesis	
		Other Urogenital Anomalies (Yes/No)	
		Other Urogenital Anomalies (Specify)	
		Cleft Lip / Palate	
		Polydactyly / Syndactyly	
		Limb Reduction(s)	
		Club Foot	
		Diaphragmatic Hemia	
		Other Musculoskeletal / Integumental Anomalies (Yes/No)	
		Other Musculoskeletal / Integumental Anomalies (Specify)	
		Down's Syndrome	
		Other Chromosomal Anomalies (Yes/No)	
		Other Chromosomal Anomalies (Specify):	
		None	
		Other Congenital Anomalies (Yes/No)	
		Other Congenital Anomalies (Specify)	

II. Other Commonly Used Variables (Not on the Fetal Death Certificate)
Available for selected years

✓	Item Number	Item Descriptor	Justification*
☐		Father's Age	
☐		Mother's Age	
☐		Mother's Combined Race / Ethnicity Field	
☐		Mother's Residence Zip Code	
☐		Calculated Weeks of Gestation	
☐		Death Inside City Limits?	
☐		Longitude - Decimal Degrees (based on mother’s street address)	
☐		Latitude - Decimal Degrees (based on mother’s street address)	
☐		GIS Match Code (not available prior to 2004)	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification*
☐		GIS Location Code (not available prior to 2004)	
☐		Geocoding Accuracy	
☐		1990 Census Tract (based on mother's street address)	
☐		2000 Census Tract (based on mother's street address)	
☐		Serologic Test Done During Pregnancy (available prior to 1994)	
☐		Rh Factor of Mother (available prior to 1994)	
☐		Rho(D) Given? (available prior to 1994)	

Last updated: March 20, 2018

Validate Form | Reset Form | ↑ Back To Start

Checklist for Fetal Death Certificate Data
2006 and beyond

Instructions:

1. Since these data are confidential, all requested certificate items need to have brief justifications according to your project aims.
2. If a certificate item is used for linkage, then state how and whether it will be removed from the resulting linked analysis file. If the certificate item will be retained in the linked analysis file, please also provide a brief justification according to your project aims.
3. For certain sensitive data elements, such as certificate number or residence address, consider alternative means of accomplishing your project aims while using less sensitive data. Examples include creating your own unique identifier instead of requesting the certificate number, and requesting geocoded census tracts instead of residence address.

I. Fetal Death Certificate Items

✓	Item Number	Item Descriptor	Justification
☐		Random Unique ID (unrelated to certificate number)	
☐		STATE FILE NUMBER (Certificate Number)	
☐	1.	Fetus Name: First	
☐		Fetus Name: Middle	
☐		Fetus Name: Last	
☐		Fetus Name: Suffix	
☐	2.	Date of Delivery	
☐		Time of Delivery – 2012 forward	
☐	4.	Sex	
☐	5.	Place of Delivery - County	
☐	6a.	Place of Delivery- City or Town	
☐	7a.	Plurality - Single, Twin, etc.	
☐	7b.	If Plural Birth, Born, 1st, 2nd, 3rd, etc.	
☐	8a.	Place of Delivery - Clinic/Doctor's Office	
☐		Licensed Birthing Center	
☐		Hospital	
☐		Home	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐	8b.	Name of Hospital or Birthing Center	
☐	9.	Mother’s Current Legal Name: First	
☐		Mother’s Current Legal Name: Middle	
☐		Mother’s Current Legal Name: Last	
☐		Mother’s Current Legal Name: Suffix – 2019 forward	
☐	10.	Date of Birth (of mother)	
☐	11.	Mother’s Name Prior to First Marriage: Last (i.e., maiden name)	
☐	12.	Mother’s Birthplace (State or Foreign Country)	
☐	13a.	Mother’s Residence State	
☐	13b.	Mother’s Residence County	
☐	13c.	Mother’s Residence City or Town	
☐	13d.	Mother’s Residence Street Address or Rural Location	
☐	13e.	Mother's Residence apartment number	
☐	13f.	Mother’s Residence Zip Code	
☐	13g.	Inside City Limits (mother’s residence)	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	14.	Father Name: First	
☐		Father Name: Middle	
☐		Father Name: Last	
☐		Father Name: Suffix	
☐	15.	Date of Birth (of father)	
☐	16.	Father's Birthplace (State or Foreign Country)	
	17b.	Attendant Type	
☐		MD	
☐		DO	
☐		CNM	
☐		Midwife	
☐		Other (Yes/No)	
☐		Other (Specify):	
	18b.	Certifier	
☐		Certifying Physician	
☐		Medical Examiner /Justice of the Peace	
	19.	Method of Disposition	
☐		Burial	
☐		Cremation	
☐		Removal from state	
☐		Donation	
☐		Entombment	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐	26a.	Initiating Cause/Condition Contributing to Fetal Death	
☐		Rupture of Membranes	
☐		Abruptio Placenta	
☐		Placental Insufficiency	
☐		Prolapsed Cord	
☐		Chorioamnionitis	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐		Other Obstetrical or Pregnancy Complications (Specify)	
☐		Fetal Anomaly (Specify)	
☐		Fetal Injury (Specify)	
☐		Fetal Infection (Specify)	
☐		Other Fetal Conditions/Disorders (Specify)	
☐		Unknown	
☐	26b.	Other Significant Causes or Conditions Contributing to Fetal Death	
☐		Rupture of Membranes	
☐		Abruptio Placenta	
☐		Placental Insufficiency	
☐		Prolapsed Cord	
☐		Chorioamnionitis	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐		Other Obstetrical or Pregnancy Complications (Specify)	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→26b.	Fetal Anomaly (Specify)	
☐		Fetal Injury (Specify)	
☐		Fetal Infection (Specify)	
☐		Other Fetal Conditions/Disorders (Specify)	
☐		Unknown	
	27.	Weight of Fetus	
☐		Grams	
☐		LB	
☐		OZ	
☐	28.	Obstetric Estimate of Gestation (Weeks)	
	29.	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	
	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 Death?	
☐		Yes	
☐		No	
		Items 34 through 53 are confidential information for medical and public health use.	
	34.	Mother's Education	
☐		8th Grade or Less	
☐		9th - 12th Grade, No Diploma	
☐		High School Graduate or GED	
☐		Some College Credit, but No Degree	
☐		Associate Degree (e.g., AA, AS)	
☐		Bachelor's Degree (e.g., BA, AB, BS)	
☐		Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)	
☐		Doctorate (e.g., PhD. EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)	
	35.	Mother of Hispanic Origin?	
☐		No, Not Spanish, Hispanic/Latina	
☐		Yes, Mexican, Mexican American, Chicana	
☐		Yes, Puerto Rican	
☐		Yes, Cuban	
☐		Yes, Other Spanish, Hispanic/Latina	
☐		Yes, Other Spanish, Hispanic/Latina (Specify)	
	36.	Mother's Race	
☐		White	
☐		Black or African American	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→36.	American Indian or Alaska Native	
☐		American Indian or Alaska Native (Name of the enrolled or principal tribe)	
☐		Asian Indian	
☐		Chinese	
☐		Filipino	
☐		Japanese	
☐		Korean	
☐		Vietnamese	
☐		Other Asian	
☐		Other Asian (Specify)	
☐		Native Hawaiian	
☐		Guamanian or Chamorro	
☐		Samoan	
☐		Other Pacific Islander	
☐		Other Pacific Islander (Specify)	
		PREVIOUS LIVE BIRTHS	
	37a.	Now Living	
☐		Number	
☐		None	
	37b.	Now Dead	
☐		Number	
☐		None	
☐	37c.	Date of Last Live Birth (mm/yyyy)	
	37d.	OTHER PREGNANCY OUTCOMES	
☐		Number	
☐		None	
☐	37e.	Date Last Other Pregnancy Ended (mm/yyyy)	
	38.	Cigarette Smoking Before and During Pregnancy	
		Average Number of Cigarettes or Packs of Cigarettes Smoked per Day	
		Three Months Before Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
		First Three Months of Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
		Second Three Months of Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
		Third Trimester of Pregnancy	
☐		# of Cigarettes	
☐		# of Packs	
	39.	SOURCE OF PRENATAL CARE (check all that apply)	
☐		Hospital Clinic	
☐		Public Health Clinic	
☐		Private Physician	
☐		Midwife	
☐		None	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→39.	Unknown	
☐		Other (Yes/No)	
☐		Other (Specify):	
☐	40.	Mother's Height (feet/inches)	
☐	41.	Mother's Prepregnancy Weight (pounds)	
☐	42.	Mother's Weight at Delivery (pounds)	
		PRENATAL CARE	
☐		No Prenatal Care	
☐	43a.	Date of First Visit (mm/dd/yyyy)	
☐	43b.	Date of Last Visit (mm/dd/yyyy)	
☐	43c.	Number of Prenatal Visits	
☐	44.	Date Last Normal Menses Began (mm/dd/yyyy)	
	45.	Did Mother get WIC Food for Herself During this Pregnancy?	
☐		Yes	
☐		No	
	46.	Mother Married?	
☐		Yes	
☐		No	
	47.	Mother Transferred for Maternal Medical or Fetus Indications for this Delivery?	
☐		Yes	
☐		No	
☐		If Yes, Enter the Name of Facility Mother Transferred From:	
	48.	Risk Factors in this Pregnancy (check all that apply)	
		Diabetes	
☐		Prepregnancy (Diagnosis prior to this pregnancy)	
☐		Gestational (Diagnosis in this pregnancy)	
		Hypertension	
☐		Prepregnancy (Chronic)	
☐		Gestational (PIH preeclampsia)	
☐		Eclampsia	
☐		Previous Preterm Birth	
☐		Other Previous Poor Pregnancy Outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted growth)	
☐		Pregnancy Resulted from Infertility Treatment (if yes, check all that apply)	
☐		Fertility-enhancing Drugs, Artificial Insemination, or Intrauterine Insemination	
☐		Assisted reproductive technology (e.g. IVF, GIFT)	
☐		Mother had Previous Cesarean Delivery.	
☐		If yes, how many	
☐		Antiretrovirals Administered During Pregnancy or at Delivery *(Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS. These data elements should normally be left unchecked)*	
☐		None of the Above	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
	49.	Infections Present and/or Treated During this Pregnancy (check all that apply) (Variables which provide or imply HIV or STD infection status cannot be provided to agencies outside of DSHS. These data elements should normally be left unchecked)	
☐		Gonorrhea	
☐		Syphillis	
☐		Chlamydia	
☐		Listeria	
☐		Group B Streptococcus	
☐		Cytomegalovirus	
☐		Parvovirus	
☐		Toxoplasmosis	
☐		None of the above	
☐		Other (Yes/No)	
☐		Other (Specify):	
	50a.	HIV Test Done Prenatally	
☐		Yes	
☐		No	
	50b.	HIV Test Done at Delivery	
☐		Yes	
☐		No	
	51.	Method of Delivery	
	51A.	Was Delivery with Forceps Attempted but Unsuccessful?	
☐		Yes	
☐		No	
	51B.	Was Delivery with Vacuum Extraction Attempted but Unsuccessful?	
☐		Yes	
☐		No	
	51C.	Fetal Presentation at Birth	
☐		Cephalic	
☐		Breech	
☐		Other	
	51D.	Final Route and Method of Delivery (Check One)	
☐		Vaginal/Spontaneous	
☐		Vaginal/Forceps	
☐		Vaginal/Vacuum	
☐		Cesarean	
		If cesarean, was a trial of labor attempted:	
☐		Yes	
☐		No	
	51E.	Hysterotomy/Hysterectomy	
☐		Yes	
☐		No	
	52.	Maternal Morbidity - Complications Associated with Labor and Delivery (Check All That Apply)	
☐		Maternal Transfusion	
☐		Third or Fourth Degree Perineal Laceration	
☐		Ruptured Uterus	

Validate Form | Reset Form | ↑ Back To Start

✓	Item Number	Item Descriptor	Justification
☐	→52.	Unplanned Hysterectomy	
☐		Admission to Intensive Care Unit	
☐		Unplanned Operating Room Procedure Following Delivery	
☐		None of the Above	
	53.	Congenital Anomalies of the Newborn (check all that apply)	
☐		Anencephaly	
☐		Menigomyelocele/Spina Bifida	
☐		Cyanotic Congenital Heart Disease	
☐		Congenital Diaphragmatic Hernia	
☐		Omphalocele	
☐		Gastroschisis	
☐		Limb Reduction Defect (excluding congenital amputation and dwarfing syndromes)	
☐		Cleft Lip With or Without Cleft Palate	
☐		Cleft Palate Alone	
☐		Down Syndrome	
☐		Karyotye Confirmed	
☐		Karyotype Pending	
☐		Suspected Chromosomal Disorder	
☐		Karyotype Confirmed	
☐		Karyotype Pending	
☐		Hypospadias	
☐		None of the Anomalies Listed Above	

II. Other Commonly Used Variables (Not on the Fetal Death Certificate)
Available for selected years

✓	Item Number	Item Descriptor	Justification*
☐		Underlying Cause of Death *(ICD codes)*	
☐		Causes of Death (multiple, including underlying) – ICD-10 codes	
☐		CDC 124 Selected Causes of Fetal Death (ICD-10)	
☐		CDC 45 Rankable Causes of Fetal Death (ICD-10)	
☐		Mother's Combined Race / Ethnicity Field	
☐		Calculated Weeks of Gestation	
☐		Weight of Fetus Calculated in Grams	
☐		Mother’s Age	
☐		Father’s Age	
☐		Longitude - Decimal Degrees (based on mother’s street address)	
☐		Latitude - Decimal Degrees (based on mother’s street address)	
☐		GIS Match Code (not available prior to 2004)	
☐		GIS Location Code (not available prior to 2004)	
☐		Geocoding Accuracy	
☐		1990 Census Tract (based on mother’s street address)	
☐		2000 Census Tract (based on mother’s street address)	
☐		2010 Census Tract (based on mother’s street address)	
☐		2020 Census Tract (based on mother’s street address) – 2020 forward	

Last updated: December 7, 2023

Validate Form Reset Form ↑ Back To Start