CERTIFICATE OF CAUSE OF PERINATAL DEATH

To be completed for stillbirths and liveborn infants dying within 168 hours (1 week) from birth

Identifying particulars

☐ This child was born live on ____ at ____ hours
and died on ____ at ____ hours
☐ This child was stillborn on ____ at ____ hours
and died before labour ☐ during labour ☐ not known ☐

Mother

Date of birth ☐☐ ☐☐ ☐☐
or, if unknow, age (years) ☐☐

Number of previous pregnancies:
Live birth ☐☐
Stillbirths ☐☐
Abortions ☐☐

Outcome of last previous pregnancy:
☐ Live birth
☐ Stillbirth
☐ Abortion
Date ☐☐ ☐☐ ☐☐

1st day last menstrual period ☐☐ ☐☐ ☐☐
or, if unknow, estimated duration of pregnancy ☐☐ (completed weeks)

Antenatal care, two or more visits:
☐ Yes
☐ No
☐ Not know

Delivery:
☐ Normal spontaneous vertex
Other (specify)
……

Child

Birthweight……grams

Sex:
☐Boy ☐Girl ☐Indeterminate

☐Single birth ☐First twin
☐Second twin ☐Other multiple

Attendant at birth

☐ Physician ☐ Trained midwife
Other trained person (specify)
……
Other (specify)
……

Causes of death

a. Main disease or condition in fetus or infant

b. Other diseases or conditions in fetus or infant

c. Main maternal disease or condition affecting fetus or infant

d. Other maternal diseases or conditions affecting fetus or infant

e. Other relevant circumstances

☐ The certified cause of death has been confirmed by autopsy
☐ Autopsy information may be available later
☐ Autopsy not being held

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Signature and qualification