Municipal Form No. 103A (To be accomplished in quadruplicate)
(Revised January 1993)

Republic of the Philippines

# CERTIFICATE OF FETAL DEATH

**(Fill out completely, accurately and legibly. Use ink or typewriter.**
**Place X before the appropriate answer in items 2, 5a, 5b, 5c, 20, 22a, 23 and 25.)**

Province _____
City/Municipality _____

Registry No.

**REMARKS/ANNOTATION**

**FETUS**

1. NAME OF FETUS (If given) (first) (Middle) (Last)

2. SEX
_____1 Male _____2 Female
_____3 Undetermined

3. DATE OF DELIVERY (day) (month) (year)

4. PLACE OF DELIVERY (Name of Hospital/Clinic/Institution/ House No., Street, Barangay) (City/Municipality) (Province)

5a. TYPE OF DELIVERY
_____ 1 Single _____ 2 Twin
_____3 Triplet, etc.

b. IF MULTIPLE DELIVERY, FETUS WAS
_____ 1 First _____2 Second
_____3 Others, Specify _____

c. METHOD OF DELIVERY
_____1 Normal spontaneous vertex
_____2 Others (specify) _____

d. BIRTH ORDER (live births and fetal deaths including this delivery (first, second, third, etc.)

e. WEIGHT OF FETUS _____ grams

**MOTHER**

6. MAIDEN NAME (First) (Middle) (Last)

7. CITIZENSHIP

8. RELIGION

9. OCCUPATION

10. Age at the time of this delivery: _____years

11a. Total number of children born alive: _____

b. No. of children still living: _____

c. No. of children born alive but are now dead: _____

12. RESIDENCE (House No./Street/Barangay) (City/Municipality) (Province)

**FATHER**

13. NAME (First) (Middle) (Last)

14. CITIZENSHIP

15. RELIGION

16 OCCUPATION

17. Age at the time of this delivery: _____years

18. DATE AND PLACE OF MARRIAGE OF PARENTS (if applicable)

**MEDICAL CERTIFICATE**

19. CAUSES OF FETAL DEATH
a. Main disease/condition of fetus _____
b. Other diseases/conditions of fetus _____
c. Main maternal disease/condition affecting fetus _____
d. Other maternal disease/condition affecting fetus _____
e. Other relevant circumstances _____

20. FETUS DIED: _____1 Before labor _____2 during labor/delivery _____3 Unknown

21. LENGTH OF PREGNANCY: _____completed weeks

22a. ATTENDANT: ____1 Physician ____Nurse ____3 Midwife ____4 Hilot (Traditional Midwife)
____ 5 Others (Specify) _____ _____None

22b. CERTIFICATION

*I hereby certify that the foregoing particulars are correct as near as same can be ascertained and I further certify that the fetus was born dead at _____ am/pm on the date indicated above.*

Signature _____
Name in Print _____
Title or Position _____
Address _____
_____
Date _____

REVIEWED BY:

Signature over printed name of Health Officer

_____
Date

23. CORPSE DISPOSAL
_____1 Burial _____ 2 Cremation
_____3 Others (Specify) _____

24. BURIAL/CREMATION PERMIT
Number _____
Date Issued _____

25. AUTOPSY
_____1 Yes
_____ 2 No

26. NAME AND ADDRESS OF CEMETERY OR CREMATORY

27. INFORMANT

Signature _____
Name in Print _____
Relationship to the fetus _____

Address _____
_____
Date _____

28. PREPARED BY

Signature _____
Name in Print _____
Title or Position _____
Date _____

29. RECEIVED AT THE OFFICE OF THE CIVIL REGISTRAR

Signature _____
Name in Print _____
Title or Position _____
Date _____

**TO BE FILLED UP AT THE OFFICE OF THE CIVIL REGISTRAR**

2 | | | | | | | |

9 |

10 |

11 | | | | | | | |

17 | | | | | |

22 |

23 | 24 | | 26 | | | |

30 | 31 | 32 | | | 35 | |

37 | | 39 | | 41 | |

43 | | | | |

48 | 49 | 50 | | | 53 | |

55 |

56 | | | |

60 | | |

64 |

65 | |

67 |

**FETAL DEATH** *is death to the expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such Separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.*

**POSTMORTEM CERTIFICATE OF DEATH**

*I HEREBY CERTIFY that I have performed an autopsy upon the body of the deceased this _____ day of _____, _____and that the cause of death was as follows: _____*

_____

_____ _____

Signature Title/Designation

_____ _____

Name in Print Address