

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK  
FOR  
INSTRUCTIONS  
SEE  
HANDBOOK

U.S. STANDARD  
CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

BIRTH NUMBER

CHILD

1. CHILD'S NAME (First, Middle, Last)		2. DATE OF BIRTH (Month, Day, Year)	3. TIME OF BIRTH M
4. SEX	5. CITY, TOWN, OR LOCATION OF BIRTH		6. COUNTY OF BIRTH
7. PLACE OF BIRTH: <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		8. FACILITY NAME (If not institution, give street and number)	

CERTIFIER/  
ATTENDANT

9. I certify that this child was born alive at the place and time and on the date stated.  Signature ▶	10. DATE SIGNED (Month, Day, Year)	11. ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print) Name _____ <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> C.N.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify) _____
12. CERTIFIER'S NAME AND TITLE (Type/Print) Name _____ <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Hospital Admin. <input type="checkbox"/> C.N.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify) _____	13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	

DEATH UNDER  
ONE YEAR OF  
AGE  
Enter State File  
Number of death  
certificate for  
this child

14. REGISTRAR'S SIGNATURE ▶	15. DATE FILED BY REGISTRAR (Month, Day, Year)
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MOTHER

16a. MOTHER'S NAME (First, Middle, Last)	16b. MAIDEN SURNAME	17. DATE OF BIRTH (Month, Day, Year)
18. BIRTHPLACE (State or Foreign Country)	19a. RESIDENCE—STATE	19b. COUNTY
19c. CITY, TOWN, OR LOCATION	19d. STREET AND NUMBER	
19e. INSIDE CITY LIMITS? (Yes or no)		20. MOTHER'S MAILING ADDRESS (If same as residence, enter Zip Code only)

FATHER

21. FATHER'S NAME (First, Middle, Last)	22. DATE OF BIRTH (Month, Day, Year)	23. BIRTHPLACE (State or Foreign Country)
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INFORMANT

24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. Signature of Parent or Other Informant ▶
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INFORMATION FOR MEDICAL AND HEALTH USE ONLY

MOTHER

FATHER

25. OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 25a. <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:		26. RACE—American Indian, Black, White, etc. (Specify below) 26a. _____ 26b. _____		27. EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)   College (1-4 or 5+) 27a. _____ 27b. _____	
28. PREGNANCY HISTORY (Complete each section)			29. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)	30. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	
LIVE BIRTHS (Do not include this child)		OTHER TERMINATIONS (Spontaneous and induced at any time after conception)		31. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. (Specify)	
28a. Now Living Number _____ <input type="checkbox"/> None	28b. Now Dead Number _____ <input type="checkbox"/> None	28d. _____ <input type="checkbox"/> None		32. PRENATAL VISITS—Total Number (If none, so state)	
28c. DATE OF LAST LIVE BIRTH (Month, Year)		28e. DATE OF LAST OTHER TERMINATION (Month, Year)		33. BIRTH WEIGHT (Specify unit)	
36. APGAR SCORE		37a. MOTHER TRANSFERRED PRIOR TO DELIVERY? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, enter name of facility transferred from:			
36a. 1 Minute	36b. 5 Minutes	37b. INFANT TRANSFERRED? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, enter name of facility transferred to:			

MULTIPLE BIRTHS  
Enter State File  
Number for Mate(s)  
LIVE BIRTH(S)

FETAL DEATH(S)

**38a. MEDICAL RISK FACTORS FOR THIS PREGNANCY***(Check all that apply)*

Anemia (Hct. <30/Hgb. <10)	01	<input type="checkbox"/>
Cardiac disease	02	<input type="checkbox"/>
Acute or chronic lung disease	03	<input type="checkbox"/>
Diabetes	04	<input type="checkbox"/>
Genital herpes	05	<input type="checkbox"/>
Hydramnios/Oligohydramnios	06	<input type="checkbox"/>
Hemoglobinopathy	07	<input type="checkbox"/>
Hypertension, chronic	08	<input type="checkbox"/>
Hypertension, pregnancy-associated	09	<input type="checkbox"/>
Eclampsia	10	<input type="checkbox"/>
Incompetent cervix	11	<input type="checkbox"/>
Previous infant 4000+ grams	12	<input type="checkbox"/>
Previous preterm or small-for-gestational-age infant	13	<input type="checkbox"/>
Renal disease	14	<input type="checkbox"/>
Rh sensitization	15	<input type="checkbox"/>
Uterine bleeding	16	<input type="checkbox"/>
None	00	<input type="checkbox"/>
Other	17	<input type="checkbox"/>

*(Specify)***38b. OTHER RISK FACTORS FOR THIS PREGNANCY***(Complete all items)*

Tobacco use during pregnancy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Average number cigarettes per day	_____			
Alcohol use during pregnancy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Average number drinks per week	_____			
Weight gained during pregnancy	_____		lbs.	

**39. OBSTETRIC PROCEDURES***(Check all that apply)*

Amniocentesis	01	<input type="checkbox"/>
Electronic fetal monitoring	02	<input type="checkbox"/>
Induction of labor	03	<input type="checkbox"/>
Stimulation of labor	04	<input type="checkbox"/>
Tocolysis	05	<input type="checkbox"/>
Ultrasound	06	<input type="checkbox"/>
None	00	<input type="checkbox"/>
Other	07	<input type="checkbox"/>

*(Specify)***40. COMPLICATIONS OF LABOR AND/OR DELIVERY***(Check all that apply)*

Febrile (> 100°F. or 38°C.)	01	<input type="checkbox"/>
Meconium, moderate/heavy	02	<input type="checkbox"/>
Premature rupture of membrane (>12 hours)	03	<input type="checkbox"/>
Abruptio placenta	04	<input type="checkbox"/>
Placenta previa	05	<input type="checkbox"/>
Other excessive bleeding	06	<input type="checkbox"/>
Seizures during labor	07	<input type="checkbox"/>
Precipitous labor (< 3 hours)	08	<input type="checkbox"/>
Prolonged labor (>20 hours)	09	<input type="checkbox"/>
Dysfunctional labor	10	<input type="checkbox"/>
Breech/Malpresentation	11	<input type="checkbox"/>
Cephalopelvic disproportion	12	<input type="checkbox"/>
Cord prolapse	13	<input type="checkbox"/>
Anesthetic complications	14	<input type="checkbox"/>
Fetal distress	15	<input type="checkbox"/>
None	00	<input type="checkbox"/>
Other	16	<input type="checkbox"/>

*(Specify)***41. METHOD OF DELIVERY *(Check all that apply)***

Vaginal	01	<input type="checkbox"/>
Vaginal birth after previous C-section	02	<input type="checkbox"/>
Primary C-section	03	<input type="checkbox"/>
Repeat C-section	04	<input type="checkbox"/>
Forceps	05	<input type="checkbox"/>
Vacuum	06	<input type="checkbox"/>

**42. ABNORMAL CONDITIONS OF THE NEWBORN***(Check all that apply)*

Anemia (Hct. <39/Hgb. <13)	01	<input type="checkbox"/>
Birth injury	02	<input type="checkbox"/>
Fetal alcohol syndrome	03	<input type="checkbox"/>
Hyaline membrane disease/RDS	04	<input type="checkbox"/>
Meconium aspiration syndrome	05	<input type="checkbox"/>
Assisted ventilation < 30 min	06	<input type="checkbox"/>
Assisted ventilation ≥ 30 min	07	<input type="checkbox"/>
Seizures	08	<input type="checkbox"/>
None	00	<input type="checkbox"/>
Other	09	<input type="checkbox"/>

*(Specify)***43. CONGENITAL ANOMALIES OF CHILD***(Check all that apply)*

Anencephalus	01	<input type="checkbox"/>
Spina bifida/Meningocele	02	<input type="checkbox"/>
Hydrocephalus	03	<input type="checkbox"/>
Microcephalus	04	<input type="checkbox"/>
Other central nervous system anomalies	_____	05 <input type="checkbox"/>
<i>(Specify)</i>		
Heart malformations	06	<input type="checkbox"/>
Other circulatory/respiratory anomalies	_____	07 <input type="checkbox"/>
<i>(Specify)</i>		
Rectal atresia/stenosis	08	<input type="checkbox"/>
Tracheo-esophageal fistula/ Esophageal atresia	09	<input type="checkbox"/>
Omphalocele/ Gastroschisis	10	<input type="checkbox"/>
Other gastrointestinal anomalies	_____	11 <input type="checkbox"/>
<i>(Specify)</i>		
Malformed genitalia	12	<input type="checkbox"/>
Renal agenesis	13	<input type="checkbox"/>
Other urogenital anomalies	_____	14 <input type="checkbox"/>
<i>(Specify)</i>		
Cleft lip/palate	15	<input type="checkbox"/>
Polydactyly/Syndactyly/Adactyly	16	<input type="checkbox"/>
Club foot	17	<input type="checkbox"/>
Diaphragmatic hernia	18	<input type="checkbox"/>
Other musculoskeletal/integumental anomalies	_____	19 <input type="checkbox"/>
<i>(Specify)</i>		
Down's syndrome	20	<input type="checkbox"/>
Other chromosomal anomalies	_____	21 <input type="checkbox"/>
<i>(Specify)</i>		
None	00	<input type="checkbox"/>
Other	_____	22 <input type="checkbox"/>
<i>(Specify)</i>		