Municipal Form No. 103A
(Revised January 1993)

(To be accomplished in quadruplicate)

Republic of the Philippines

CERTIFICATE OF FETAL DEATH

(Fill out completely 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

TO BE FILLED UP AT THE OFFICE OF THE CIVIL REGISTRAR

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
_____ Triplet, etc.

b. IF MULTIPLE DELIVERY, FETUS WAS
_____ 1 First _____ 2 Second
_____ 3 Others, Specify _____

MOTHER

c. METHOD OF DELIVERY
_____ 1 Normal spontaneous vertex
_____ 2 Other (specify) _____

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

e. WEIGHT OF FETUS
_____ grams

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

7. CITIZENSHIP | 8. RELIGION | 9. OCCUPATION | 10. Age at the time o 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 o 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 ___ 2 Nurse ____ 3 Midwife ____ 4 Hilot (Traditional Midwife)
____ 5 Others (Specify) _____ _____ 6 None

22b. CERTIFICATION
I hereby certify that the foregoing particulars are correct as near as same can 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

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 prior 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