ACOG State Legislative Toolkit

Improving Pregnancy Outcomes:

Maternal Mortality Reviews & Standardized Reporting

Contents:

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ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

YOUR Section
(insert your contact info here)

ACOG is the representative organization of physicians who are qualified specialists in providing health services unique to women. ACOG represents over 54,000 ob-gyn physicians and partners in women's health, including XXX Fellows and Junior Fellows-In-Practice here in [YOUR STATE].

Legislative Position Statement

Improving Pregnancy Outcomes: Maternal Mortality Review & Standardized Reporting

Summary and Facts:

Despite advances in medical care, the maternal mortality rate in the US appears to be rising and has reached a rate that is four times higher than the federal government's 2010 goal.

- As measured by the CDC, the aggregate US pregnancy-related mortality ratio was 14.5 per 100,000 live births for the 8 year period 1998-2005 – ***higher than any other period in the previous 20 years.*** US officials had hoped to decrease the rate to about 3.3 deaths in 2010.
- Many experts caution that there is a 30% to 100% under-reporting of maternal deaths. Experts also estimate that only 30% - 40% of the rise in maternal deaths can be attributed to new data collection techniques and better reporting.
- Maternal deaths are classified as those that occur within 42 days after delivery and are directly related to pregnancy or childbirth. Current leading causes include cardiac disease and cardiomyopathy, venous thromboembolism, obstetric hemorrhage and pre-eclampsia. The majority of deaths from these causes are believed to be preventable.
- Black women are at least three times more likely to die from pregnancy complications than white women. In 2006, the maternal mortality ratio for non-Hispanic white women was 9.1 deaths per 100,000 live births compared with 34.8 deaths from non-Hispanic black women. This African American maternal mortality is among the worst of any health outcome measure. The reasons are unclear although current evidence indicates a combination of social, behavioral and medical care factors.
- For every woman who dies of a pregnancy-related cause, many more suffer morbidity related to pregnancy. These morbidities are a significant burden on women, their families and society in economic, social and personal terms.

[YOUR STATE] ACOG Position:

- **Maternal deaths in [our state] should be investigated by a multi-disciplinary peer-review protected maternal mortality review (MMR) committee.**
- **[Our state] should use the recommended standard death certificate which includes a set of questions that help identify a deceased woman's pregnancy status at the time of death, within 42 days of death, or within 43 to 365 days of death including a pregnancy checkbox.**

ACOG POSITION: *Maternal Mortality Review (MMR) Committees*

ACOG, CDC, the Association of Maternal and Child Health Programs, and the Maternal and Child Health Bureau within HHS-HRSA recommend that maternal deaths in each state be investigated by a multi-disciplinary peer-review protected MMR committee.

The problem: Currently, less than half of the states have an active MMR committee.

An MMR committee:

- examines the medical and non-medical circumstances of women's deaths that occur during or around the time of pregnancy
- identifies gaps in services and systems that should be improved to prevent future deaths
- disseminates review results to health care practitioners and facilities
- makes recommendations to help prevent future deaths and improve maternal health
- identifies systems problems that must be addressed
- also identifies strengths in the systems of care that should be supported or expanded
- must be confidential, protecting the privacy of women who have died and their families
- must be peer-review protected with findings non-discoverable.

ACOG POSITION: *Standardized Reporting of Maternal Deaths*

States make policy decisions based on data on the death certificate. ACOG, CDC and NCHS recommend that all states use uniform standardized data collection and reporting tools. Accurate data collection will better inform research priorities, clinical practice and intervention strategies.

The problem: One major problem is that national data on maternal mortality is incomplete and variable due to lack of standardized reporting by states. Data on maternal deaths is collected at state or municipality levels and then reported to the National Center for Health Statistics (NCHS). But death certificates are not uniform across all states.

- Only 30 states are using the recommended US Standard Death Certificate which includes a set of questions that help identify a deceased woman's pregnancy status at the time of death, within 42 days of death, or within 43-365 days of death, including a pregnancy checkbox.

- Few states use the ACOG and CDC recommended definitions that differentiate between pregnancy-related and pregnancy-associated deaths.

- The CDC found that in states that asked about pregnancy on the death certificate in a single year – 2002 to 2003 – there was a 20% increase in reported maternal deaths. In states that had a question or a checkbox both years, there was a 40% increase in the number of maternal deaths reported.

- Many experts caution that there is a 30% to 100% under-reporting of maternal deaths. Experts also estimate that only 30% - 40% of the rise in maternal deaths can be attributed to new data collection techniques and better reporting.

DEFINITION of TERMS

Maternal mortality ratio. Technically, this is a ratio of maternal deaths over live births. The ratio is defined as the number of pregnancy-related deaths per 100,000 live births. Data on the number of pregnancy-related deaths in the 52 reporting areas, the numerator, are from the CDC's Pregnancy Mortality Surveillance System. Data on the number of live births, the denominator, are from the National Center for Health Statistics' natality files. Because pregnancy-related deaths are relatively rare and year-to-year reporting by states can vary unpredictably, pregnancy-related mortality ratios are reported each year.

Maternal death. The death of a woman from any cause related to or aggravated by pregnancy or its management (regardless of the duration or site of pregnancy), but not from accidental or incidental causes. [Note: Deaths occurring during pregnancy or after its termination from causes not related to the pregnancy or its complications or management are not considered a maternal death. Nonmaternal deaths may result from accidental causes (eg, auto accident or gunshot wound) or incidental causes (eg, concurrent malignancy).]

Pregnancy-associated death. The death of any woman, from any cause, while pregnant or within 1 calendar year of termination of pregnancy, regardless of duration and the site of pregnancy. This definition was developed by ACOG and CDC.

Pregnancy-related death. A pregnancy-associated death resulting from: 1) complications of the pregnancy itself, 2) the chain of events initiated by the pregnancy that led to death or, 3) aggravation of an unrelated condition by the physiologic or pharmacologic effects of the pregnancy that subsequently caused death. This definition was developed by ACOG and CDC.

Direct obstetric death. Deaths resulting from obstetric complications of the pregnant state (pregnancy, labor, and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of these.

Indirect obstetric death. Deaths resulting from pre-existing disease or disease such as a cancer that developed during pregnancy, not due to direct obstetric causes, but aggravated by physiologic effects of pregnancy.

International Classification of Diseases (ICD). Beginning in 1999, all death certificates were coded using the new ICD-10, replacing ICD-9. This change increased the number of codes (0-codes), allowing more deaths to be identified as maternal because of a causal or indirect relationship to pregnancy. The WHO/ICD-10 definitions are used by the US Center for Health Statistics to monitor trends and make comparisons.

US Standard Certificate of Death. In 2003, the certificate was revised. It includes a question asking if the decedent had been pregnant at the time of death or within a defined time period.

ACOG Supporting Documents:

Strategies to Reduce Pregnancy-Related Deaths: From Identification and Review to Action, 2001. Available on-line: www.cdc.gov/reproductivehealth/ProductsPubs/PDFs/Strategies_taged.pdf
ACOG Committee Opinion #315, Obesity in Pregnancy, 2005.
ACOG Guidelines for Perinatal Care, 6th Edition, 2007.
ACOG Making Obstetrics and Maternity Safer (MOMs) Initiative, 2010.

Drafting your MMR bill

STATE LEGISLATIVE CONSIDERATIONS*

Do you need to pass legislation to set-up a state MMR committee? YES, if no authorizing legislation exists. If your state passed a law, but your MMR committee is inactive, you do not need to pass another bill.

You will need to consider the following:

- ✓ What is MMR
- ✓ Mandatory confidential case reporting of pregnancy-related deaths
- ✓ Location of the committee
- ✓ Appointment of members & staffing
- ✓ Committee duties: standardized case finding and reporting; review of deaths; dissemination of findings and recommendations
- ✓ Access to records & confidentiality and immunity protections
- ✓ Funding
- ✓ Use of the terms *pregnancy-related* and *pregnancy-associated* deaths
- ✓ Autopsies

These issues are discussed in the next pages. ACOG's position is also noted.

WHAT IS THE PURPOSE OF MATERNAL MORTALITY REVIEW (MMR)

1. What is the purpose of MMR? To examine the medical and non-medical circumstances of women's deaths that occur during pregnancy or up to one year of pregnancy termination and to identify gaps in services and systems that should be improved to prevent future deaths. MMR also can identify strengths in the system of care that should be supported or expanded. MMR is anonymous, confidential and nonjudgmental.

MMR committees:

- ✓ Collect relevant information pertaining to maternal deaths.
- ✓ Review all cases of maternal deaths.
- ✓ Identify systems problems that must be addressed in order to decrease maternal deaths.
- ✓ Make recommendations to help prevent future deaths and improve maternal health in general.
- ✓ Disseminate findings & recommendations to health care practitioners and facilities.
- ✓ Collaborate with partners.
- ✓ Do not have legal authority to revoke licensure, take disciplinary action, or judge the qualifications of health care providers.

ACOG POSITION: Review of every maternal death by a qualified committee in each state is critical to understanding the role in maternal death of geography, age, preexisting conditions, access to appropriate care, as well as race, ethnicity, community education, and services. ACOG urges Fellows to become involved to make maternal mortality review meaningful in their states.

2. Isn't MMR already part of each state's core public health function? Pregnancy-related death identification and review should be a routine component of the work of state health departments, but often is not. State MMR committees make important contributions to public health by improving the identification of pregnancy-related deaths; conducting or overseeing the review of these deaths; recommending actions to help prevent future deaths; and synthesizing and disseminating findings and recommendations.

ACOG POSITION: ACOG supports robust MMR in all states apart from any existing sentinel event reporting. ACOG supports mandatory and confidential case reporting of pregnancy-related deaths to the state health department.

COMMITTEE LOCATION, MEMBERS & STAFFING, DUTIES

3. State, versus local, versus federal review. In most cases, the state is the level at which pregnancy-related deaths are reviewed, although it can occur in some very large cities and counties. Because pregnancy-related deaths are relatively uncommon, it is usually more appropriate for states to review these deaths than for cities or communities, although it is important for state-level committees to have input from local communities most affected by pregnancy-related mortality. Review should occur at the level at which decisions can be made and resources allocated to reduce pregnancy-related deaths—which is the state level.

ACOG POSITION: ACOG supports state-level review committees but also supports the option of forming a regional committee among neighboring states.

4. Placement in state agencies is preferable. Establishing the MMR in a state government agency provides:

- ✓ access to key programs such as vital statistics, reproductive health, maternal and child health and epidemiology
- ✓ increased ability to obtain and share data
- ✓ access to federal funding
- ✓ legal protections
- ✓ program neutrality without limitation to any one project, institute or facility
- ✓ integration of findings into state programs
- ✓ increased ability to foster beneficial partnerships

ACOG POSITION: State health agencies have the advantage of protection for gathering data.

5. Relationship to fetal and infant and child death reviews. The MMR committee should be its own distinct entity. It can base its methodology on existing groups doing similar work such as Fetal and Infant Mortality Review (FIMR) committees.

The National Fetal and Infant Mortality Review Program (NFIMR) – carried out jointly by ACOG and the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA) – promotes *community*-based review of fetal and infant deaths. NFIMR was a leader in including both medical and nonmedical factors in death reviews.

6. Membership. Review committees have evolved from a single physician or group of obstetricians reviewing only clinical aspects of maternal deaths to multidisciplinary teams that review medical and nonmedical factors such as environmental, social, and economic factors, through a more structured process.

- ✓ MMR committees are becoming more multidisciplinary.
- ✓ The experience and expertise of members should reflect the broad scope of review and should include various disciplines and organizations.
- ✓ Members should be selected as official representatives of the leaders of their organizations, rather than as individuals from particular disciplines.
- ✓ There should be a diverse community membership particularly by those communities most affected by pregnancy-related morbidity and mortality.
- ✓ It is helpful to have individuals who are knowledgeable and interested in trying to reduce pregnancy-related mortality.
- ✓ State government members include: public health departments; state Title V maternal and child health agencies; state Title X family planning programs; social services programs for women including family planning, WIC, domestic violence and substance abuse; and the medical examiner's office.

ACOG POSITION: Review committees should be multi-disciplinary. Members should include persons listed below. Additional members with specific expertise should be added whenever needed.

Required members should include:

- ✓ obstetricians including generalists and maternal fetal medicine specialists
- ✓ family practice physicians
- ✓ certified nurse-midwives, certified midwives & APNs
- ✓ hospital-based nurses
- ✓ representatives of the state health department's MCH agency
- ✓ social services providers or social workers
- ✓ the chief medical examiner or designee
- ✓ facility representatives such as hospitals and freestanding birth centers
- ✓ community or patient advocates who represent communities most affected

7. Staffing. Specific tasks that need to be carried out at a staff level include:

1. **examining surveillance data**
2. **broad case identification**
3. **abstracting case data from all sources**
4. **summarizing case data for review**

5. **summarizing the findings & recommendations.**

States meet these needs in various ways. Some states have the equivalent of one full-time position divided between three people: a half-time coordinator, a quarter-time data analyst, and a quarter-time clerk. States can hire experienced health care professionals for a flat fee to abstract case data and write case summaries. In states with perinatal care regions, some review functions including data collection and family and care provider interviews can be delegated to the staff of the regional perinatal center. States can also use Title V program staff to coordinate meetings.

ACOG POSITION: Staff of the review committee must include: vital health statisticians, MCH statisticians or epidemiologists, a designated MMR coordinator, and administrative staff.

COMMITTEE DUTIES

For a complete discussion, please see the two booklets developed jointly by ACOG, CDC and partners:

> *Strategies to Reduce Pregnancy-Related Deaths: From Identification and Review to Action* published in 2001 by CDC and partners including ACOG, HRSA/MCHB, AMCHP, ACNM, CityMatch, and NAPHSIS.
>
> *State Maternal Mortality Review: Accomplishments of Nine States* published by CDC in 2006.

CONFIDENTIALITY and IMMUNITY PROTECTIONS

8. Access to records, confidentiality and immunity. It is important to ensure the privacy and protection of the women who have died, their families, their caregivers, and MMR committee members. The relatively small number of maternal deaths makes confidentiality requirements a special challenge.

There are two types of legal protection for MMR:

- ✓ state statutes which give derivative immunity to individuals who contract with state agencies or work on state-funded projects
- ✓ court decisions interpreting immunity and confidentiality provisions.

Statutory legal protection and confidentiality must be ensured at the outset of the MMR process to protect committee members and the collected data from lawsuits and subpoenas. Reviews of relevant state laws, first done in 1989 and updated by ACOG in 2000, have shown that – in most states – statutes

protect the reports, proceedings, and findings of the review committee from being used (discovered or admitted in to evidence) in civil lawsuits. Most states also have laws that grant immunity from liability to participants on expert review panels.

Regarding access to records, most states have laws that permit access to records for public health research and epidemiologic purposes. The National Fetal and Infant Mortality Review (NFIMR) program publishes information about HIPAA privacy regulations that states can refer to when conducting MMR.

ACOG POSITION: Maternal mortality review should be confidential and protected from any discovery or legal action.

9. How is MMR different from hospital-based peer review? MMR committees are considered expert review committees but have no authority to take disciplinary action or judge the qualifications of health care providers. Many hospitals have peer-review maternal mortality committees that monitor and assess the medical care given to any pregnant woman who dies at their facility. Hospital-based review committees generally do not address systems issues that may have contributed to the death, including care the pregnant woman may have received in other facilities. Hospital reviews generally do not address psychosocial contributors of death. Also, hospital reviews do not provide population-based information.

FUNDING and COSTS

10. What is the cost of conducting MMR? Costs vary by state and depend on several factors; these include:

- ✓ number of maternal deaths in the state
- ✓ type and quantity of information being collected including record abstraction
- ✓ challenges in case finding
- ✓ existing infrastructure of the MMR process including frequency of review meetings
- ✓ how widely review findings & recommendations are disseminated

Most of the work of MMR committees is voluntary and members cover their own travel/time. Committee chairs may receive small stipends. Costs relate to data retrieval by the epidemiologist and other staff, case finding, case abstraction and reporting.

Note: There are also costs associated with translating MMR findings into action. Funding to implement recommended strategies to reduce pregnancy-related deaths often is inadequate.

State cost examples:

- Florida estimates $75,000 per year including staff time
- Michigan estimates $100,000 per year including staff time
- New York's costs for July 1, 2009-June 30, 2010 were $249,500. This includes educational programs.

11. State funding opportunities. In many states, programs are pieced together on an in-kind basis with no specific funding for conducting reviews or disseminating reports. Dedicated funding is critical. Sources include the Title V Maternal and Child Health Block Grant from HRSA/MCHBs, the state health commissioner's discretionary fund, and general revenue funds. Placement of MMR in a state agency gives you access to Title V monies. States also tap private sources such as community and philanthropic groups, foundations, and professional associations.

12. Federal funding opportunities. Currently, most funding comes from the Title V Maternal and Child Health Block Grant and CDC. These funds support epidemiology and analysis, often case abstraction, and some meeting coordination. As block grant funding becomes tight, funding for MMR could be cut.

ACOG POSITION: ACOG supports dedicated funding from both state and federal governments**.**

DEFINITIONS

In 1987, CDC, ACOG, the Association of Vital Records and Health Statistics, and state and local health departments collaborated to initiate the National Pregnancy Maternal Mortality Surveillance System. At that time, CDC and ACOG introduced two new terms to identify cases for review and quality improvement activities which are being used today by CDC and increasingly some states and researchers. These differentiate between pregnancy-associated and pregnancy-related death.

The ACOG/CDC definitions are more inclusive than the WHO/ICD-10 definitions. A variety of data sources, including vital records and hospital data, can be used to identify deaths that meet ACOG/CDC definitions. Only cause of death data from death certificates can be used to identify deaths that meet ICD-10 definitions.

- ***Maternal death:*** The death of a woman from any cause related to or aggravated by pregnancy or its management (regardless of the duration or site of pregnancy), but not from accidental or incidental causes. [Note: Deaths occurring during pregnancy or after its termination from causes not related to the pregnancy or its complications or management is not considered a maternal death. Nonmaternal deaths may result from accidental causes (eg, auto accident or gunshot wound) or incidental causes (eg, concurrent malignancy).]
- ***Pregnancy-associated death:*** The death of any woman, from any cause, while pregnant or within 1 calendar year of termination of pregnancy, regardless of duration and the site of pregnancy. This definition was developed by ACOG and CDC.
- ***Pregnancy-related death:*** A pregnancy-associated death resulting from: 1) complications of the pregnancy itself, 2) the chain of events initiated by the pregnancy that led to death or, 3) aggravation of an unrelated condition by the physiologic or pharmacologic effects of the pregnancy that subsequently caused death. This definition was developed by ACOG and CDC.
- ***Direct obstetric death:*** Deaths resulting from obstetric complications of the pregnant state (pregnancy, labor, and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of these.
- ***Indirect obstetric death:*** Deaths resulting from pre-existing disease or disease such as a cancer that developed during pregnancy, was not due to direct obstetric causes, but was aggravated by physiologic effects of pregnancy.
- ***International Classification of Diseases (ICD):*** Beginning in 1999, all death certificates were coded using the new ICD-10, replacing ICD-9. This change increased the number of codes (0-codes), allowing more deaths to be identified as maternal because of a causal or indirect relationship to pregnancy. The WHO/ICD-10 definitions are used by the US Center for Health Statistics to monitor trends and make comparisons.

OTHER CONSIDERATIONS: Autopsies & Severe Maternal Morbidity

Autopsies. Maternal deaths related to pregnancy or childbirth are sometimes unidentified when only death certificates are used to identify the cause of death. Autopsies can provide an important source of information about the cause of death.

The cost of an autopsy may be prohibitive for some families. This should be a factor in deciding whether to mandate autopsies for all maternal deaths.

ACOG POSITION: No ACOG position; finding the cause of death is problematic and often not done well.

"Near miss" or severe maternal morbidity. There is no scientific consensus on uniform definitions of severe maternal morbidity or best practices for data collection, making it difficult both to measure and develop evidence-based interventions. Severe maternal morbidity merits more investigation: the factors that permit some women to survive and others die may be instructive.

ACOG POSITION: ACOG supports federal government examination, with relevant stakeholder organizations including ACOG, of severe maternal morbidity to: 1) identify definitions of severe maternal morbidity and 2) make recommendations for research and surveillance. This would include data collection protocols to assist States in identifying and monitoring cases of severe maternal morbidity.

*** This fact sheet has been compiled primarily from two documents: The 2001 *Strategies to Reduce Pregnancy-Related Deaths: From Identification and Review to Action* published by CDC and partners including ACOG, HRSA/MCHB, AMCHP, ACNM, CityMatch, and NAPHSIS; and *State Maternal Mortality Review: Accomplishments of Nine States* published by CDC in 2006.**

Maternal Mortality - How Does Your State Fare?

- In 1998 through 2005, the maternal mortality ratio was 14.5 per 100,000 births, higher than any other period in the previous 20 years.

- Women of color and low income women, in particular, face added risks in terms of death, complications, and access to quality health care. African-American women are three to four times more likely to die of pregnancy-related complications than white women. In 2006, the maternal mortality ratio for non-Hispanic white women was 9.1 deaths per 100,000 births compared with 34.8 deaths per 100,000 births for non-Hispanic black women. These rates and disparities have not improved in more than 20 years.

- Healthy People 2010, a comprehensive, nationwide health promotion and disease prevention agenda launched by the Department of Health and Human Services, had set a target goal of reducing maternal mortality in the United States to 4.3 deaths per 100,000 live births by 2010.

STATE	Maternal Mortality Ratio (per 100,000 births)[1]	Rank	Active Maternal Mortality Review Committee (MMR)[2]
Alabama	11.6	33	
Alaska	3.2	4	X
Arizona	7.5	11	Law enacted in 2011
Arkansas	16.0	40	
California	12.5	35	X
Colorado	10.9	29	X
Connecticut	7.5	11	
Delaware	10.3	25	X
District of Columbia	38.2	51	
Florida	14.8	38	X
Georgia	20.9	49	
Hawaii	13.9	37	
Idaho	15.0	39	
Illinois	7.8	13	X
Indiana	2.9	3	X
Iowa	8.2	15	X
Kansas	7.1	9	
Kentucky	8.1	14	X
Louisiana	17.9	44	X
Maine	1.2	1	X
Maryland	18.7	45	X

STATE	Maternal Mortality Ratio (per 100,000 births)[1]	Rank	Active Maternal Mortality Review Committee (MMR)[2]
Massachusetts	4.8	5	X
Michigan	21.0	50	X
Minnesota	5.0	6	
Mississippi	19.0	47	
Missouri	12.7	36	X
Montana	10.1	23	
Nebraska	9.0	17	
Nevada	10.0	22	
New Hampshire	9.2	20	X
New Jersey	16.5	41	X
New Mexico	16.5	41	X
New York	18.9	46	*
North Carolina	10.9	29	X
North Dakota	10.3	25	
Ohio	7.2	10	
Oklahoma	20.1	48	X
Oregon	6.5	8	
Pennsylvania	10.1	23	
Rhode Island	5.2	7	
South Carolina	12.0	34	X
South Dakota	9.0	17	
Tennessee	11.0	32	
Texas	10.5	28	
Utah	9.9	21	X
Vermont	2.6	2	Law enacted in 2011
Virginia	8.3	16	X
Washington	9.0	17	
West Virginia	10.4	27	X
Wisconsin	10.9	29	
Wyoming	17.0	43	

1. Centers for Disease Control and Prevention, National Center for Health Statistics. 2001-2006 data. Retrieved 2-10-11 from http://hrc.nwlc.org/status-indicators/maternal-mortality-rate-100000

2. List represents best available information, including from ACOG survey of state Maternal Child Health officers conducted in January and February, 2011. Staffing, funding and activity levels of MMR committees are in flux in many States.

* Project run by ACOG District II/New York recently de-funded.

U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO. STATE FILE NO.

NAME OF DECEDENT
For use by physician or institution

To Be Completed/ Verified By: FUNERAL DIRECTOR:

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) | 2. SEX | 3. SOCIAL SECURITY NUMBER

4a. AGE-Last Birthday (Years) | 4b. UNDER 1 YEAR: Months / Days | 4c. UNDER 1 DAY: Hours / Minutes | 5. DATE OF BIRTH (Mo/Day/Yr) | 6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE-STATE | 7b. COUNTY | 7c. CITY OR TOWN

7d. STREET AND NUMBER | 7e. APT. NO. | 7f. ZIP CODE | 7g. INSIDE CITY LIMITS? ☐ Yes ☐ No

8. EVER IN US ARMED FORCES? ☐ Yes ☐ No

9. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown

10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)

11. FATHER'S NAME (First, Middle, Last)

12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

13a. INFORMANT'S NAME | 13b. RELATIONSHIP TO DECEDENT | 13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

14. PLACE OF DEATH (Check only one; see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):

15. FACILITY NAME (If not institution, give street & number) | 16. CITY OR TOWN, STATE, AND ZIP CODE | 17. COUNTY OF DEATH

18. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify):

19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)

20. LOCATION-CITY, TOWN, AND STATE | 21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT | 23. LICENSE NUMBER (Of Licensee)

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr) | 25. TIME PRONOUNCED DEAD

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable) | 27. LICENSE NUMBER | 28. DATE SIGNED (Mo/Day/Yr)

29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month) | 30. ACTUAL OR PRESUMED TIME OF DEATH | 31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition resulting in death) ⟶ a. _____ Due to (or as a consequence of):

Sequentially list conditions if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

To Be Completed By: MEDICAL CERTIFIER

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

36. 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

37. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

38. DATE OF INJURY (Mo/Day/Yr) (Spell Month) | 39. TIME OF INJURY | 40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area) | 41. INJURY AT WORK? ☐ Yes ☐ No

42. LOCATION OF INJURY: State: City or Town: Street & Number: Apartment No.: Zip Code:

43. DESCRIBE HOW INJURY OCCURRED

44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

45. CERTIFIER (Check only one):
☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

Signature of certifier: _____

46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32)

47. TITLE OF CERTIFIER | 48. LICENSE NUMBER | 49. DATE CERTIFIED (Mo/Day/Yr) | 50. FOR REGISTRAR ONLY- DATE FILED (Mo/Day/Yr)

To Be Completed By: FUNERAL DIRECTOR

51. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.
☐ 8th grade or less
☐ 9th - 12th grade; no diploma
☐ High school graduate or GED completed
☐ 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)

52. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino (Specify) _____

53. DECEDENT'S RACE (Check 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 (Specify) _____
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify) _____
☐ Other (Specify) _____

54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED)

55. KIND OF BUSINESS/INDUSTRY

REV 11/2003

MEDICAL CERTIFIER INSTRUCTIONS for selected items on U.S. Standard Certificate of Death

(See Physicians' Handbook or Medical Examiner/Coroner Handbook on Death Registration for instructions on all items)

ITEMS ON WHEN DEATH OCCURRED

Items 24-25 and 29-31 should always be completed. If the facility uses a separate pronouncer or other person to indicate that death has taken place with another person more familiar with the case completing the remainder of the medical portion of the death certificate, the pronouncer completes items 24-28. If a certifier completes items 24-25 as well as items 29-49, Items 26-28 may be left blank.

ITEMS 24-25, 29-30 – DATE AND TIME OF DEATH

Spell out the name of the month. If the exact date of death is unknown, enter the **approximate** date. If the date cannot be approximated, enter the date the body is found and identify as **date found**. Date pronounced and actual date may be the same. Enter the exact hour and minutes according to a 24-hour clock; estimates may be provided with "Approx." placed before the time.

ITEM 32 – CAUSE OF DEATH (See attached examples)

Take care to make the entry legible. Use a computer printer with high resolution, typewriter with good black ribbon and clean keys, or print legibly using permanent **black** ink in completing the CAUSE OF DEATH Section. **Do not abbreviate** conditions entered in section.

Part I (Chain of events leading directly to death)

•Only **one** cause should be entered on each line. Line (a) **MUST ALWAYS** have an entry. **DO NOT** leave blank. Additional lines may be added if necessary.
•If the condition on Line (a) resulted from an underlying condition, put the underlying condition on Line (b), and so on, until the full sequence is reported. **ALWAYS** enter the **underlying cause of death** on the lowest used line in Part I.
•For each cause indicate the best estimate of the interval between the presumed onset and the date of death. The terms "unknown" or "approximately" may be used. General terms, such as minutes, hours, or days, are acceptable, if necessary. **DO NOT** leave blank.
•The terminal event (for example, cardiac arrest or respiratory arrest) should not be used. If a mechanism of death seems most appropriate to you for line (a), then you must always list its cause(s) on the line(s) below it (for example, cardiac arrest **due to** coronary artery atherosclerosis *or* cardiac arrest **due to** blunt impact to chest).
• If an organ system failure such as congestive heart failure, hepatic failure, renal failure, or respiratory failure is listed as a cause of death, always report its etiology on the line(s) beneath it (for example, renal failure **due to** Type I diabetes mellitus).
•When indicating neoplasms as a cause of death, include the following: 1) primary site *or* that the primary site is unknown, 2) benign or malignant, 3) cell type *or* that the cell type is unknown, 4) grade of neoplasm, and 5) part or lobe of organ affected. (For example, a primary well-differentiated squamous cell carcinoma, lung, left upper lobe.)
•Always report the fatal injury (for example, stab wound of chest), the trauma (for example, transection of subclavian vein), and impairment of function (for example, air embolism).

PART II (Other significant conditions)

•Enter all diseases or conditions contributing to death that were not reported in the chain of events in Part I and that did not result in the **underlying cause of death**. See attached examples.
•If two or more possible sequences resulted in death, or if two conditions seem to have added together, report in Part I the one that, in your opinion, most directly caused death. Report in Part II the other conditions or diseases.

CHANGES TO CAUSE OF DEATH

Should additional medical information or autopsy findings become available that would change the cause of death originally reported, the original death certificate should be amended by the certifying physician by **immediately** reporting the revised cause of death to the State Vital Records Office.

ITEMS 33-34 - AUTOPSY

•33 - Enter "Yes" if either a partial or full autopsy was performed. Otherwise enter "No."
•34 - Enter "Yes" if autopsy findings were available to complete the cause of death; otherwise enter "No". Leave item blank if no autopsy was performed.

ITEM 35 - DID TOBACCO USE CONTRIBUTE TO DEATH?

Check "yes" if, in your opinion, the use of tobacco contributed to death. Tobacco use may contribute to deaths due to a wide variety of diseases; for example, tobacco use contributes to many deaths due to emphysema or lung cancer and some heart disease and cancers of the head and neck. Check "no" if, in your clinical judgment, tobacco use did not contribute to this particular death.

ITEM 36 - IF FEMALE, WAS DECEDENT PREGNANT AT TIME OF DEATH OR WITHIN PAST YEAR?

This information is important in determining pregnancy-related mortality.

ITEM 37 - MANNER OF DEATH

•Always check Manner of Death, which is important: 1) in determining accurate causes of death; 2) in processing insurance claims; and 3) in statistical studies of injuries and death.
•Indicate "Pending investigation" if the manner of death cannot be determined whether due to an accident, suicide, or homicide within the statutory time limit for filing the death certificate. This should be changed later to one of the other terms.
•Indicate "Could not be Determined" **ONLY** when it is impossible to determine the manner of death.

ITEMS 38-44 - ACCIDENT OR INJURY – to be filled out in all cases of deaths due to injury or poisoning.

•38 - Enter the exact month, day, and year of injury. Spell out the name of the month. **DO NOT** use a number for the month. (Remember, the date of injury may differ from the date of death.) Estimates may be provided with "Approx." placed before the date.
•39 - Enter the exact hour and minutes of injury or use your best estimate. Use a 24-hour clock.
•40 - Enter the general place (such as restaurant, vacant lot, or home) where the injury occurred. **DO NOT** enter firm or organization names. (For example, enter "factory", **not** "Standard Manufacturing, Inc.")
•41 - Complete if anything other than natural disease is mentioned in Part I or Part II of the medical certification, including homicides, sulcides, and accidents. This includes all motor vehicle deaths. The item **must** be completed for decedents ages 14 years or over and may be completed for those less than 14 years of age if warranted. Enter "Yes" if the injury occurred at work. Otherwise enter "No". An injury may occur at work regardless of whether the injury occurred in the course of the decedent's "usual" occupation. Examples of injury at work and injury not at work follow:

Injury at work	**Injury not at work**
Injury while working or in vocational training on job premises	Injury while engaged in personal recreational activity on job premises
Injury while on break or at lunch or in parking lot on job premises	Injury while a visitor (not on official work business) to job premises
Injury while working for pay or compensation, including at home	Homemaker working at homemaking activities
Injury while working as a volunteer law enforcement official etc.	Student in school
Injury while traveling on business, including to/from business contacts	Working for self for no profit (mowing yard, repairing own roof, hobby)
	Commuting to or from work

•42 - Enter the complete address where the injury occurred including zip code.
•43 - Enter a brief but specific and clear description of how the injury occurred. Explain the circumstances or cause of the injury. Specify **type of gun or type of vehicle** (e.g., car, bulldozer, train, etc.) when relevant to circumstances. Indicate if more than one vehicle involved; specify type of vehicle decedent was in.
•44 -Specify role of decedent (e.g. driver, passenger). Driver/operator and passenger should be designated for modes other than motor vehicles such as bicycles. Other applies to watercraft, aircraft, animal, or people attached to outside of vehicles (e.g. surfers).

Rationale: Motor vehicle accidents are a major cause of unintentional deaths; details will help determine effectiveness of current safety features and laws.

REFERENCES

For more information on how to complete the medical certification section of the death certificate, refer to tutorial at http://www.TheNAME.org and resources including instructions and handbooks available by request from NCHS, Room 7318, 3311 Toledo Road, Hyattsville, Maryland 20782-2003 or at www.cdc.gov/nchs/about/major/dvs/handbk.htm

Cause-of-death – Background, Examples, and Common Problems

Accurate cause of death information is important
•to the public health community in evaluating and improving the health of all citizens, and
•often to the family, now and in the future, and to the person settling the decedent's estate.

The cause-of-death section consists of two parts. Part I is for reporting a chain of events leading directly to death, with the immediate cause of death (the final disease, injury, or complication directly causing death) on line a and the underlying cause of death (the disease or injury that initiated the chain of events that led directly and inevitably to death) on the lowest used line. Part II is for reporting all other significant diseases, conditions, or injuries that contributed to death but which did not result in the underlying cause of death given in Part I. The cause-of-death information should be YOUR best medical OPINION. A condition can be listed as "probable" even if it has not been definitively diagnosed.

Examples of properly completed medical certifications

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition ——> resulting in death)	a. Rupture of myocardium	Minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the	b. Acute myocardial infarction	6 days
	Due to (or as a consequence of):	
UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c. Coronary artery thrombosis	5 years
	Due to (or as a consequence of):	
	d. Atherosclerotic coronary artery disease	7 years

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

Diabetes, Chronic obstructive pulmonary disease, smoking

33. WAS AN AUTOPSY PERFORMED? ■ Yes ☐ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ■ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?
■ Yes ☐ Probably
☐ No ☐ Unknown

36. 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

37. MANNER OF DEATH
■ Natural ☐ Homicide
☐ Accident ☐ Pending Investigation
☐ Suicide ☐ Could not be determined

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition ——> resulting in death)	a. Aspiration pneumonia	2 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the	b. Complications of coma	7 weeks
	Due to (or as a consequence of):	
UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	c. Blunt force injuries	7 weeks
	Due to (or as a consequence of):	
	d. Motor vehicle accident	7 weeks

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

33. WAS AN AUTOPSY PERFORMED? ■ Yes ☐ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ■ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?
☐ Yes ☐ Probably
■ No ☐ Unknown

36. 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

37. MANNER OF DEATH
☐ Natural ☐ Homicide
■ Accident ☐ Pending Investigation
☐ Suicide ☐ Could not be determined

38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)	39. TIME OF INJURY	40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area)	41. INJURY AT WORK?
August 15, 2003	Approx. 2320	road side near state highway	☐ Yes ■ No

42. LOCATION OF INJURY: State: Missouri | City or Town: near Alexandria | Street & Number: mile marker 17 on state route 46a | Apartment No.: | Zip Code:

43. DESCRIBE HOW INJURY OCCURRED:

Decedent driver of van, ran off road into tree

44. IF TRANSPORTATION INJURY, SPECIFY:
■ Driver/Operator
☐ Passenger
☐ Pedestrian
☐ Other (Specify)

Common problems in death certification

The elderly decedent should have a clear and distinct etiological sequence for cause of death, if possible. Terms such as senescence, infirmity, old age, and advanced age have little value for public health or medical research. Age is recorded elsewhere on the certificate. When a number of conditions resulted in death, the physician should choose the single sequence that, in his or her opinion, best describes the process leading to death, and place any other pertinent conditions in Part II. If after careful consideration the physician cannot determine a sequence that ends in death, then the medical examiner or coroner should be consulted about conducting an investigation or providing assistance in completing the cause of death.

The infant decedent should have a clear and distinct etiological sequence for cause of death, if possible. "Prematurity" should not be entered without explaining the etiology of prematurity. Maternal conditions may have initiated or affected the sequence that resulted in infant death, and such maternal causes should be reported in addition to the infant causes on the infant's death certificate (e.g., Hyaline membrane disease due to prematurity, 28 weeks due to placental abruption due to blunt trauma to mother's abdomen).

When SIDS is suspected, a complete investigation should be conducted, typically by a medical examiner or coroner. If the infant is under 1 year of age, no cause of death is determined after scene investigation, clinical history is reviewed, and a complete autopsy is performed, then the death can be reported as Sudden Infant Death Syndrome.

When processes such as the following are reported, additional information about the etiology should be reported:

Abscess
Abdominal hemorrhage
Adhesions
Adult respiratory distress syndrome
Acute myocardial infarction
Altered mental status
Anemia
Anoxia
Anoxic encephalopathy
Arrhythmia
Ascites
Aspiration
Atrial fibrillation
Bacteremia
Bedridden
Biliary obstruction
Bowel obstruction
Brain injury
Brain stem herniation
Carcinogenesis
Carcinomatosis
Cardiac arrest
Cardiac dysrhythmia
Cardiomyopathy
Cardiopulmonary arrest
Cellulitis
Cerebral edema
Cerebrovascular accident
Cerebellar tonsillar herniation
Chronic bedridden state
Cirrhosis
Coagulopathy
Compression fracture
Congestive heart failure
Convulsions
Decubiti
Dehydration
Dementia (when not otherwise specified)
Diarrhea
Disseminated intra vascular coagulopathy
Dysrhythmia
End-stage liver disease
End-stage renal disease
Epidural hematoma
Exsanguination
Failure to thrive
Fracture
Gangrene
Gastrointestinal hemorrhage
Heart failure
Hemothorax
Hepatic failure
Hepatitis
Hepatorenal syndrome
Hyperglycemia
Hyperkalemia
Hypovolemic shock
Hyponatremia
Hypotension
Immunosuppression
Increased intra cranial pressure
Intra cranial hemorrhage
Malnutrition
Metabolic encephalopathy
Multi-organ failure
Multi-system organ failure
Myocardial infarction
Necrotizing soft-tissue infection
Old age
Open (or closed) head injury
Paralysis
Pancytopenia
Perforated gallbladder
Peritonitis
Pleural effusions
Pneumonia
Pulmonary arrest
Pulmonary edema
Pulmonary embolism
Pulmonary insufficiency
Renal failure
Respiratory arrest
Seizures
Sepsis
Septic shock
Shock
Starvation
Subdural hematoma
Subarachnoid hemorrhage
Sudden death
Thrombocytopenia
Uncal herniation
Urinary tract infection
Ventricular fibrillation
Ventricular tachycardia
Volume depletion

If the certifier is unable to determine the etiology of a process such as those shown above, the process must be qualified as being of an unknown, undetermined, probable, presumed, or unspecified etiology so it is clear that a distinct etiology was not inadvertently or carelessly omitted.

The following conditions and types of death might seem to be specific or natural but when the medical history is examined further may be found to be complications of an injury or poisoning (possibly occurring long ago). Such cases should be reported to the medical examiner/coroner.

Asphyxia
Bolus
Choking
Drug or alcohol overdose/drug or alcohol abuse
Epidural hematoma
Exsanguination
Fall
Fracture
Hip fracture
Hyperthermia
Hypothermia
Open reduction of fracture
Pulmonary emboli
Seizure disorder
Sepsis
Subarachnoid hemorrhage
Subdural hematoma
Surgery
Thermal burns/chemical burns

REV. 11/2003

FUNERAL DIRECTOR INSTRUCTIONS for selected items on U.S.

Standard Certificate of Death (For additional information concerning all items on certificate see Funeral Directors' Handbook on Death Registration)

ITEM 1. DECEDENT'S LEGAL NAME
Include any other names used by decedent, if substantially different from the legal name, after the abbreviation AKA (also known as) e.g. Samuel Langhorne Clemens AKA Mark Twain, **but not** Jonathon Doe AKA John Doe

ITEM 5. DATE OF BIRTH
Enter the full name of the month (January, February, March etc.) Do not use a number or abbreviation to designate the month.

ITEM 7A-G. RESIDENCE OF DECEDENT (information divided into seven categories)
Residence of decedent is the place where the decedent actually resided. The place of residence is not necessarily the same as "home state" or "legal residence". Never enter a temporary residence such as one used during a visit, business trip, or vacation. Place of residence during a tour of military duty or during attendance at college is considered permanent and should be entered as the place of residence. If the decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in item 7. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. **Never** use an acute care hospital's location as the place of residence for any infant. If Canadian residence, please specify Province instead of State.

ITEM 10. SURVIVING SPOUSE'S NAME
If the decedent was married at the time of death, enter the full name of the surviving spouse. If the surviving spouse is the wife, enter her name prior to first marriage. This item is used in establishing proper insurance settlements and other survivor benefits.

ITEM 12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE
Enter the name used prior to first marriage, commonly known as the maiden name. This name is useful because it remains constant throughout life.

ITEM 14. PLACE OF DEATH
The place where death is pronounced should be considered the place where death occurred. If the place of death is unknown but the body is found in your State, the certificate of death should be completed and filed in accordance with the laws of your State. Enter the place where the body is found as the place of death.

ITEM 51. DECEDENT'S EDUCATION *(Check appropriate box on death certificate)*
Check the box that corresponds to the highest level of education that the decedent completed. **Information in this section will not appear on the certified copy of the death certificate. This information is used to study the relationship between mortality and education (which roughly corresponds with socioeconomic status). This information is valuable in medical studies of causes of death and in programs to prevent illness and death.**

ITEM 52. WAS DECEDENT OF HISPANIC ORIGIN? *(Check "No" or appropriate "Yes" box)*
Check "No" or check the "Yes" box that best corresponds with the decedent's ethnic Spanish identity as given by the informant. Note that "Hispanic" is not a race and item 53 must also be completed. Do not leave this item blank. With respect to this item, "Hispanic" refers to people whose origins are from Spain, Mexico, or the Spanish-speaking Caribbean Islands or countries of Central or South America. Origin includes ancestry, nationality, and lineage. There is no set rule about how many generations are to be taken into account in determining Hispanic origin; it may be based on the country of origin of a parent, grandparent, or some far-removed ancestor. Although the prompts include the major Hispanic groups, other groups may be specified under "other". "Other" may also be used for decedents of multiple Hispanic origin (e.g. Mexican-Puerto Rican). **Information in this section will not appear on the certified copy of the death certificate. This information is needed to identify health problems in a large minority population in the United States. Identifying health problems will make it possible to target public health resources to this important segment of our population.**

ITEM 53. RACE *(Check appropriate box or boxes on death certificate)*
Enter the race of the decedent as stated by the informant. Hispanic is not a race; information on Hispanic ethnicity is collected separately in item 52. American Indian and Alaska Native refer only to those native to North and South America (including Central America) and does not include Asian Indian. Please specify the name of enrolled or principal tribe (e.g., Navajo, Cheyenne, etc.) for the American Indian or Alaska Native. For Asians check Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or specify other Asian group; for Pacific Islanders check Guamanian or Chamorro, Samoan, or specify other Pacific Island group. If the decedent was of mixed race, enter each race (e.g., Samoan-Chinese-Filipino or White, American Indian). **Information in this section will not appear on the certified copy of the death certificate. Race is essential for identifying specific mortality patterns and leading causes of death among different racial groups. It is also used to determine if specific health programs are needed in particular areas and to make population estimates.**

ITEMS 54 AND 55. OCCUPATION AND INDUSTRY
Questions concerning occupation and industry must be completed for all decedents 14 years of age or older. This information is useful in studying deaths related to jobs and in identifying any new risks. For example, the link between lung disease and lung cancer and asbestos exposure in jobs such as shipbuilding or construction was made possible by this sort of information on death certificates. **Information in this section will not appear on the certified copy of the death certificate.**

ITEM 54. DECEDENT'S USUAL OCCUPATION
Enter the usual occupation of the decedent. This is not necessarily the last occupation of the decedent. Never enter "retired". Give kind of work decedent did during most of his or her working life, such as claim adjuster, farmhand, coal miner, janitor, store manager, college professor, or civil engineer. If the decedent was a homemaker at the time of death but had worked outside the household during his or her working life, enter that occupation. If the decedent was a homemaker during most of his or her working life, and never worked outside the household, enter "homemaker". Enter "student" if the decedent was a student at the time of death and was never regularly employed or employed full time during his or her working life. **Information in this section will not appear on the certified copy of the death certificate.**

ITEM 55. KIND OF BUSINESS/INDUSTRY
Kind of business to which occupation in item 54 is related, such as insurance, farming, coal mining, hardware store, retail clothing, university, or government. DO NOT enter firm or organization names. If decedent was a homemaker as indicated in item 54, then enter either "own home" or "someone else's home" as appropriate. If decedent was a student as indicated in item 54, then enter type of school, such as high school or college, in item 55. **Information in this section will not appear on the certified copy of the death certificate.**

NOTE: This recommended standard death certificate is the result of an extensive evaluation process. Information on the process and resulting recommendations as well as plans for future activities is available on the Internet at: http://www.cdc.gov/nchs/vital_certs_rev.htm.

REV. 11/2003

2003

MONTANA CERTIFICATE OF DEATH

Local File Number: State File Number

To Be Completed By: Funeral Director

DECEDENT'S NAME (*First, Middle, Last*) | AKA'S If Any | 29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month)

Sex	SOCIAL SECURITY NUMBER	Age – Last Birthday (Years)	4 b. Under 1 Year Months	Days	4c. Under 1 Day Hours	Minutes	DATE OF BIRTH (Month, Day, Year)	COUNTY OF DEATH
2.	3.	4a.					5.	17.

14. PLACE OF DEATH (*Check only one*) HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ Dead on Arrival

OTHER: ☐ Nursing Home/Long term care facility ☐ Residence ☐ Hospice ☐ Other (Specify)

FACILITY NAME (*If not institution, give street and number*) 15.

CITY, TOWN OR LOCATION OF DEATH 16.

BIRTHPLACE (City, and State or Foreign Country) 6.

9. MARITAL STATUS ☐ Never Married ☐ Widowed ☐ Married ☐ Married but separated ☐ Divorced ☐ Unknown

SURVIVING SPOUSE (If wife, give last name before first marriage) 10.

DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life.) (Do not use retired) 54.

KIND OF BUSINESS/INDUSTRY 55.

WAS DECEDENT EVER IN U. S. ARMED FORCES? 8. ☐ Yes ☐ No

7a.RESIDENCE- State	7b.COUNTY	7c.CITY, TOWN, OR LOCATION	7d. STREET NUMBER	7f.ZIP CODE	7g. INSIDE CITY LIMITS
					☐ Yes ☐ No

51. DECEDENT'S EDUCATION (Specify only the highest diploma or degree received)
- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no degree
- ☐ Associates 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)

52. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if the decedent is not Spanish/Hispanic/Latino.
- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify)

53. DECEDENT'S RACE (Check one or more races to indicate what the decedents considers himself or herself to be)
- ☐ White
- ☐ Black African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify)
- ☐ Other Pacific Islander (Specify)
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)
- ☐ Other (Specify)

11. FATHER'S NAME (First, Middle, Last)

12. MOTHERS NAME (First, Middle, last name before first marriage)

13a. INFORMANT'S NAME

RELATIONSHIP TO DECEDENT 13b.

MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13c.

METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Removal from State 18. ☐ Entombment ☐ Donation ☐ Other (Specify)

PLACE OF DISPOSITION (Name of Cemetery, crematory, or other place) 19.

LOCATION –City or Town, State 20.

SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER PERSON IN CHARGE OF DISPOSITION 22.

MONTANA LICENSE NUMBER (of licensee if applicable) 23.

NAME AND ADDRESS OF FUNERAL FACILITY 21.

To Be Completed By: Medical Certifier

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Year)

25. TIME PRONOUNCED DEAD

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)

27. LICENSE NUMBER

28. DATE SIGNED (Mo/Day/Year)

30. ACTUAL OR PRESUMED TIME OF DEATH

31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART I Enter the chain of events –disease, injuries, or complications– that directly caused the death. DO NOT enter terminal events such as cardiac or respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on each line. Add additional lines if necessary.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (final disease or Condition resulting in death)	a.	
Sequentially list conditions if any, leading to cause listed on line a. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death.) Last	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part 1

WAS AN AUTOPSY PERFORMED? 33. ☐ Yes ☐ No

34. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH ☐ Yes ☐ No

37. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be Determined

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

36. IF FEMALE: ☐ Not pregnant within past year ☐ Not pregnant but pregnant within 42 days of death ☐ Not pregnant but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Unknown if pregnant within past year

DATE OF INJURY (Month, Day, Year) 38.	TIME OF INJURY 39.	INJURY AT WORK 41. ☐ Yes ☐ No	40. PLACE OF INJURY (E.g. Decedent's Home, Construction Site, Restaurant, wooded area)	44. IF TRAFFIC ACCIDENT SPECIFY ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (specify)

43. DESCRIBE HOW INJURY OCCURRED

LOCATION (Street and Number or Rural Route Number, City, Town, State, zip Code) 42.

45. TO BE COMPLETED BY CERTIFIER. (A certifier can be a MD, PA, APRN, or coroner)
- ☐ Certifying Physician: To the best of my knowledge death occurred at the time, date, and place and due to cause(s) and manner stated
- ☐ Pronouncing and Certifying Physician: To the best of my Knowledge death occurred at the time, date, and place and due to cause(s) and manner stated.
- ☐ Medical Examiner/Coroner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and place and due to the cause(s) and manner stated.

SIGNATURE

DATE CERTIFIED (Month, Day, Year) 49.

48. LICENSE NUMBER

47. Title

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Standardized Vital Statistics Reporting Act

An Act

To adopt and implement standardized vital statistics reporting forms.

Be it enacted by the [General Assembly] of the State/Commonwealth of _____ :

Section 1. Title.

This Act shall be known and may be cited as "The Standardized Vital Statistics Reporting Act of _____".

Section 2. Findings.

The [General Assembly] makes the following findings:

(1) [State/Commonwealth] should collect and report birth and death information in a standardized manner to promote the health of women and infants.

(2) Adoption of the most recent U.S. Standard Certificate of Live Birth and use of the National Center for Health Statistics' most recent recommended standard collection and reporting forms and worksheets, standardized definitions, and classification guidelines will help reduce [State's/Commonwealth's] infant mortality,

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premature and low birth weight births, maternal mortality and morbidity, disparities in health status, and aid in the prevention of perinatal mortality and morbidity statewide.

(3) Adoption of the most recent U.S. Standard Certificate of Death and use of the National Center for Health Statistics' most recent recommended standard collection and reporting forms and worksheets, standardized definitions, and classification guidelines will address the under-reporting and variable reporting of maternal deaths and increase the accuracy and reliability of state and national comparative data and rankings, which will help lead to the reduction of maternal mortality and morbidity.

(4) Adoption of the most recent U.S. Standard Report of Fetal Death and use of the National Center of Health Statistics' most recent recommended standard collection and reporting forms and worksheets, standardized definitions, and classification guidelines will help our State/Commonwealth reduce the incidence of premature and low birth weight births and lead to improved prevention strategies for the future.

Section 3. Definitions.

In this Act—

(1) the term "live birth" means the complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached, but heartbeats are to be distinguished from

transient cardiac contractions, and respirations are to be distinguished from fleeting respiratory efforts or gasps;

(2) the term "pregnancy-associated death" means the death of any woman, from any cause, while pregnant or within one calendar year of termination of pregnancy, regardless of the duration and the site of pregnancy;

(3) the term "pregnancy-related death" means a pregnancy-associated death resulting from:

(A) complications of the pregnancy itself;

(B) the chain of events initiated by the pregnancy that led to death; or

(C) aggravation of an unrelated condition by the physiologic or pharmacologic effects of the pregnancy that subsequently caused death;

(4) the term "vital records" means certificates or reports of birth, death, marriage, (divorce, dissolution of marriage, or annulment) and data related thereto; and

(5) the term "vital statistics" means the data derived from certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage, [divorce, dissolution of marriage, annulment], and related reports.

Section 4. Adoption of Standardized Collection and Reporting Methods.

(a) STANDARD CERTIFICATES OF BIRTH AND DEATH.—The [Secretary/Commissioner] of the Department of [Public Health/Human Services] may adopt and implement use of the U.S. Standard Certificate of Live Birth, U.S. Standard

Certificate of Death, and U.S. Standard Report of Fetal Death, each as promulgated most recently by the National Center for Health Statistics, for use by the [Office of Vital Statistics] to record [State's/Commonwealth's] vital statistics concerning births, deaths, and related health and demographic information.

(b) STANDARD COLLECTION AND REPORTING FORMS AND WORKSHEETS.—The [Secretary/Commissioner] of the Department of [Public Health/Human Services] may adopt and implement use of the collection and reporting forms and worksheets most recently recommended by the American Congress of Obstetricians and Gynecologists and the National Center for Health Statistics, including the reporting of fetal deaths at 20 weeks or greater of gestation or a weight greater than or equal to 350 grams if the gestational age is not known.

(c) STANDARD TERMINOLOGY.—The [Secretary/Commissioner] of the Department of [Public Health/Human Services] may adopt and implement use of the standardized terminology most recently recommended by the American Congress of Obstetricians and Gynecologists and the National Center for Health Statistics, including use of the terms pregnancy-associated death and pregnancy-related death as they are defined in section 3 of this Act.

(d) CLASSIFICATION GUIDELINES.—The [Secretary/Commissioner] of the Department of [Public Health/Human Services] may adopt and implement use of the classification guidelines most recently recommended by the American Congress of Obstetricians and Gynecologists and the National Center for Health Statistics.

(e) TRAINING.—The [Secretary/Commissioner] of the Department of [Public Health/Human Services] may implement training programs, including training in any standard web-based applications available through the [State Office of Vital Statistics], directed to birth clerks and hospitals and physicians concerning the proper use of the standard collection and reporting forms and worksheets, standardized definitions, and classification guidelines adopted by the [Secretary/Commissioner] pursuant to this Act.

(f) PUBLIC HEALTH CAMPAIGNS.—The [Secretary/Commissioner] of the Department of [Public Health/Human Services] may act to ensure that current and future public health campaigns promoting maternal and child health include a focus on the importance of universal and uniform reporting of vital birth and death statistics.

Section 5. Authorization of Appropriations.

Such sums as may be necessary to carry out the purposes of this Act are authorized to be appropriated.

Section 6. Effective Date.

This Act shall take effect _____ , the public welfare requiring it.

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Standardized Vital Statistics Reporting Act

Model Statement of Introduction

Because high quality health care data is so important to improving the health of women and infants, including the reduction of premature and low birth weight births, maternal mortality and morbidity, and disparities in health status, today we introduce the Standardized Vital Statistics Reporting Act of Act _____ (SVSRA). SVSRA authorizes the [Secretary/Commissioner] of the Department of [Public Health/Human Services] to adopt and implement the use of standardized certificates, forms, worksheets, terminology, and classification guidelines for collecting and recording vital birth and death information. [State/Commonwealth] should collect and report birth and death information in a standardized manner to address the problem of under-reporting and variable reporting and to increase the accuracy and reliability of state and national comparative data and rankings, which will aid our efforts to improve public health. In particular, infant mortality rates are one of the most widely used measures to assess the overall health of our communities, and standardized collection and reporting systems, as well as high quality data, are invaluable tools in the ongoing struggle to prevent such tragedies. Likewise, maternal mortality and morbidity can be reduced by adopting strategies based on high quality data obtained through standardized methods of collection and reporting.

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Birth and death certificates are a source of credible vital and health statistics for use in studying and improving public health by research institutions, government, and the general public. For example, the information collected on birth and death certificates can help our State/Commonwealth improve perinatal outcomes, direct public health monitoring, inform national women's health research, and encourage state and national legislative action to improve the health of mothers and their children. Therefore, under SVSRA, the [Secretary/Commissioner] will be authorized to adopt and implement the most recent U.S. Standard Certificate of Live Birth, the U.S. Standard Certificate of Death, and the U.S. Standard Report of Fetal Death, as well as the associated standard worksheets, forms, and terminology.

The National Center for Health Statistics (NCHS) offers guidance to state and local registration officials concerning the development and promotion of standard certificates and reporting forms, including the U.S. Standard Certificate of Live Birth, the U.S. Standard Certificate of Death, and the U.S. Standard Report of Fetal Death. Numerous organizations support a uniform standard for vital records collection and reporting, including the American Congress of Obstetricians and Gynecologists, American Academy of Pediatrics, March of Dimes, American Medical Association, Centers for Disease Control and Prevention, American Public Health Association, American Bar Association, and the American Statistical Association.

The NCHS-recommended standardized birth and death certificates are the result of extensive evaluation and are designed to collect important medical and health information on mothers and their infants. For example, under SVSRA, the NCHS's most recently recommended Standard Certificate of Live Birth would collect information

concerning the utilization of prenatal care, a newborn's Apgar score, and important maternal demographic information. Use of the standard birth certificate would also prevent the misclassification of important information, including the mother's place of delivery and neonatal and maternal outcomes. It would also help ensure the accurate collection and reporting of birth outcomes in different birth settings, including accurately classifying the type of birth attendant.

Under SVSRA, the Standard Certificate of Death would include a checkbox on death certificates identifying whether a woman was pregnant at the time of her death or shortly before. It would also use standard terms that differentiate between pregnancy-associated death and pregnancy-related death. Together, these steps will help increase the accuracy and reliability of state and national comparative data and ultimately lead to reduced maternal mortality and morbidity. This approach also is recommended by the American Congress of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the Centers for Disease Control and Prevention.

Finally, under SVSRA, the [Secretary/Commissioner] is authorized to collect and report fetal deaths by both birth weight and gestational age and adopt the NCHS's most recently recommended Standard Report of Fetal Death. This will help reduce infant mortality and morbidity. Tragically, the number of babies that die in [State/Commonwealth] each year before they reach their first birthday is __, and [State/Commonwealth] ranks ___ in infant mortality in the United States. The infant mortality rate nationally is especially high at 6.9 infant deaths per 1,000 live births, and the United States ranks 30th among developed countries. Yet we know standardized collection and reporting systems and high quality data are invaluable tools in the ongoing

struggle to improve those statistics. The American Congress of Obstetricians and Gynecologists and the NCHS advise that fetal deaths can be reported most reliably by using the recommended birth weight and gestational age criteria. They also recommend that states report fetal deaths of a weight 350 grams or greater if the gestational age is not known, or at 20 weeks or greater of gestation if the gestational age is known. The Standard Report of Fetal Death allows us to record this important data, which ultimately helps reduce the incidence of premature, low birth weight and very low birth weight births and leads to improved prevention strategies for the future.

In short, passage of SVSRA is an important step that will give us the data we need to reduce maternal and infant mortality and morbidity. We urge our colleagues to support this vital effort and pass this important legislation. After all, protecting and improving the health of mothers and infants is fundamental to the health and future prosperity of our State/Commonwealth.

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