

# APPENDIX

Kansas Department Of Health And Environment  
Office of Vital Statistics

**CERTIFICATE OF DEATH**

State File Number

1. DECEDENT'S LEGAL NAME (First, Middle, Last)		2. SEX	3. IF FEMALE, NAME PRIOR TO FIRST MARRIAGE		4. DATE OF DEATH (Month, Day, Year)		
5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH (Month, Day, Year)	7a. AGE-Last Birthday (Years)	7b. UNDER 1 YEAR Months    Days	7c. UNDER 1 DAY Hours    Minutes	8. PLACE OF BIRTH (City and State or Foreign Country)		
9. WAS DECEDENT EVER IN U.S. ARMED FORCES?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	10a. PLACE OF DEATH (Check only one)						
	HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> DOA <input type="checkbox"/> ER/Outpatient		<input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Decedent's Residence <input type="checkbox"/> Other (Specify) _____				
10b. FACILITY NAME (If not institution, give street and number)		10c. COUNTY OF DEATH		10d. CITY OR TOWN OF DEATH		10e. ZIP CODE	
11. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				12. SURVIVING SPOUSE (If wife, give name before first marriage)			
13a. RESIDENCE-STREET ADDRESS & APARTMENT NO.				13b. STATE			
13c. COUNTY		13d. CITY OR TOWN		13e. ZIP CODE	13f. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
14. FATHER'S NAME (First, Middle, Last)			15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)				
16a. INFORMANT'S NAME (First, Middle, Last)		16b. MAILING ADDRESS (Street and Number, City, State, Zip Code)			16c. RELATIONSHIP TO DECEDENT		
17. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify) _____		18a. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)		18b. LOCATION-City or Town, and State			
19. FUNERAL SERVICE LICENSEE & LICENSE NO. (Signature)			20. NAME OF EMBALMER & LICENSE NO.				
21. NAME AND ADDRESS OF FIRM							
22. CAUSE OF DEATH - 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.							
IMMEDIATE CAUSE (Final disease or condition resulting in death)						Approximate Interval: Onset to Death	
a. DUE TO (OR AS A CONSEQUENCE OF)						.....	
Sequentially list conditions, if any, leading to immediate 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. DUE TO (OR AS A CONSEQUENCE OF)						.....	
PART II. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part I.			23a. AUTOPSY <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable	23c. WAS CORONER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
24. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	25. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the last year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death			26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined			
27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY A.M. P.M.	27c. INJURY AT WORK <input type="checkbox"/> Yes <input type="checkbox"/> No	27d. DESCRIBE HOW INJURY OCCURRED				
27e. PLACE OF INJURY-Residence, farm, street, factory, building, etc. (Specify)			27f. LOCATION (Street and Number or Rural Route, City or Town, State, Zip Code)				
28a. DATE PRONOUNCED DEAD (Month, Day, Year)	28b. TIME PRONOUNCED DEAD A.M. P.M.	28c. ACTUAL OR PRESUMED TIME OF DEATH A.M. P.M.	28d. NAME OF PERSON PRONOUNCING DEATH (If applicable)		28e. LICENSE NO.		
29a. CERTIFIER (Check only one) <input type="checkbox"/> Certifying physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 >			LICENSE NO.	DATE CERTIFIER SIGNED			
29b. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH			<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> SPEC. DEPUTY	30. DATE FILED BY STATE REGISTRAR (Month, Day, Year)			

<p>31. ANCESTRY-What is this person's ancestry or ethnic origin? Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)</p>	<p>33. RACE (Check one or more boxes to indicate what race(s) the decedent considered himself or herself to be.)</p>	<p>34. EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death.)</p>
<p>32. HISPANIC ORIGIN (Check the box or boxes that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "no" box if the decedent is not Spanish/Hispanic/Latino)</p>	<p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes)</p> <p>_____</p>	<p><input type="checkbox"/> 8<sup>th</sup> grade or less</p> <p><input type="checkbox"/> 9<sup>th</sup> - 12<sup>th</sup> grade; no diploma</p> <p><input checked="" type="checkbox"/> High school graduate or GED</p> <p><input type="checkbox"/> Some College credit, but no degree</p> <p><input type="checkbox"/> Associate degree (e.g., AA, AS)</p> <p><input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)</p> <p><input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)</p> <p><input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)</p> <p><input type="checkbox"/> Unknown</p>
<p><input type="checkbox"/> No, not Spanish/Hispanic/Latino</p> <p><input type="checkbox"/> Yes, Mexican/Mexican American/Chicano</p> <p><input type="checkbox"/> Yes, Puerto Rican</p> <p><input type="checkbox"/> Yes, Cuban</p> <p><input type="checkbox"/> Yes, Central American</p> <p><input type="checkbox"/> Yes, South American</p> <p><input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify)</p> <p>_____</p> <p><input type="checkbox"/> Unknown</p>	<p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian (Specify)</p> <p>_____</p> <p>_____</p>	<p>35. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)</p>
	<p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input checked="" type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Other Pacific Islander (Specify)</p> <p>_____</p> <p><input checked="" type="checkbox"/> Other (Specify)</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Unknown</p>	<p>36. KIND OF BUSINESS/INDUSTRY (Do not give name of company.)</p>

Kansas Department of Health and Environment  
Office of Vital Statistics

**CERTIFICATE OF LIVE BIRTH**

115-

State File Number

1. CHILD'S NAME (First, Middle, Last, Suffix)		2. DATE OF BIRTH (Month, Day, Year)		3. TIME OF BIRTH  M	
4. SEX	5. BIRTH WEIGHT (Grams)	6. CITY, TOWN, OR LOCATION OF BIRTH		7. COUNTY OF BIRTH	
8. PLACE OF BIRTH <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Home Birth <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Other (Specify) _____			9. FACILITY NAME (if not institution, give street and number)		
10. I CERTIFY THAT THE STATED INFORMATION CONCERNING THIS CHILD IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.  Certifier's Signature ➤ _____		11. DATE SIGNED (Month, Day, Year)	12. ATTENDANT'S NAME AND TITLE (Type) 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) _____		
13. Certifier's Name and Title (Type) Name _____ <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Hosp Adm. <input type="checkbox"/> C.N.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify) _____		14. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route, City, or Town, State, Zip Code)			
15. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			16. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE		
17. DATE OF BIRTH (Month, Day, Year)		18. BIRTHPLACE (State, Territory, or Foreign Country)		19. PRESENT RESIDENCE-STATE	
20. COUNTY		21. CITY, TOWN, OR LOCATION		22. STREET AND NUMBER OF PRESENT RESIDENCE	
23. ZIP CODE	24. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	25. MOTHER'S MAILING ADDRESS (if same as residence, leave blank)			
26. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		27. DATE OF BIRTH (Month, Day, Year)		28. BIRTHPLACE (State, Territory, or Foreign Country)	
29. PARENTS REQUEST SOCIAL SECURITY NUMBER ISSUANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		30. IMMUNIZATION REGISTRY I wish to enroll my child in the Immunization Registry <input type="checkbox"/> YES <input type="checkbox"/> NO			
31. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THE CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.  Signature of Parent (or Other Informant) ➤ _____		32. DATE SIGNED (Month, Day, Year)		33. DATE FILED BY STATE REGISTRAR (Month, Day, Year) (Vital Statistics only)	

34. IF HOME BIRTH, WAS DELIVERY PLANNED AT HOME? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
35. MOTHER'S SOCIAL SECURITY NUMBER	36. FATHER'S SOCIAL SECURITY NUMBER
37a. WAS MOTHER EVER MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
37b. MOTHER MARRIED? (At birth, conception or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
37c. IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
37d. MOTHER REFUSES TO GIVE HUSBAND'S INFORMATION <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. WHAT IS THE PRIMARY LANGUAGE SPOKEN IN THE HOME? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Ukrainian <input type="checkbox"/> Mandarin <input type="checkbox"/> Cantonese <input type="checkbox"/> Sign Language <input type="checkbox"/> Other (Specify) _____	
39. PARENT'S HISPANIC ORIGIN (Check the box or boxes that best describes whether the parent is Spanish, Hispanic, or Latino. Check the "No" box if the parent is not Spanish, Hispanic, or Latino.)	
39a. MOTHER	39b. FATHER
<input type="checkbox"/> No, not Spanish/Hispanic/Latina	<input type="checkbox"/> No, not Spanish/Hispanic/Latino
<input type="checkbox"/> Yes, Mexican/Mexican American/Chicana	<input type="checkbox"/> Yes, Mexican/Mexican American/Chicano
<input type="checkbox"/> Yes, Puerto Rican	<input type="checkbox"/> Yes, Puerto Rican
<input type="checkbox"/> Yes, Cuban	<input type="checkbox"/> Yes, Cuban
<input type="checkbox"/> Yes, Central American	<input type="checkbox"/> Yes, Central American
<input type="checkbox"/> Yes, South American	<input type="checkbox"/> Yes, South American
<input type="checkbox"/> Yes, other Spanish/Hispanic/Latina	<input type="checkbox"/> Yes, other Spanish/Hispanic/Latino
(Specify) _____	(Specify) _____
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
40. PARENT'S RACE (Check one or more races to indicate what you consider yourself to be.)	
40a. MOTHER	40b. FATHER
<input type="checkbox"/> White	<input type="checkbox"/> White
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American
<input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) _____	<input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) _____
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Asian Indian
<input type="checkbox"/> Chinese	<input type="checkbox"/> Chinese
<input type="checkbox"/> Filipino	<input type="checkbox"/> Filipino
<input type="checkbox"/> Japanese	<input type="checkbox"/> Japanese
<input type="checkbox"/> Korean	<input type="checkbox"/> Korean
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Other Asian (Specify) _____	<input type="checkbox"/> Other Asian (Specify) _____
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Samoan	<input type="checkbox"/> Samoan
<input type="checkbox"/> Other Pacific Islander (Specify) _____	<input type="checkbox"/> Other Pacific Islander (Specify) _____
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
41. ANCESTRY - What is the parents' ancestry or ethnic origin? - Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)	
42. OCCUPATION AND BUSINESS/INDUSTRY	
Occupation	Business/Industry (Do not give name of company.)
41a. MOTHER	42a. MOTHER (Most recent)
41b. FATHER	42b. FATHER (Usual)
42c. MOTHER	42d. FATHER
43. EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery.)	
43a. MOTHER'S EDUCATION	43b. FATHER'S EDUCATION
<input type="checkbox"/> 8 <sup>th</sup> grade or less	<input type="checkbox"/> 8 <sup>th</sup> grade or less
<input type="checkbox"/> Some College credit, but no degree	<input type="checkbox"/> Some College credit, but no degree
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)	<input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
<input type="checkbox"/> 9 <sup>th</sup> - 12 <sup>th</sup> grade; no diploma	<input type="checkbox"/> 9 <sup>th</sup> - 12 <sup>th</sup> grade; no diploma
<input type="checkbox"/> Associate degree (e.g., AA,AS)	<input type="checkbox"/> Associate degree (e.g., AA,AS)
<input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)	<input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)
<input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	<input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
<input type="checkbox"/> High school graduate or GED	<input type="checkbox"/> High school graduate or GED
44. PREVIOUS LIVE BIRTHS (Do not include this child.)	
44a. Now living Number _____	44b. Now dead Number _____
<input type="checkbox"/> None	<input type="checkbox"/> None
45. NUMBER OF OTHER OUTCOMES (Spontaneous or induced losses or ectopic or stillbirth pregnancies)	
45a. Before 20 weeks Number _____	45b. 20 weeks & over Number _____
<input type="checkbox"/> None	<input type="checkbox"/> None
46. PRENATAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
47. DATE OF FIRST PRENATAL CARE VISIT (Month, Day, Year)	
48. DATE OF LAST PRENATAL CARE VISIT (Month, Day, Year)	
49. PRENATAL VISITS-Total Number (If none, enter "0")	
50. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	
51. OBSTETRIC ESTIMATE OF GESTATION (Completed Weeks)	
52. PLURALITY-Single, Twin, Triplet, etc. (Specify)	53. IF NOT A SINGLE BIRTH - Born First, Second, Third, etc. (Specify)
54. TOTAL LIVE BIRTHS AT THIS DELIVERY	
55. IS INFANT ALIVE AT THE TIME OF THIS REPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
56. IS INFANT BEING BREAST-FED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
57. CIGARETTE SMOKING BEFORE & DURING PREGNANCY: Did mother smoke 3 mos. before or during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked <b>per day</b> during each time period. If none, enter "0".	
Average number of cigarettes or packs of cigarettes <b>smoked per day</b> for each period:	
No. No.	
Three months before pregnancy: _____ cigarettes or _____ packs	
First three months of pregnancy: _____ cigarettes or _____ packs	
Second three months of pregnancy: _____ cigarettes or _____ packs	
Third Trimester of pregnancy: _____ cigarettes or _____ packs	
58. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Employer Ins. <input type="checkbox"/> Self-pay	
<input type="checkbox"/> Indian Health Service <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Other government	
<input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown	
59. MOTHER'S MEDICAL RECORD NO.	60. NEWBORN'S MEDICAL RECORD NO.
61. MOTHER TRANSFERRED IN FOR DELIVERY DUE TO MATERNAL, MEDICAL, OR FETAL INDICATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enter facility name)	
62. INFANT TRANSFERRED (Within 24 hours of delivery) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enter facility name)	
FACILITY TRANSFERRED FROM:	
FACILITY TRANSFERRED TO:	

CHILD'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

PRENATAL (Birth)	LABOR-DELIVERY/NEWBORN				
<b>63. NUTRITION OF MOTHER</b> 1. Height _____ 2. Prepregnancy Weight _____ 3. Weight at delivery _____ 4. Did mother get WIC food for herself? Yes _____ No _____ Unknown _____	<b>66. OBSTETRICAL PROCEDURES</b> (Check all that apply.) 1. <input type="checkbox"/> Cervical cerclage 2. <input type="checkbox"/> Tocolysis 3. External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed 4. <input type="checkbox"/> None of the above	<b>70. INFECTIONS PRESENT AND/OR TREATED</b> (During this pregnancy, check all that apply.) 1. <input type="checkbox"/> Gonorrhea 2. <input type="checkbox"/> Syphilis 3. <input type="checkbox"/> Herpes Simplex Virus (HSV) 4. <input type="checkbox"/> Chlamydia 5. <input type="checkbox"/> Hepatitis B 6. <input type="checkbox"/> Hepatitis C 7. <input type="checkbox"/> AIDS or HIV antibody 8. <input type="checkbox"/> None of the above			
	<b>64. MEDICAL RISK FACTORS</b> (Check all that apply.) 1. <input type="checkbox"/> Diabetes, prepregnancy 2. <input type="checkbox"/> Diabetes, gestational 3. Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia 4. <input type="checkbox"/> Previous preterm birth 5. <input type="checkbox"/> Other previous poor pregnancy outcome (SGA, perinatal death, etc.) 6. <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to labor 7. <input type="checkbox"/> Pregnancy resulted from infertility treatment (If yes, check all that apply.) <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)) 8. <input type="checkbox"/> Mother had a previous cesarean delivery, if yes, how many? Number: _____ 9. <input type="checkbox"/> Alcohol use No. of drinks per week: _____ 10. <input type="checkbox"/> None of the above	<b>67. ONSET OF LABOR</b> (Check all that apply.) 1. <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, $\geq 12$ hours) 2. <input type="checkbox"/> Precipitous Labor (< 3 hrs) 3. <input type="checkbox"/> Prolonged Labor ( $\geq 20$ hrs) 4. <input type="checkbox"/> None of the above	<b>71. ABNORMAL CONDITIONS OF NEWBORN</b> (Check all that apply) 1. <input type="checkbox"/> Assisted ventilation required immediately following delivery 2. <input type="checkbox"/> Assisted ventilation required for more than six hours 3. <input type="checkbox"/> NICU admission 4. <input type="checkbox"/> Newborn given surfactant replacement therapy 5. <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis 6. <input type="checkbox"/> Seizure or serious neurologic dysfunction 7. <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) 8. <input type="checkbox"/> None of the above		
<b>65. METHOD OF DELIVERY</b> 1. Forceps attempted? Yes _____ No _____ Successful Yes _____ No _____ 2. Vacuum extraction attempted? Yes _____ No _____ Successful Yes _____ No _____ 3. Fetal presentation at delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other 4. Final route and method of delivery (check one) <input type="checkbox"/> Vaginal/spontaneous <input type="checkbox"/> Vaginal/forceps <input type="checkbox"/> Vaginal/vacuum <input type="checkbox"/> Cesarean, if cesarean was a trial of labor attempted? Yes _____ No _____	<b>68. CHARACTERISTICS OF LABOR AND DELIVERY</b> (Check all that apply.) 1. <input type="checkbox"/> Induction of labor 2. <input type="checkbox"/> Augmentation of labor 3. <input type="checkbox"/> Non-vertex presentation 4. <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery 5. <input type="checkbox"/> Antibiotics received by the mother during labor 6. <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38$ C (100.4 F) 7. <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid 8. <input type="checkbox"/> Fetal intolerance of labor: (examples: in-utero resuscitative measures, further fetal assessment, or operative delivery) 9. <input type="checkbox"/> Epidural or spinal anesthesia during labor 10. <input type="checkbox"/> None of the above	<b>72. VACCINES ADMINISTERED TO NEWBORN</b> 1. <input type="checkbox"/> Hepatitis B Date Given: _____ 2. <input type="checkbox"/> Other* Specify: _____ Date Given: _____			
	<b>69. MATERNAL MORBIDITY</b> (Check all that apply.) (These are complications associated with labor and delivery.) 1. <input type="checkbox"/> Maternal transfusion 2. <input type="checkbox"/> Third or fourth degree perineal laceration 3. <input type="checkbox"/> Ruptured uterus 4. <input type="checkbox"/> Unplanned hysterectomy 5. <input type="checkbox"/> Admission to intensive care unit 6. <input type="checkbox"/> Unplanned operating room procedure following delivery 7. <input type="checkbox"/> None of the above	<b>73. APGAR SCORE</b> <table border="1"> <tr> <td>1 min</td> <td>5 min</td> <td>10 min</td> </tr> </table>		1 min	5 min
1 min	5 min	10 min			
		<b>74. CONGENITAL ANOMALIES OF THE NEWBORN</b> (Check all that apply.) 1. <input type="checkbox"/> Anencephaly 2. <input type="checkbox"/> Meningomyelocele/Spina bifida 3. <input type="checkbox"/> Cyanotic congenital heart disease 4. <input type="checkbox"/> Congenital diaphragmatic hernia 5. <input type="checkbox"/> Omphalocele 6. <input type="checkbox"/> Gastroschisis 7. <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) 8. <input type="checkbox"/> Cleft Lip with or without Cleft Palate 9. <input type="checkbox"/> Cleft Palate alone 10. <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending 11. <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending 12. <input type="checkbox"/> Hypospadias 13. <input type="checkbox"/> Fetal alcohol syndrome 14. <input type="checkbox"/> Other congenital anomalies (Specify) _____ 15. <input type="checkbox"/> None of the above			

Parent's Telephone Number: \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

<p>Test required by K.S.A. 65-153f 153G Serological Test Made:</p> <p>_____ 1<sup>st</sup> _____ 2<sup>nd</sup> _____ 3<sup>rd</sup> (Trimester) _____ At Delivery _____ Not Performed</p> <p>If no test made, state reason:</p>	<p>Test required by K.S.A. 65-180 Infant Neonatal Screening specimen taken:</p> <p>_____ Yes _____ No</p> <p>Kit Number _____</p> <p>If no test made, state reason:</p>	<p>Test required by K.S.A. 65-1157A Newborn Hearing Screening Accomplished:</p> <p>_____ Yes _____ No</p>
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Infant's patient number: \_\_\_\_\_

Infant's Primary Care Physician

First	Middle	Last	Title (MD, DO, etc.)
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<p>If screening accomplished, Date hearing screened _____</p> <p>Month / Day / Year</p>	<p>The results of the hearing screening ✓:</p> <p>Right ear: _____ Pass _____ Refer for further testing Left ear: _____ Pass _____ Refer for further testing</p>
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Physiologic equipment used ✓: \_\_\_\_\_ OAE \_\_\_\_\_ AABR \_\_\_\_\_ ABR

If screening not accomplished, ✓ one reason:

_____ b – missed appointment	_____ o – other
_____ c – could not test	_____ r – did not consent
_____ d – deceased	_____ s – scheduled but not completed
_____ i – Incomplete test	_____ t – transferred to another hospital
_____ m – Infant discharged before screening	_____ u – no information
_____ n – transferred to NICU	_____ x – invalid results

Kansas Department of Health and Environment  
Office of Vital Statistics

**CERTIFICATE OF STILLBIRTH (FETAL DEATH)**

**State File Number**

1. NAME (First, Middle, Last, Suffix)		2. DATE OF DELIVERY (Month, Day, Year)	3. TIME OF DELIVERY M
4. SEX	5. CITY, TOWN, OR LOCATION OF DELIVERY		6. COUNTY OF DELIVERY
7. PLACE OF DELIVERY <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Home Delivery <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Other (Specify) _____		8. FACILITY NAME (If not institution, give street and number and zip code)	
9. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			10. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE
11. DATE OF BIRTH (Month, Day, Year)	12. BIRTHPLACE (State, Territory, or Foreign Country)		13. PRESENT RESIDENCE-STATE
14. COUNTY	15. CITY, TOWN, OR LOCATION	16. STREET AND NUMBER OF PRESENT RESIDENCE	
17. ZIPCODE	18. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. MOTHER'S MAILING ADDRESS (If same as residence, leave blank)	
20. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		21. DATE OF BIRTH (Month, Day, Year)	22. BIRTHPLACE (State, Territory, or Foreign Country)
23. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THE CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.  Signature of Parent (or Other Informant) >			24. DATE SIGNED (Month, Day, Year)
<b>25. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH</b>			
25a. INITIATING CAUSE/CONDITION (Among the choices below, please select the <u>one</u> which most likely began the sequence of events resulting in the death of the fetus.)			
Maternal Conditions/Diseases (Specify) _____			
Complications of Placenta, Cord, or Membranes – <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord			
<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____			
Other Obstetrical or Pregnancy Complications (Specify) _____		Fetal Anomaly (Specify) _____	
Fetal Injury (Specify) _____		Fetal Infection (Specify) _____	
Other Fetal Conditions/Disorders (Specify) _____		<input type="checkbox"/> Unknown	
25b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (Select or specify all other conditions contributing to death in item 25a.)			
Maternal Conditions/Diseases (Specify) _____			
Complications of Placenta, Cord, or Membranes – <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord			
<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____			
Other Obstetrical or Pregnancy Complications (Specify) _____		Fetal Anomaly (Specify) _____	
Fetal Injury (Specify) _____		Fetal Infection (Specify) _____	
Other Fetal Conditions/Disorders (Specify) _____		<input type="checkbox"/> Unknown	
26. ESTIMATED TIME OF FETAL DEATH <input type="checkbox"/> Dead at time of first assessment, no labor ongoing <input type="checkbox"/> Dead at time of first assessment, labor ongoing <input type="checkbox"/> Died during labor, after first assessment <input type="checkbox"/> Unknown time of fetal death		27a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned	27b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned
		27c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28. I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD.  Signature >		29. DATE SIGNED (Month, Day, Year)	30. ATTENDANT'S NAME AND TITLE (If delivery not attended by physician) Name (Type) _____ <input type="checkbox"/> CNM/CM <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify) _____
31. CERTIFIER'S NAME AND TITLE (Type)  <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other (Specify) _____		32. CERTIFIER'S MAILING ADDRESS (Street and Number or Rural Route, City or Town, State, Zip Code)	
		33a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Hospital Disposition <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) _____	
33b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)		33c. LOCATION (City or Town, and State)	
34. FUNERAL DIRECTOR OR HOSPITAL ADMINISTRATOR  Signature >		35. FIRM OR HOSPITAL NAME AND ADDRESS	
		36. DATE FILED BY STATE REGISTRAR (Month, Day, Year)	

CONFIDENTIAL INFORMATION FOR INTERNAL USE ONLY

37. IF HOME DELIVERY, WAS DELIVERY PLANNED AT HOME? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				38. MOTHER'S MEDICAL RECORD NO.	
39a. WAS MOTHER EVER MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		39b. MOTHER MARRIED? (At birth, conception or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
40. PARENT'S HISPANIC ORIGIN (Check the box or boxes that best describes whether the parent is Spanish, Hispanic, or Latino. Check the "no" box if the parent is not Spanish, Hispanic, or Latino.)			41. PARENT'S RACE (Check one or more races to indicate what you consider yourself to be.)		
40a. MOTHER-		40b. FATHER-		41a. MOTHER	
<input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican/Mexican American/Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Central American <input type="checkbox"/> Yes, South American <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican/Mexican American/Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Central American <input type="checkbox"/> Yes, South American <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown	
				41b. FATHER	
				<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown	
42. ANCESTRY - What is the parents' ancestry or ethnic origin? - Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)			43. OCCUPATION AND BUSINESS/INDUSTRY		
			Occupation		Business/Industry (Do not give name of company.)
42a. MOTHER		43a. MOTHER (Most recent)		43c. MOTHER	
42b. FATHER		43b. FATHER (Usual)		43d. FATHER	
44. EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery.)					
44a. MOTHER'S EDUCATION		<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some College credit, but no degree <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Unknown		<input type="checkbox"/> 9 <sup>th</sup> - 12 <sup>th</sup> grade, no diploma <input type="checkbox"/> Associate degree (e.g., AA,AS) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	
				<input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)	
44a. FATHER'S EDUCATION		<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some College credit, but no degree <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Unknown		<input type="checkbox"/> 9 <sup>th</sup> - 12 <sup>th</sup> grade, no diploma <input type="checkbox"/> Associate degree (e.g., AA,AS) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	
				<input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)	
45. PREVIOUS LIVE BIRTHS (Do not include this child.)		46. NUMBER OF OTHER OUTCOMES (Spontaneous or induced losses or ectopic or stillbirth pregnancies)		47. PLURALITY - Single, Twin, Triplet, etc. (Specify)	
45a. Now living Number _____ <input type="checkbox"/> None	45b. Now dead Number _____ <input type="checkbox"/> None	46a. Before 20 weeks Number _____ <input type="checkbox"/> None	46b. 20 weeks & over Number _____ <input type="checkbox"/> None	49. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	
45c. DATE OF LAST LIVE BIRTH (Month, Year)		46c. DATE OF LAST OTHER PREGNANCY OUTCOME (Month, Year)		50. OBSTETRIC ESTIMATE OF GESTATION (Completed Weeks)	
52. PRENATAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No		53. DATE OF FIRST PRENATAL CARE VISIT (Month, Day, Year)		54. DATE OF LAST PRENATAL CARE VISIT (Month, Day, Year)	
				55. PRENATAL VISIT - Total number (If none, enter "0")	
56. CIGARETTE SMOKING BEFORE & DURING PREGNANCY: Did mother smoke 3 mos. before or during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown For each time period, enter either the number of cigarettes or the number of packs of cigarettes <b>smoked per day</b> . If none, enter "0". Average number of cigarettes or packs of cigarettes smoked <b>per day</b> : No. No. Three months before pregnancy: _____ cigarettes or _____ packs First three months of pregnancy: _____ cigarettes or _____ packs Second three months of pregnancy: _____ cigarettes or _____ packs Third Trimester of pregnancy: _____ cigarettes or _____ packs				57. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Employer Ins. <input type="checkbox"/> Self-pay <input type="checkbox"/> Indian Health Service <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Other government <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
				58a. MOTHER TRANSFERRED IN FOR DELIVERY DUE TO MATERNAL, MEDICAL, OR FETAL INDICATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enter facility name)	
				58b. FACILITY TRANSFERRED FROM:	

CHILD'S NAME \_\_\_\_\_  
VS233 Rev. 05/01/2010

MOTHER'S NAME \_\_\_\_\_

PRENATAL	LABOR-DELIVERY/STILLBORN FETUS
<p><b>59. NUTRITION OF MOTHER</b></p> <p>1. Height _____</p> <p>2. Prepregnancy Weight _____</p> <p>3. Weight at delivery _____</p> <p>4. Did mother get WIC food for herself? Yes _____ No _____ Unknown _____</p> <p><b>60. MEDICAL RISK FACTORS</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Diabetes, prepregnancy</p> <p>2. <input type="checkbox"/> Diabetes, gestational</p> <p>3. Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia</p> <p>4. <input type="checkbox"/> Previous preterm birth</p> <p>5. <input type="checkbox"/> Other previous poor pregnancy outcome (SGA, perinatal death, etc.)</p> <p>6. <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to labor</p> <p>7. <input type="checkbox"/> Pregnancy resulted from infertility treatment (If yes, check all that apply.) <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))</p> <p>8. <input type="checkbox"/> Mother had a previous cesarean delivery, if yes, how many Number _____</p> <p>9. <input type="checkbox"/> Alcohol use No. of drinks per week: _____</p> <p>10. <input type="checkbox"/> None of the above</p> <p><b>61. METHOD OF DELIVERY</b></p> <p>1. Forceps attempted? Yes _____ No _____ Successful: Yes _____ No _____</p> <p>2. Vacuum extraction attempted? Yes _____ No _____ Successful: Yes _____ No _____</p> <p>3. Fetal presentation at delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other</p> <p>4. Final route and method of delivery (check one) <input type="checkbox"/> Vaginal/spontaneous <input type="checkbox"/> Vaginal/forceps <input type="checkbox"/> Vaginal/vacuum <input type="checkbox"/> Cesarean, if cesarean was a trial of labor attempted? Yes _____ No _____</p> <p>5. Hysterotomy/Hysterectomy Yes _____ No _____</p>	<p><b>62. MATERNAL MORBIDITY</b> (Check all that apply.) (These are complications associated with labor and delivery.)</p> <p>1. <input type="checkbox"/> Maternal transfusion</p> <p>2. <input type="checkbox"/> Third or fourth degree perineal laceration</p> <p>3. <input type="checkbox"/> Ruptured uterus</p> <p>4. <input type="checkbox"/> Unplanned hysterectomy</p> <p>5. <input type="checkbox"/> Admission to intensive care unit</p> <p>6. <input type="checkbox"/> Unplanned operating room procedure following delivery</p> <p>7. <input type="checkbox"/> None of the above</p> <p><b>63. INFECTIONS PRESENT AND/OR TREATED</b> (During this pregnancy, check all that apply.)</p> <p>1. <input type="checkbox"/> Gonorrhea</p> <p>2. <input type="checkbox"/> Syphilis</p> <p>3. <input type="checkbox"/> Herpes Simplex Virus (HSV)</p> <p>4. <input type="checkbox"/> Chlamydia</p> <p>5. <input checked="" type="checkbox"/> Listeria</p> <p>6. <input type="checkbox"/> Group B Streptococcus</p> <p>7. <input type="checkbox"/> Cytomeglovirus</p> <p>8. <input type="checkbox"/> Parvo virus</p> <p>9. <input type="checkbox"/> Toxoplasmosis</p> <p>10. <input type="checkbox"/> AIDS or HIV antibody</p> <p>11. <input type="checkbox"/> None of the above</p> <p>12. <input type="checkbox"/> Other (Specify) _____</p> <p><b>64. CONGENITAL ANOMALIES OF THE NEWBORN</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Anencephaly</p> <p>2. <input type="checkbox"/> Meningocele/Spina bifida</p> <p>3. <input type="checkbox"/> Cyanotic congenital heart disease</p> <p>4. <input type="checkbox"/> Congenital diaphragmatic hernia</p> <p>5. <input type="checkbox"/> Omphalocele</p> <p>6. <input type="checkbox"/> Gastroschisis</p> <p>7. <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes)</p> <p>8. <input type="checkbox"/> Cleft Lip with or without Cleft Palate</p> <p>9. <input type="checkbox"/> Cleft Palate alone</p> <p>10. <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending</p> <p>11. <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending</p> <p>12. <input type="checkbox"/> Hypospadias</p> <p>13. <input type="checkbox"/> Fetal alcohol syndrome</p> <p>14. <input type="checkbox"/> Other congenital anomalies (Specify) _____</p> <p>15. <input type="checkbox"/> None of the above</p>

THIS IS NOT PART OF THE CERTIFICATE OF STILLBIRTH  
Test required by K.S.A. 65-153F, 153G

Serological Test Made: \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> (Trimester) \_\_\_\_\_ At Delivery \_\_\_\_\_ Not Performed

If no test made, state reason: \_\_\_\_\_

## ***Kansas County Codes and Groupings***

<b>County Name</b>	<b>FIPS Code</b>	<b>Abbreviation</b>	<b>Population Density Peer Group (2010)</b>	<b>Population Density Peer Group (2000)</b>	<b>NCHS Urban-Rural 6-Level Classification (2013)</b>	<b>NCHS Urban-Rural 2-Level Classification (2013)</b>
Allen	001	AL	Densely-Settled Rural	Densely-Settled Rural	Non-core	Rural
Anderson	003	AN	Rural	Rural	Non-core	Rural
Atchison	005	AT	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Barber	007	BA	Frontier	Frontier	Non-core	Rural
Barton	009	BT	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Bourbon	011	BB	Densely-Settled Rural	Densely-Settled Rural	Non-core	Rural
Brown	013	BR	Rural	Rural	Non-core	Rural
Butler	015	BU	Semi-Urban	Semi-Urban	Medium metropolitan	Urban
Chase	017	CS	Frontier	Frontier	Non-core	Rural
Chautauqua	019	CQ	Frontier	Rural	Non-core	Rural
Cherokee	021	CK	Densely-Settled Rural	Densely-Settled Rural	Non-core	Rural
Cheyenne	023	CN	Frontier	Frontier	Non-core	Rural
Clark	025	CA	Frontier	Frontier	Non-core	Rural
Clay	027	CY	Rural	Rural	Non-core	Rural
Cloud	029	CD	Rural	Rural	Non-core	Rural
Coffey	031	CF	Rural	Rural	Non-core	Rural
Comanche	033	CM	Frontier	Frontier	Non-core	Rural
Cowley	035	CL	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Crawford	037	CR	Semi-Urban	Semi-Urban	Micropolitan	Rural
Decatur	039	DC	Frontier	Frontier	Non-core	Rural
Dickinson	041	DK	Densely-Settled Rural	Densely-Settled Rural	Non-core	Rural
Doniphan	043	DP	Densely-Settled Rural	Densely-Settled Rural	Small metropolitan	Urban
Douglas	045	DG	Urban	Urban	Small metropolitan	Urban
Edwards	047	ED	Frontier	Frontier	Non-core	Rural
Elk	049	EK	Frontier	Frontier	Non-core	Rural
Ellis	051	EL	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Ellsworth	053	EW	Rural	Rural	Non-core	Rural
Finney	055	FI	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Ford	057	FO	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Franklin	059	FR	Semi-Urban	Semi-Urban	Micropolitan	Rural
Gearv	061	GE	Semi-Urban	Semi-Urban	Micropolitan	Rural
Gove	063	GO	Frontier	Frontier	Non-core	Rural
Graham	065	GH	Frontier	Frontier	Non-core	Rural
Grant	067	GT	Rural	Rural	Non-core	Rural
Gray	069	GY	Rural	Rural	Non-core	Rural
Greeley	071	GL	Frontier	Frontier	Non-core	Rural

<b>County Name</b>	<b>FIPS Code</b>	<b>Abbreviation</b>	<b>Population Density Peer Group (2010)</b>	<b>Population Density Peer Group (2000)</b>	<b>NCHS Urban-Rural 6-Level Classification (2013)</b>	<b>NCHS Urban-Rural 2-Level Classification (2013)</b>
Greenwood	073	GW	Frontier	Rural	Non-core	Rural
Hamilton	075	HM	Frontier	Frontier	Non-core	Rural
Harper	077	HP	Rural	Rural	Non-core	Rural
Harvey	079	HV	Semi-Urban	Semi-Urban	Medium metropolitan	Urban
Haskell	081	HS	Rural	Rural	Non-core	Rural
Hodgeman	083	HG	Frontier	Frontier	Non-core	Rural
Jackson	085	JA	Densely-Settled Rural	Rural	Small metropolitan	Urban
Jefferson	087	JF	Densely-Settled Rural	Densely-Settled Rural	Small metropolitan	Urban
Jewell	089	JW	Frontier	Frontier	Non-core	Rural
Johnson	091	JO	Urban	Urban	Large fringe metropolitan	Urban
Kearny	093	KE	Frontier	Frontier	Micropolitan	Rural
Kingman	095	KM	Rural	Rural	Medium metropolitan	Urban
Kiowa	097	KW	Frontier	Frontier	Non-core	Rural
Labette	099	LB	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Lane	101	LE	Frontier	Frontier	Non-core	Rural
Leavenworth	103	LV	Urban	Semi-Urban	Large fringe metropolitan	Urban
Lincoln	105	LC	Frontier	Frontier	Non-core	Rural
Linn	107	LN	Rural	Rural	Large fringe metropolitan	Urban
Logan	109	LG	Frontier	Frontier	Non-core	Rural
Lyon	111	LY	Densely-Settled Rural	Semi-Urban	Micropolitan	Rural
McPherson	113	MP	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Marion	115	MN	Rural	Rural	Non-core	Rural
Marshall	117	MS	Rural	Rural	Non-core	Rural
Meade	119	ME	Frontier	Frontier	Non-core	Rural
Miami	121	MI	Semi-Urban	Semi-Urban	Large fringe metropolitan	Urban
Mitchell	123	MC	Rural	Rural	Non-core	Rural
Montgomery	125	MG	Semi-Urban	Semi-Urban	Micropolitan	Rural
Morris	127	MR	Rural	Rural	Non-core	Rural
Morton	129	MT	Frontier	Frontier	Non-core	Rural
Nemaha	131	NM	Rural	Rural	Non-core	Rural
Neosho	133	NO	Densely-Settled Rural	Densely-Settled Rural	Non-core	Rural
Ness	135	NS	Frontier	Frontier	Non-core	Rural
Norton	137	NT	Rural	Rural	Non-core	Rural
Osage	139	OS	Densely-Settled Rural	Densely-Settled Rural	Small metropolitan	Urban
Osborne	141	OB	Frontier	Frontier	Non-core	Rural
Ottawa	143	OT	Rural	Rural	Micropolitan	Rural
Pawnee	145	PN	Rural	Rural	Non-core	Rural
Phillips	147	PL	Rural	Rural	Non-core	Rural
Pottawatomie	149	PT	Densely-Settled Rural	Densely-Settled Rural	Small metropolitan	Urban

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Pratt	151	PR	Rural	Rural	Non-core	Rural
Rawlins	153	RA	Frontier	Frontier	Non-core	Rural
Reno	155	RN	Semi-Urban	Semi-Urban	Micropolitan	Rural
Republic	157	RP	Rural	Rural	Non-core	Rural
Rice	159	RC	Rural	Rural	Non-core	Rural
Riley	161	RL	Semi-Urban	Semi-Urban	Small metropolitan	Urban
Rooks	163	RO	Frontier	Rural	Non-core	Rural
Rush	165	RH	Frontier	Frontier	Non-core	Rural
Russell	167	RS	Rural	Rural	Non-core	Rural
Saline	169	SA	Semi-Urban	Semi-Urban	Micropolitan	Rural
Scott	171	SC	Rural	Rural	Non-core	Rural
Sedgwick	173	SG	Urban	Urban	Medium metropolitan	Urban
Seward	175	SW	Densely-Settled Rural	Densely-Settled Rural	Micropolitan	Rural
Shawnee	177	SN	Urban	Urban	Small metropolitan	Urban
Sheridan	179	SD	Frontier	Frontier	Non-core	Rural
Sherman	181	SH	Frontier	Rural	Non-core	Rural
Smith	183	SM	Frontier	Frontier	Non-core	Rural
Stafford	185	SF	Frontier	Rural	Non-core	Rural
Stanton	187	ST	Frontier	Frontier	Non-core	Rural
Stevens	189	SV	Rural	Rural	Non-core	Rural
Sumner	191	SU	Densely-Settled Rural	Densely-Settled Rural	Medium metropolitan	Urban
Thomas	193	TH	Rural	Rural	Non-core	Rural
Trego	195	TR	Frontier	Frontier	Non-core	Rural
Wabaunsee	197	WB	Rural	Rural	Small metropolitan	Urban
Wallace	199	WA	Frontier	Frontier	Non-core	Rural
Washington	201	WS	Rural	Rural	Non-core	Rural
Wichita	203	WH	Frontier	Frontier	Non-core	Rural
Wilson	205	WL	Rural	Rural	Non-core	Rural
Woodson	207	WO	Rural	Rural	Non-core	Rural
Wyandotte	209	WY	Urban	Urban	Large fringe metropolitan	Urban