

Republic of the Philippines  
**CERTIFICATE OF FETAL DEATH**

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

Province \_\_\_\_\_  
City/Municipality \_\_\_\_\_

Registry No. \_\_\_\_\_

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E  
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S

1. NAME OF FETUS (first) (Middle) (Last) (If given)		
2. SEX ____ 1 Male ____ 2 Female ____ 3 Undetermined		3. DATE OF DELIVERY (day) (month) (year)
4. PLACE OF DELIVERY (Name of Hospital/Clinic/Institution/ House No., Street, Barangay) (City/Municipality) (Province)		
5a. TYPE OF DELIVERY ____ 1 Single ____ 2 Twin ____ 3 Triplet, etc.		b. IF MULTIPLE DELIVERY, FETUS WAS ____ 1 First ____ 2 Second ____ 3 Others, Specify _____
c. METHOD OF DELIVERY ____ 1 Normal spontaneous vertex ____ 2 Others (specify) _____		d. BIRTH ORDER (live births and fetal deaths including this delivery (first, second, third, etc.) e. WEIGHT OF FETUS _____ grams

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6. MAIDEN NAME (First) (Middle) (Last)		
7. CITIZENSHIP	8. RELIGION	9. OCCUPATION
11a. Total number of children born alive: _____		b. No. of children still living: _____
		c. No. of children born alive but are now dead: _____

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12. RESIDENCE (House No./Street/Barangay) (City/Municipality) (Province)		
13. NAME (First) (Middle) (Last)		
14. CITIZENSHIP	15. RELIGION	16. OCCUPATION
		17. Age at the time of this delivery: _____ years

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

**MEDICAL CERTIFICATE**

19. CAUSES OF FETAL DEATH

a. Main disease/condition of fetus \_\_\_\_\_

b. Other diseases/conditions of fetus \_\_\_\_\_

c. Main maternal disease/condition affecting fetus \_\_\_\_\_

d. Other maternal disease/condition affecting fetus \_\_\_\_\_

e. Other relevant circumstances \_\_\_\_\_

20. FETUS DIED: \_\_\_\_ 1 Before labor \_\_\_\_ 2 during labor/delivery \_\_\_\_ 3 Unknown

21. LENGTH OF PREGNANCY: \_\_\_\_\_ completed weeks

22a. ATTENDANT: \_\_\_\_ 1 Physician \_\_\_\_ Nurse \_\_\_\_ 3 Midwife \_\_\_\_ 4 Hilot (Traditional Midwife)  
\_\_\_\_ 5 Others (Specify) \_\_\_\_\_ None

22b. CERTIFICATION

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

Signature \_\_\_\_\_  
Name in Print \_\_\_\_\_  
Title or Position \_\_\_\_\_  
Address \_\_\_\_\_  
Date \_\_\_\_\_

REVIEWED BY:

Signature over printed name  
of Health Officer

Date

23. CORPSE DISPOSAL  
\_\_\_\_ 1 Burial \_\_\_\_ 2 Cremation  
\_\_\_\_ 3 Others (Specify) \_\_\_\_\_

24. BURIAL/CREMATION PERMIT  
Number \_\_\_\_\_  
Date Issued \_\_\_\_\_

25. AUTOPSY  
\_\_\_\_ 1 Yes  
\_\_\_\_ 2 No

26. NAME AND ADDRESS OF CEMETERY OR CREMATORY

27. INFORMANT

Signature \_\_\_\_\_  
Name in Print \_\_\_\_\_  
Relationship to the fetus \_\_\_\_\_

Address \_\_\_\_\_  
Date \_\_\_\_\_

28. PREPARED BY

Signature \_\_\_\_\_  
Name in Print \_\_\_\_\_  
Title or Position \_\_\_\_\_  
Date \_\_\_\_\_

29. RECEIVED AT THE OFFICE OF  
THE CIVIL REGISTRAR

Signature \_\_\_\_\_  
Name in Print \_\_\_\_\_  
Title or Position \_\_\_\_\_  
Date \_\_\_\_\_

TO BE FILLED UP AT THE  
OFFICE OF THE CIVIL  
REGISTRAR

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

**POSTMORTEM CERTIFICATE OF DEATH**

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title/Designation

\_\_\_\_\_  
Name in Print

\_\_\_\_\_  
Address