

LIVE BIRTH

DATA ELEMENTS BEGINNING JANUARY 1, 2010

The following is a list of data items developed by the Missouri Department of Health and Senior Services (DHSS) that may be requested for administrative, statistical, or research use. Requests for these data items are reviewed for adequate justification and only the minimum necessary items will be provided. These data elements are obtained from the 2003 revision of the Certificate of Live Birth form for all **births occurring on or after January 1, 2010**.

<p>State of Birth</p> <p>Child Name <i>(First, Middle, Last, Surname Suffix)</i></p> <p>Date of Birth <i>(Month, Day, Year)</i></p> <p>Time of Birth</p> <p>Sex</p> <p>City/Town of Birth</p> <p>County Where Birth Occurred</p> <p>Place Where Birth Occurred <i>(Type)</i></p> <p style="padding-left: 20px;"><i>If Home Birth, Planned Home Delivery (Yes/No)</i></p> <p>Name of Facility of Birth</p> <p>Mother Name <i>(First, Middle, Last, Surname Suffix)</i></p> <p>Mother Date of Birth <i>(Month, Day, Year)</i></p> <p>Mother Maiden Name <i>(First, Middle, Surname, Surname Suffix)</i></p> <p>Mother Birthplace State/Province</p> <p>Mother Birthplace Country</p> <p>Mother Residence State</p> <p>Mother Residence Country</p> <p>Mother Residence County</p> <p>Mother Residence City/Town</p> <p>Mother Residence Street Address</p> <p>Mother Residence Zip Code</p> <p>Mother Residence Inside City Limits <i>(Yes/No)</i></p> <p>Mother Mailing Address</p> <p>Father Name <i>(First, Middle, Last, Surname Suffix)</i></p> <p>Father Date of Birth <i>(Month, Day, Year)</i></p> <p>Father Birthplace State/Province</p> <p>Father Birthplace Country</p> <p>Certifier Title/Type</p> <p>Attendant Title/Type</p> <p>Mother Married at Conception, at Birth, or any Time in Between</p> <p>Paternity Acknowledgement Signed <i>(Yes/No)</i></p> <p>Mother Education</p>	<p>Mother Hispanic Origin <i>(Mexican, Puerto Rican, Cuban, Other)*</i></p> <p>Mother Race <i>(White, Black/African American, American Indian/Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Guamanian/Chamorro, Samoan, Other Pacific Islander, Other)*</i></p> <p>Father Education</p> <p>Father Hispanic Origin <i>(Mexican, Puerto Rican, Cuban, Other)*</i></p> <p>Father Race <i>(White, Black/African American, American Indian/Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Guamanian/Chamorro, Samoan, Other Pacific Islander, Other)*</i></p> <p>Mother Transferred From Another Facility <i>(Yes/No)</i></p> <p style="padding-left: 20px;">Mother Transferred From Facility Name</p> <p>Date of First Prenatal Care Visit <i>(Month, Day, Year)</i></p> <p>Date of Last Prenatal Care Visit <i>(Month, Day, Year)</i></p> <p>Total # of Prenatal Care Visits</p> <p>Mother Height <i>(Feet & Inches)</i></p> <p>Mother Prepregnancy Weight</p> <p>Mother Weight at Delivery</p> <p>Principal source of Payment for this delivery¹</p> <p>Did Mother get WIC Food for Herself¹</p> <p>Participate in Food Stamp Program¹</p> <p># Previous Live Births Now Living</p> <p># Previous Live Births Now Dead</p> <p>Date of Last Live Birth <i>(Month/Year)</i></p> <p># Previous Other Pregnancy Outcomes</p> <p>Date of Last Other Pregnancy Outcome <i>(Month/Year)</i></p> <p># of Cigarettes Smoked in 3 months prior to Pregnancy</p> <p># of Cigarettes Smoked in 1st 3 months</p> <p># of Cigarettes Smoked in 2nd 3 months</p> <p># of Cigarettes Smoked in third trimester</p> <p>Date Last Normal Menses <i>(Month, Day, Year)</i></p>
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<p>Risk Factors –</p> <ul style="list-style-type: none"> Prepregnancy Diabetes Gestational Diabetes Insulin Dependent (Diabetes) Hypertension Prepregnancy Hypertension Gestational Hypertension Eclampsia Previous Preterm Births Poor Pregnancy Outcomes Infertility Treatment <ul style="list-style-type: none"> Infertility: Fertility Enhancing Drugs Infertility: Asst. Rep. Technology Previous Cesarean <ul style="list-style-type: none"> # Previous Cesareans <p>Obstetric Procedures –</p> <ul style="list-style-type: none"> Cervical Cerclage Tocolysis <ul style="list-style-type: none"> Successful External Cephalic Version Failed External Cephalic Version <p>Onset of Labor –</p> <ul style="list-style-type: none"> Premature Rupture of Membranes Precipitous Labor (<3 hours) Prolonged Labor (≥20 hours) <p>Characteristics of Labor & Delivery –</p> <ul style="list-style-type: none"> Induction of Labor Augmentation of Labor Non-vertex Presentation Steroids Antibiotics Chorioamnionitis Meconium Staining Fetal Intolerance Anesthesia <p>Method of Delivery –</p> <ul style="list-style-type: none"> Attempted Forceps Attempted Vacuum Fetal Presentation (<i>Cephalic, Breech, Other</i>) 	<p>Method of Delivery (<i>continued</i>) –</p> <ul style="list-style-type: none"> Route and Method of Delivery (<i>Vaginal/Spontaneous, Vaginal/Forceps, Vaginal/Vacuum, Cesarean</i>) Trial of Labor Attempted <p>Infections Present and/or Treated During Pregnancy –</p> <ul style="list-style-type: none"> Gonorrhea Syphilis Chlamydia HIV² <ul style="list-style-type: none"> <i>If yes, mother treated with anti-retroviral (Yes/No)²</i> <i>If yes, infant treated with anti-retroviral (Yes/No)²</i> Hepatitis C Hepatitis B <ul style="list-style-type: none"> <i>If yes, was mother positive for HBsAg (Yes/No)²</i> <i>If yes, newborn rec'd HBIG within 12 hrs of birth (Yes/No)²</i> <p>Maternal Morbidity –</p> <ul style="list-style-type: none"> Maternal Transfusion Perineal Laceration Ruptured Uterus Unplanned Hysterectomy Admit to Intensive Care Unplanned Operation <p>Child Birth weight (<i>Grams</i>)</p> <p>Obstetric Estimation of Gestation (<i>Weeks</i>)</p> <p>APGAR Score at 5 Minutes</p> <p>APGAR Score at 10 Minutes</p> <p>Plurality <ul style="list-style-type: none"> <i>If not a single birth, Order Born</i> </p> <p># of Live Born</p> <p>Abnormal Conditions of the Newborn –</p> <ul style="list-style-type: none"> Assisted Ventilation Assisted Ventilation > 6 hours Admission to NICU Surfactant Antibiotics Seizures Birth Injury
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Was Infant Transferred Within 24 Hours of Delivery <i>(Yes/No)</i>	Is Infant Living at Time of Report <i>(Yes/No)</i>
Infant Transferred To Facility Name	Is Infant Being Breastfed at discharge <i>(Yes/No)</i>
Congenital Anomalies of the Newborn –	Eye Drug Used <i>(Yes/No)</i>
Anencephaly	Newborn Received Hepatitis B Shot <i>(Yes/No)</i>
Meningomyelocele/Spina Bifida	
Cyanotic congenital heart disease	
Congenital diaphragmatic hernia	
Omphalocele	
Gastroschisis	
Limb Reduction Defect	
Cleft Lip with or without Cleft Palate	
Cleft Palate Alone	
Down Syndrome	
Suspected Chromosomal disorder	
Hypospadias	

* Multiple ethnic or race categories may be selected.

¹Not available for identified records.

²Only with appropriate justification for de-identified data

[Live births through December 31, 2009](#)

The following is a list of additional data elements **created** by the Missouri Department of Health and Senior Services for administrative, statistical, or research use. Requests for these additional data items are reviewed for adequate justification and will be provided on a case-by-case basis.

Residence Latitude <i>(Mother)</i>	Length of Pregnancy <i>(Weeks)</i>
Residence Longitude <i>(Mother)</i>	Calculated Gestational Age <i>(Weeks)</i>
Residence Census Tract <i>(Mother)</i>	Mother Age <i>(Calculated)</i>
Public Services Participation Flag <i>(Yes/No)</i>	Father Age <i>(Calculated)</i>
Delivery Paid by Private Insurance <i>(Yes/No)</i>	Mother Race <i>(NCHS Bridged Race)</i>
Month of Pregnancy Prenatal Care Began	Father Race <i>(NCHS Bridged Race)</i>
Inadequate Prenatal Care <i>(MO Index)</i>	Child Race