LIVE BIRTH

The following is a complete list of data items **reported** to the Missouri Department of Health and Senior Services during registration of a live birth. 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.**

Birth State File Number	Certifier Name and Title/Type
Child Name *(First, Middle, Last, Suffix)*	Attendant Name & Title/Type
Newborn Date of Birth *(Month, Day, Year)*	Attendant MO License #
Time of Birth	Attendant NPI #
Sex	Registrar Signature
City/Town of Birth	Date Filed *(Month, Day, Year)*
County Where Birth Occurred	Permission to get SSN? *(Yes/No)*
Place Where Birth Occurred *(Type)*	Mother Married at Conception, at Birth, or any Time in Between
If Home Birth, Planned Home Delivery *(Yes/No)*	*If no*, Paternity Acknowledgement Signed *(Yes/No)*
Name of Facility of Birth	Mother Refuses To Give Husband's Information *(Yes/No)*
Mother Current Legal Name *(First, Middle, Last, Suffix)*	Mother SSN
Mother Date of Birth *(Month, Day, Year)*	Father SSN
Mother Name Prior to 1st Marriage *(First, Middle, Last, Suffix)*	Mother Education
Mother Birthplace Country	Mother Hispanic Origin *(No, Mexican, Puerto Rican, Cuban, Other)**
Mother Birthplace State/Territory/Province	Mother Race *(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, Unknown)**
Mother Residence Country	
Mother Residence State/Territory/Province	
Mother Residence County	
Mother Residence City/Town	Father Education
Mother Residence Street and Number	Father Hispanic Origin *(No, Mexican, Puerto Rican, Cuban, Other)**
Mother Residence Zip Code	Father Race *(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, Unknown)**
Mother Residence Inside City Limits *(Yes/No)*	
Mother Mailing Address Same as Residence *(Yes/No)*	
If no, Mother Mailing Address Country	Mother Transferred From Another Facility *(Yes/No)*
Mother Mailing Address State/Territory/Province	*If yes,* Mother Transferred From Facility Name
Mother Mailing Address City/Town	Date of First Prenatal Care Visit *(Month, Day, Year)*
Mother Mailing Address Street and Number	Date of Last Prenatal Care Visit *(Month, Day, Year)*
Mother Mailing Address Zip Code	Total # of Prenatal Care Visits
Father Current Legal Name *(First, Middle, Last, Suffix)*	Mother Height *(feet/inches)*
Father Date of Birth *(Month, Day, Year)*	Mother Prepregnancy Weight *(pounds)*
Father Birthplace Country	Mother Weight at Delivery *(pounds)*
Father Birthplace State/Territory/Province	Principal source of Payment for this delivery
Certifier Signature	Did Mother get WIC Food for Herself
Date Certified *(Month, Day, Year)*	

LIVE BIRTH

Mother Participate in Food Stamp Program

Previous Live Births –

- # Previous Live Births Now Living or None
- # Previous Live Births Now Dead or None
- Date of Last Live Birth *(Month, Day, Year)*

Other Pregnancy Outcomes –

- # Previous Other Pregnancy Outcomes or None
- Date of Last Other Pregnancy Outcome *(Month, Year)*

Cigarettes Smoked Before and During Pregnancy –

- # of Cigarettes OR # of Packs Smoked in 3 months prior
- # of Cigarettes OR # of Packs Smoked in 1st 3 months
- # of Cigarettes OR # of Packs Smoked in 2nd 3 months
- # of Cigarettes OR # of Packs Smoked in 3rd trimester

Date Last Normal Menses *(Month, Day, Year)*

Mother Medical Record #

Risk Factors in this Pregnancy –

- Diabetes
  - Prepregnancy Diabetes
  - Gestational Diabetes
  - Insulin Dependent
- Hypertension
  - Prepregnancy
  - Gestational
  - Eclampsia
- Previous Preterm Births
- Poor Pregnancy Outcomes
- Infertility Treatment
  - *If yes*, Fertility Enhancing Drugs
  - *If yes*, Assisted Reproductive Technology
- Previous Cesarean
  - *If yes*, # of Previous Cesareans
- None of the above

Obstetric Procedures –

- Cervical Cerclage
- Tocolysis
- External Cephalic Version
  - *If yes*, Successful/Failed
- None of the above

Onset of Labor –

- Premature Rupture of Membranes
- Precipitous Labor *(<3 hours)*
- Prolonged Labor *(≥20 hours)*
- None of the above

Characteristics of Labor & Delivery –

- Induction of labor
- Augmentation of labor
- Non-vertex presentation
- Steroids
- Antibiotics
- Chorioamnionitis
- Meconium Staining
- Fetal Intolerance
- Anesthesia
- None of the above

Method of Delivery –

- Attempted Forceps *(Yes/No)*
- Attempted Vacuum *(Yes/No)*
- Fetal Presentation
  - Cephalic
  - Breech
  - Other
- Final Route and Method of Delivery
  - Vaginal/Spontaneous
  - Vaginal/Forceps
  - Vaginal/Vacuum
  - Cesarean
    - *If cesarean*, Trial of Labor Attempted *(Yes/No)*

Infections Present and/or Treated During Pregnancy –

- Gonorrhea
- Syphilis
- Chlamydia
- HIV
  - *If yes*, mother treated with anti-retroviral *(Yes/No)*
  - *If yes*, infant treated with anti-retroviral *(Yes/No)*
- Hepatitis C

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Infections Present and/or Treated During Pregnancy*(Continued)*–	Abnormal Conditions of the Newborn *(Continued)* –
Hepatitis B	Seizures
If yes, was mother positive for HBsAg *(Yes/No)*	Birth Injury
If yes, did newborn receive HBIG within 12 hours *(Yes/No)*	None of the above
None of the above	Was Infant Transferred Within 24 Hours of Delivery *(Yes/No)*
Mother Tested During Pregnancy –	*If yes,* Infant Transferred To Facility Name
Syphilis *(Yes/No/Unknown)*	Congenital Anomalies of the Newborn –
HIV *(Yes/No/Unknown)*	Anencephaly
Hepatitis B *(Yes/No/Unknown)*	Meningomyelocele/Spina bifida
Maternal Morbidity –	Cyanotic congenital heart disease
Maternal Transfusion	Congenital diaphragmatic hernia
Perineal Laceration	Omphalocele
Ruptured Uterus	Gastroschisis
Unplanned Hysterectomy	Limb reduction defect
Admit to Intensive Care	Cleft Lip with or without Cleft Palate
Unplanned Operation	Cleft Palate alone
None of the above	Down Syndrome
Newborn Medical Record #	Karyotype confirmed
Child Birthweight *(grams)*	Karyotype pending
Obstetric Estimation of Gestation *(weeks)*	Other chromosomal disorder
APGAR Score	Karyotype confirmed
5 Minutes	Karyotype pending
10 Minutes	Hypospadias
Plurality	None
If not single birth, Order Born	Other *(Specify)*
If not single birth, # of Live Born	Is Newborn Living at Time of Report *(Yes/No/Transferred)*
Abnormal Conditions of the Newborn –	Is Infant Being Breastfed at discharge *(Yes/No)*
Assisted Ventilation	Eye Drug Used *(Yes/No)*
Assisted Ventilation > 6 hours	*If yes,* Name of Eye Drug
Admission to NICU	Newborn Received Hepatitis B Shot *(Yes/No)*
Surfactant	*If yes,* Date of Vaccination *(Month, Day, Year)*
Antibiotics	Adoption Pending *(Yes/No)*

** Multiple ethnic or race categories may be selected.*

Live births through December 31, 2009