MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

# CERTIFICATE OF LIVE BIRTH

VS 100C MO 580-0697 (1-17)

STATE FILE NUMBER

**124 -**

## CHILD

1. CHILD'S NAME *(First, Middle, Last, Suffix)*

| 2. DATE OF BIRTH *(Month, Day, Year)* | 3. TIME OF BIRTH | 4. SEX | 5. CITY, TOWN OR LOCATION OF BIRTH | 6. COUNTY OF BIRTH |
|---|---|---|---|---|
| | | | | |

7. PLACE OF BIRTH *(Check one)*

☐ Hospital
☐ Freestanding Birthing Center
☐ Home Birth: Planned to deliver at home? ☐ Yes ☐ No
☐ Clinic/Doctor's Office
☐ Other (Specify):

8. FACILITY NAME *(if not institution, give street and number)*

## MOTHER

9a. MOTHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*

9b. DATE OF BIRTH *(Month, Day, Year)*

9c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE *(First, Middle, Last, Suffix)*

9d. BIRTHPLACE *(Country)* | *(State, Territory or Province)*

| 10a. RESIDENCE OF MOTHER *(Country)* | *(State, Territory or Province)* | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION |
|---|---|---|---|
| | | | |

10d. STREET AND NUMBER

10e. ZIP CODE

10f. INSIDE CITY LIMITS? ☐ Yes ☐ No

11a. MOTHER'S MAILING ADDRESS *(Country)* ☐ SAME AS RESIDENCE **OR** *(State, Territory or Province)*

11b. CITY, TOWN OR LOCATION

11c. STREET AND NUMBER

11d. ZIP CODE

## FATHER

12a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*

12b. DATE OF BIRTH *(Month, Day, Year)*

12c. BIRTHPLACE *(Country)* | *(State, Territory or Province)*

## CERTIFIER

13a. I certify that this child was born alive at the place and time on the date stated.

SIGNATURE ▶

13b. DATE SIGNED *(Month, Day, Year)*

13c. CERTIFIER'S NAME AND TITLE *(Type/Print)*

NAME _____

☐ MD ☐ DO ☐ CNM/CM ☐ CPM ☐ OTHER MIDWIFE
☐ HOSPITAL ADMINISTRATOR ☐ OTHER (Specify) _____

## ATTENDANT

14. ATTENDANT NAME AND TITLE *(if other than certifier) (Type/Print)*

NAME _____

☐ MD ☐ DO ☐ CNM/CM ☐ CPM ☐ OTHER MIDWIFE
☐ OTHER (Specify) _____

15a. ATTENDANT'S MO LICENSE NUMBER

15b. ATTENDANT'S NPI NUMBER

**VITAL RECORDS USE ONLY**

16. REGISTRAR'S SIGNATURE

DATE FILED *(Month, Day, Year)*

## AFFIRMATION OF BIRTH

I DO SOLEMNLY DECLARE AND AFFIRM THAT THE INFORMATION APPEARING ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF UNDER THE PAINS AND PENALTIES OF PERJURY.

*(Printed Name)* _____ *(Signature)* _____

*(Address)* _____

*(Printed Name)* _____ *(Signature)* _____

*(Address)* _____

(Seal)

Subscribed, declared and affirmed before me this _____ day of _____ , _____ .

My commission expires _____

_____
Notary Public

## CONFIDENTIAL INFORMATION FOR INTERNAL USE ONLY

17. PERMISSION GIVEN TO PROVIDE THE SOCIAL SECURITY ADMINISTRATION WITH THE NECESSARY BIRTH INFORMATION TO ISSUE A SOCIAL SECURITY NUMBER

☐ Yes ☐ No

18a. MOTHER MARRIED? *(At birth, conception or any time between)*

☐ Yes ☐ No ☐ Unknown

18b. IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED?

☐ Yes ☐ No

18c. MOTHER REFUSES TO GIVE HUSBAND'S INFORMATION?

☐ Yes ☐ No

19. MOTHER'S SOCIAL SECURITY NUMBER

20. FATHER'S SOCIAL SECURITY NUMBER

**MOTHER**

21. MOTHER'S EDUCATION
*(Check the box that best describes the highest degree or level of school completed at the time of this delivery.)*

- ☐ 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)

22. MOTHER OF HISPANIC ORIGIN?
*(Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina.)*

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina

*(Specify)* _____

23. MOTHER'S RACE
*(Check one or more races to indicate what the mother considers herself to be.)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribes) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian *(Specify)* _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander *(Specify)* _____
- ☐ Other *(Specify)* _____
- ☐ Unknown

**FATHER**

24. FATHER'S EDUCATION
*(Check the box that best describes the highest degree or level of school completed at the time of this delivery.)*

- ☐ 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)

25. FATHER OF HISPANIC ORIGIN?
*(Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father 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)* _____

26. FATHER'S RACE
*(Check one or more races to indicate what the father considers himself to be.)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribes) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian *(Specify)* _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander *(Specify)* _____
- ☐ Other *(Specify)* _____
- ☐ Unknown

27a. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?

☐ Yes ☐ No

27b. IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM

28a. DATE OF FIRST PRENATAL CARE VISIT *(Month, Day, Year)*

28b. DATE OF LAST PRENATAL CARE VISIT *(Month, Day, Year)*

28c. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY *(If none enter "0")*

29. MOTHER'S HEIGHT *(feet/inches)*

30. MOTHER'S PREPREGNANCY WEIGHT *(pounds)*

31. MOTHER'S WEIGHT AT DELIVERY *(pounds)*

32. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY

☐ Private Insurance ☐ Self-pay
☐ Medicaid ☐ Other *(Specify)* _____

33. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

☐ Yes ☐ No ☐ Don't know

34. DID MOTHER PARTICIPATE IN THE FOOD STAMP PROGRAM?

☐ Yes ☐ No ☐ Don't know

NUMBER OF PREVIOUS LIVE BIRTHS
*(Do not include this child)*

35a. Now Living
Number _____
☐ None

35b. Now Dead
Number _____
☐ None

NUMBER OF OTHER PREGNANCY OUTCOMES
*(Spontaneous or induced losses or ectopic pregnancies)*

36a. Other Outcomes
Number _____
☐ None

35c. DATE OF LAST LIVE BIRTH *(Month, Day, Year)*

36b. DATE OF LAST OTHER PREGNANCY OUTCOME *(Month, Year)*

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY?
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. **[IF NONE, ENTER "0"]**

Average number of cigarettes or packs of cigarettes smoked per day.

| | # of cigarettes | | # of packs |
|---|---|---|---|
| Three Months Before Pregnancy | _____ | or | _____ |
| First Three Months of Pregnancy | _____ | or | _____ |
| Second Three Months of Pregnancy | _____ | or | _____ |
| Third Trimester of Pregnancy | _____ | or | _____ |

38. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

39. MOTHER'S MEDICAL RECORD NUMBER

## CONFIDENTIAL INFORMATION FOR INTERNAL USE ONLY

## MEDICAL AND HEALTH INFORMATION

**40. RISK FACTORS IN THIS PREGNANCY** *(Check all that apply)*

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)
- ☐ Insulin Dependent

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

☐ Previous preterm birth

☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment (If yes, check all that apply).
- ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)

☐ Mother had a previous cesarean delivery
If yes, how many _____

☐ None of the above

**41. OBSTETRIC PROCEDURES** *(Check all that apply)*

☐ Cervical cerclage

☐ Tocolysis

☐ External cephalic version:
- ☐ Successful
- ☐ Failed

☐ None of the above

**42. ONSET OF LABOR** *(Check all that apply)*

☐ Premature Rupture of the Membranes (prolonged, ≥ 12 hrs.)

☐ Precipitous Labor (< 3 hrs.)

☐ Prolonged Labor (≥ 20 hrs.)

☐ None of the above

**43. CHARACTERISTICS OF LABOR AND DELIVERY** *(Check all that apply)*

☐ Induction of labor

☐ Augmentation of labor

☐ Non-vertex presentation

☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery

☐ Antibiotics received by the mother during labor

☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > 38° C (100.4° F)

☐ Moderate/heavy meconium staining of the amniotic fluid

☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment or operative delivery

☐ Epidural or spinal anesthesia during labor

☐ None of the above

**44. METHOD OF DELIVERY**

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No

C. Fetal presentation at birth *(Check one)*
- ☐ Cephalic
- ☐ Breech
- ☐ Other

D. Final route and method of delivery *(Check one)*
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
- ☐ Cesarean

If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

**45. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY** *(Check all that apply)*

☐ Gonorrhea

☐ Syphilis

☐ Chlamydia

☐ HIV
If HIV checked, was mother treated with anti-retroviral medication during labor?
☐ Yes ☐ No
If HIV checked, was infant treated with anti-retroviral medication?
☐ Yes ☐ No

☐ Hepatitis C

☐ Hepatitis B
If Hepatitis B checked was mother positive for HBsAg?
☐ Yes ☐ No
If "YES" to HBsAg question, did newborn receive HBIG within 12 hours of birth?
☐ Yes ☐ No

☐ Zika Virus

☐ None of the above

**46. WAS MOTHER TESTED DURING PREGNANCY FOR**

| | | | |
|---|---|---|---|
| Syphilis? | ☐ Yes | ☐ No | ☐ Unknown |
| HIV? | ☐ Yes | ☐ No | ☐ Unknown |
| Hepatitis B? | ☐ Yes | ☐ No | ☐ Unknown |

**47. MATERNAL MORBIDITY** *(Check all that apply)*

☐ Maternal transfusion

☐ Third or fourth degree perineal laceration

☐ Ruptured uterus

☐ Unplanned hysterectomy

☐ Admission to intensive care unit

☐ Unplanned operating room procedure following delivery

☐ None of the above

## NEWBORN INFORMATION

**48. NEWBORN MEDICAL RECORD NUMBER**

**49. BIRTHWEIGHT** (grams preferred, specify unit)
☐ grams
☐ lb/oz

**50. OBSTETRIC ESTIMATE OF GESTATION** *(completed weeks)*

**51. APGAR SCORE**

Score at 5 minutes: _____

**If 5 minute score is less than 6,**

Score at 10 minutes: _____

**52. PLURALITY** - Single, Twin, Triplet, etc. *(Specify)*

**53a. IF NOT SINGLE BIRTH** - Born First, Second, Third, etc.
*(Specify)* _____

**53b. NUMBER OF INFANTS BORN ALIVE IN THIS DELIVERY** _____

**54. ABNORMAL CONDITIONS OF THE NEWBORN** *(Check all that apply)*

☐ Assisted ventilation required immediately following delivery

☐ Assisted ventilation required for more than six hours

☐ NICU admission

☐ Newborn given surfactant replacement therapy

☐ Antibiotics received by the newborn for suspected neonatal sepsis

☐ Seizure or serious neurologic dysfunction

☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)

☐ None of the above

**55a. WAS NEWBORN TRANSFERRED WITHIN 24 HOURS OF DELIVERY?**
☐ Yes ☐ No

**55b. IF YES, NAME OF FACILITY NEWBORN TRANSFERRED TO**

**56. CONGENITAL ANOMALIES OF THE NEWBORN** *(Check all that apply)*

☐ Anencephaly

☐ Microcephaly

☐ Meningomyelocele/Spina bifida

☐ Cyanotic congenital heart disease

☐ Congenital diaphragmatic hernia

☐ Omphalocele

☐ Gastroschisis

☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)

☐ Cleft Lip with or without Cleft Palate

☐ Cleft Palate alone

☐ Down Syndrome
- ☐ Karyotype confirmed
- ☐ Karyotype pending

☐ Other chromosomal disorder
- ☐ Karyotype confirmed
- ☐ Karyotype pending

☐ Hypospadias

☐ None

☐ Other *(Specify)* _____

**57. IS NEWBORN LIVING AT TIME OF REPORT?**
☐ Yes ☐ No ☐ Newborn transferred, status unknown

**58. IS THE NEWBORN BEING BREASTFED AT DISCHARGE?**
☐ Yes ☐ No

**59a. PROPHYLACTIC DRUG USED IN NEWBORN'S EYES?**
☐ Yes ☐ No

**59b. NAME OF PROPHYLACTIC DRUG**

**60 DID NEWBORN RECEIVE HEPATITIS B VACCINATION?**
☐ Yes ☐ No
If "YES" date of vaccination: _____
*(Month, Day, Year)*

**61. IS ADOPTION PENDING?**
☐ Yes ☐ No