STATE OF IOWA

IOWA DEPARTMENT OF PUBLIC HEALTH

114-

CERTIFICATE OF FETAL DEATH

TYPE OR PRINT IN PERMANENT BLACK INK

FOR INSTRUCTIONS SEE HANDBOOK

CHILD

1. FETUS - NAME (Optional): FIRST BRAYDEN | MIDDLE BRUCE | LAST Buntemeyer
2. SEX OF FETUS: Male
3a. DATE OF DELIVERY (Mo., Day, Yr.): 10/21/11
3b. HOUR OF DELIVERY: 1704 M.
4a. COUNTY OF DELIVERY: Scott
4b. FACILITY NAME (If not institution, give street and number): Genesis Medical Center
4c. CITY, TOWN, OR LOCATION OF DELIVERY: Davenport
4d. INSIDE CITY LIMITS (Specify yes or no): yes
4e. PLACE OF DELIVERY: ☒ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence ☐ Other (Specify)

CERTIFIER

I certify that this delivery occurred on the date stated above and the fetus was born dead.

5a. (Signature) ▶ Jessica A. Thorpe CNM
5b. DATE SIGNED (Mo., Day, Yr.): 10/21/2011
5c. CERTIFIER'S NAME AND TITLE (Type/Print) NAME: Jessica A. Thorpe CNM
☐ M.D. ☐ D.O. ☐ Hospital Admin. ☒ C.N.M. ☐ Other Midwife ☐ Other (Specify)
5d. CERTIFIER'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2322 E. Kimberly Rd. Davenport, IA 52807

ATTENDANT

6a. ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print) NAME:
☐ M.D. ☐ D.O. ☒ C.N.M. ☐ Other Midwife ☐ Other (Specify)
6b. ATTENDANT'S MAILING ADDRESS (If other than certifier) (Street and Number or Rural Route Number, City or Town, State, Zip Code):

REGISTRAR

7a. REGISTRAR (Signature) ▶
7b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.):

MOTHER

8a. MOTHER'S NAME: FIRST Jessica | MIDDLE Marie | MAIDEN Aiken
8b. DATE OF BIRTH (Mo., Day, Yr.): March 2, 1989
8c. STATE OF BIRTH (If not in U.S.A. name country): Missouri
9a. RESIDENCE - STATE: Iowa
9b. COUNTY: Scott
9c. CITY, TOWN OR LOCATION: Davenport
9d. STREET AND NUMBER OF RESIDENCE: 3235 Covington Dr.
9e. INSIDE CITY LIMITS (Specify yes or no): yes
10. MOTHER'S MAILING ADDRESS (If same as above, enter Zip Code only): 52806

FATHER

11a. FATHER'S NAME: FIRST JENNIFER | MIDDLE LEE | LAST BUNTEMEYER
11b. DATE OF BIRTH (Mo., Day, Yr.): September 16, 1984
11c. STATE OF BIRTH (If not in U.S.A. name country): Iowa

INFORMANT

12a. INFORMANT'S NAME (Signature of Parent or other informant) ▶ [signature]
12b. RELATION TO CHILD: Mother

BURIAL

13a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
13b. PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place): Fairmount Crematory
13c. LOCATION (City or Town, State): Davenport, Iowa
14a. FUNERAL HOME - NAME AND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Weerts Funeral Home 3625 Jersey Ridge Rd., Davenport, Iowa 52807
14b. FUNERAL DIRECTOR - SIGNATURE ▶ Mark Saunders
14c. F.D. LICENSE #: 2316

	15. OF HISPANIC ORIGIN? (Specify No or Yes below) If yes, specify Cuban, Mexican, Puerto Rican, etc.	16. RACE - White, Black, American Indian, etc. (Specify below)	17. EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)	18. OCCUPATION AND BUSINESS/INDUSTRY (Worked during last year) Occupation	Business/Industry
MOTHER	15a. ☒ No ☐ Yes Specify:	16a. White	17a.	2	18a. STUDENT/USAR	COLLEGE/ARMY
FATHER	15b. ☒ No ☐ Yes Specify:	16b. WHITE	17b.	6	18b. OPERATIONS SPECIALIST	[illegible]

19. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS		OTHER TERMINATIONS (Spontaneous and Induced)	
19a. Now Living Number ☒ None	19b. Now Dead Number ☒ None	19d. Before 20 weeks Number ☒ None	19e. After 20 weeks Number (Do not include this fetus) ☒ None
19c. DATE OF LAST LIVE BIRTH (Month, Year)		19f. DATE OF LAST OTHER TERMINATION (as indicated in d or e above) (Month, Year)	

20. WEIGHT OF FETUS (Specify unit): 3 lbs 7 oz
21a. PLURALITY (Specify Single, Twin, Triplet, etc.): Single
21b. IF NOT SINGLE (Specify First, Second, Third, etc.):
22. MOTHER MARRIED? (At conception, delivery, or any time between) (Specify yes or no): yes
23. DATE LAST NORMAL MENSES BEGAN (Mo., Day, Yr.): May 25, 2011
24a. MONTH OF PREGNANCY PRENATAL CARE BEGAN (Specify First, Second, etc.): Third
24b. TOTAL PRENATAL VISITS (If none, so state): 8
25. CLINICAL ESTIMATE OF GESTATION (Specify weeks): 30 weeks
26. MOTHER TRANSFERRED PRIOR TO DELIVERY? (Specify no or yes) If Yes, enter name of facility transferred from: no

MEDICAL AND HEALTH INFORMATION

27a. MEDICAL HISTORY FOR THIS PREGNANCY (Check all that apply)

- Anemia (Hct. <30/Hgb. <10) 1. ☐
- Cardiac disease 2. ☐
- Acute or chronic lung disease 3. ☐
- Diabetes 4. ☐
- Genital herpes 5. ☐
- Hydramnios/Oligohydramnios 6. ☐
- Hemoglobinopathy 7. ☐
- Hypertension, chronic 8. ☐
- Hypertension, pregnancy-associated 9. ☐
- Eclampsia 10. ☐
- Incompetent cervix 11. ☐
- Previous infant 4000+ grams 12. ☐
- Previous preterm or small-for-gestational-age infant 13. ☐
- Renal disease 14. ☐
- Rh sensitization 15. ☐
- Uterine bleeding 16. ☐
- None 00. ☒
- Other (Specify) 17. ☐

27b. OTHER HISTORY FOR THIS PREGNANCY (Complete all items)

- Tobacco use during pregnancy Yes ☐ No ☒
- Average number cigarettes per day
- Alcohol use during pregnancy Yes ☐ No ☒
- Average number drinks per week
- Weight gained during pregnancy 17 lbs.

28. OBSTETRIC PROCEDURES (Check all that apply)

- Amniocentesis 1. ☐
- Electronic fetal monitoring 2. ☐
- Induction of labor 3. ☒
- Stimulation of labor 4. ☐
- Tocolysis 5. ☐
- Ultrasound 6. ☒

29. EVENTS OF LABOR AND/OR DELIVERY (Check all that apply)

- Febrile (>100° F. or 38° C.) 1. ☐
- Meconium, moderate/heavy 2. ☐
- Premature rupture of membrane (>12 hours) 3. ☐
- Abruptio placenta 4. ☐
- Placenta previa 5. ☐
- Other excessive bleeding 6. ☐
- Seizures during labor 7. ☐
- Precipitous labor (<3 hours) 8. ☐
- Prolonged labor (>20 hours) 9. ☐
- Dysfunctional labor 10. ☐
- Breech/Malpresentation 11. ☐
- Cephalopelvic disproportion 12. ☐
- Cord prolapse 13. ☐
- Anesthetic complications 14. ☐
- Fetal distress 15. ☐
- None 00. ☐
- Other (Specify) fetal demise, known 16. ☒

30. METHOD OF DELIVERY (Check all that apply)

- Vaginal 1. ☒
- Vaginal birth after previous C-section 2. ☐
- Primary C-section 3. ☐
- Repeat C-section 4. ☐
- Forceps 5. ☐
- Vacuum 6. ☐
- Hysterotomy/Hysterectomy 7. ☐

31. CONGENITAL ANOMALIES OF FETUS (Check all that apply)

- Anencephalus 1 ☐
- Spina bifida/Meningocele 2 ☐
- Hydrocephalus 3 ☐
- Microcephalus 4 ☐
- Other central nervous system anomalies (Specify) 5 ☐
- Heart malformations 6 ☐
- Other circulatory/respiratory anomalies (Specify) 7 ☐
- Rectal atresia/stenosis 8 ☐
- Tracheo-esophageal fistula/Esophageal atresia 9 ☐
- Omphalocele/Gastroschisis 10 ☐
- Other gastrointestinal anomalies (Specify) 11 ☐
- Malformed genitalia 12 ☐
- Renal agenesis 13 ☐
- Other urogenital anomalies (Specify) 14 ☐
- Cleft lip/palate 15 ☐
- Polydactyly/Syndactyly/Adactyly 16 ☐
- Club foot 17 ☐
- Diaphragmatic hernia 18 ☐
- Other musculoskeletal/integumental anomalies (Specify) 19 ☐
- Down's syndrome 20 ☐
- Other chromosomal anomalies (Specify) 21 ☐
- None 00 ☐
- Other (Specify) Unknown 22 ☒