STATE OF IOWA
IOWA DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF FETAL DEATH

114-

TYPE OR PRINT IN PERMANENT BLACK INK

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

FOR INSTRUCTIONS SEE HANDBOOK

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

ATTENDANT

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

REGISTRAR

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

MOTHER

MOTHER'S NAME — FIRST: Jessica — MIDDLE: Marie — MAIDEN: Aiken
8a.
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

FATHER'S NAME — FIRST: JENNIFER — MIDDLE: LEE — LAST: BUNTEMEYER
11a.
11b. DATE OF BIRTH (Mo., Day, Yr.): February 16, 1974
11c. STATE OF BIRTH (If not in U.S.A. name country): Iowa

INFORMANT

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

BURIAL

13a. METHOD OF DISPOSITION: [ ] Burial [X] 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)	17. College (1-4 or 5+)	18. OCCUPATION AND BUSINESS/INDUSTRY (Worked during last year) Occupation	Business/Industry
MOTHER	15a. [X] No [ ] Yes	16a. White	17a.	2	18a. STUDENT/USAR	COLLEGE/ARMY
FATHER	15b. [X] No [ ] Yes	16b. WHITE	17b.	6	18b. OPERATIONS SPECIALIST	DE PARTMENT

19. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS		OTHER TERMINATIONS (Spontaneous and Induced)	
19a. Now Living	19b. Now Dead	19d. Before 20 weeks	19e. After 20 weeks
Number	Number	Number	Number (Do not include this fetus)
[X] None	[X] None	[X] None	[X] 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): 3lbs, 7oz
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. ☐	Genital herpes	5. ☐
Cardiac disease	2. ☐	Hydramnios/Oligohydramnios	6. ☐
Acute or chronic lung disease	3. ☐	Hemoglobinopathy	7. ☐
Diabetes	4. ☐	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. ☐	Abruptio placenta	4. ☐
Meconium, moderate/heavy	2. ☐	Placenta previa	5. ☐
Premature rupture of membrane (> 12 hours)	3. ☐	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. ☐	Other central nervous system anomalies (Specify)	5. ☐
Spina bifida/Meningocele	2. ☐	Heart malformations	6. ☐
Hydrocephalus	3. ☐	Other circulatory/respiratory anomalies (Specify)	7. ☐
Microcephalus	4. ☐	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. ☒		