

FIGURE 3

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Public Health Service		(1949 Revision of Standard Certificate) CERTIFICATE OF DEATH	
BIRTH NO. _____		STATE OF _____ STATE FILE NO. _____	
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) _____ OR TOWN _____		c. CITY (If outside corporate limits, write RURAL and give township) _____ OR TOWN _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) _____		d. STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) _____
5. SEX _____	6. COLOR OR RACE _____	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____	8. DATE OF BIRTH _____
9. AGE (In years last birthday) _____		IF UNDER 1 YEAR _____ Months Days	IF UNDER 24 HRS. _____ Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) _____
12. CITIZEN OF WHAT COUNTRY? _____		13. FATHER'S NAME _____	
14. MOTHER'S MAIDEN NAME _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT _____	
MEDICAL CERTIFICATION			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____ <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) _____		23b. ADDRESS _____	23c. DATE SIGNED _____
24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE _____	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) _____
DATE REC'D BY LOCAL REG. _____	REGISTRAR'S SIGNATURE _____	25. FUNERAL DIRECTOR ADDRESS _____	

FIGURE 4

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Public Health Service		(1949 Revision of Standard Certificate) CERTIFICATE OF STILLBIRTH¹	
STATE OF _____		STATE FILE NO. _____	
1. PLACE OF STILLBIRTH a. COUNTY _____		2. USUAL RESIDENCE OF MOTHER (Where does mother live?) a. STATE _____ b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____	
c. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) _____		d. STREET ADDRESS (If rural, give location) _____	
3. CHILD'S NAME (Type or Print) _____			
4. SEX	5a. THIS BIRTH SINGLE <input type="checkbox"/> TWIN <input type="checkbox"/> TRIPLET <input type="checkbox"/>	5b. IF TWIN OR TRIPLET (This child born) 1ST <input type="checkbox"/> 2ND <input type="checkbox"/> 3RD <input type="checkbox"/>	6. DATE OF STILLBIRTH (Month) (Day) (Year)
7. FATHER'S NAME a. (First) _____ b. (Middle) _____ c. (Last) _____			8. COLOR OR RACE _____
9. AGE (At time of this birth) YEARS _____	10. BIRTHPLACE (State or foreign country) _____	11a. USUAL OCCUPATION _____	11b. KIND OF BUSINESS OR INDUSTRY _____
12. MOTHER'S MAIDEN NAME a. (First) _____ b. (Middle) _____ c. (Last) _____			13. COLOR OR RACE _____
14. AGE (At time of this birth) YEARS _____	15. BIRTHPLACE (State or foreign country) _____	16. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child) a. How many children are now living? _____ b. How many children were born alive but are now dead? _____ c. How many OTHER children were stillborn (born dead after 20 weeks pregnancy)? _____	
17. INFORMANT _____			
18a. LENGTH OF PREGNANCY WEEKS _____	18b. WEIGHT AT BIRTH LBS. _____ OZS. _____	19. LEGITIMATE YES <input type="checkbox"/> NO <input type="checkbox"/>	
CAUSE OF STILLBIRTH State only morbid conditions causing fetal death (do NOT use such terms as Stillbirth, Prematurity, Asphyxia, etc.)	20a. FETAL CAUSES _____		
	20b. MATERNAL CAUSES _____		
21. STATE ANY COMPLICATIONS OF PREGNANCY AND LABOR _____		22. STATE ALL OPERATIONS FOR DELIVERY _____	
I hereby certify that I attended the birth of this child who was born dead on the date stated above at _____ m.	23a. ATTENDANT'S SIGNATURE (Specify if M. D., midwife, or other) _____		23b. DATE SIGNED _____
	23c. ATTENDANT'S ADDRESS _____	If NOT attended by physician 24. SIGNATURE OF AUTHORIZED OFFICIAL _____	TITLE _____
25a. BURIAL, CREMATION, REMOVAL (Specify) _____	25b. DATE _____	25c. NAME OF CEMETERY OR CREMATORY _____	25d. LOCATION (City, town, or county) (State) _____
DATE REC'D BY LOCAL REG. _____	REGISTRAR'S SIGNATURE _____	26. FUNERAL DIRECTOR _____	ADDRESS _____

¹The title of this certificate is being shown as it appeared on the 1949 revision of the standard certificate. More recently, however, there has been a change in terminology from "stillbirth" to "fetal death" in conformity with the recommendations of the Third World Health Assembly (May 1950). Future changes in the standard certificate will reflect the new terminology.