MINISTRY OF HEALTH
MANATŪ HAUORA

Burial and Cremation Act 1964

HP4721

Medical Certificate of Causes of Fetal and Neonatal Death

This certificate should be completed for stillbirths and for liveborn infants dying within 28 days of birth, and given to the funeral director or other person in charge of the body without delay

Certification status

Tick one: ◯ **Stillbirth** (a dead fetus that weighed 400g or more when issued from its mother or issued from its mother after the 20th week of pregnancy) ◯ **A liveborn infant dying within 28 days of birth**

NOTE: a midwife may complete a certificate for a stillbirth if there was no medical practitioner in attendance

Infant

Name of infant (if given) ..... (Surname or family name) ..... (First or given name(s))

Infant's NHI number (if available) | | | | | | | |

Sex ◯ Female ◯ Male ◯ Indeterminate

Ethnic group(s) ◯ New Zealand European ◯ Māori ◯ Samoan ◯ Cook Island Māori ◯ Tongan

Mark the space or spaces that apply ◯ Niuean ◯ Chinese ◯ Indian ◯ other (*such as DUTCH, JAPANESE, TOKELAUAN*). Please state: .....

Birthweight ..... grams *(excluding placenta)* Number of **completed** weeks in utero ..... weeks

Date and time of birth ..... day / ..... month / ..... year at ..... am / pm

If born alive, date and time of death ..... day / ..... month / ..... year at ..... am / pm Place of death .....

If born dead, infant died: ◯ Before labour ◯ During labour ◯ Not known

Date last thought to be alive: ..... day / ..... month / ..... year or ◯ Not known

Single or multiple birth ◯ Single ◯ Multiple → Number of babies ..... Birth order ..... *(1st, 2nd, 3rd, etc)*

Mother

Name of mother ..... (Surname or family name) ..... (First or given name(s))

Mother's NHI number (if available) | | | | | | | |

Place of delivery ..... Expected date of delivery ..... day / ..... month / ..... year

Mother's date of birth ..... day / ..... month / ..... year First day of last menstrual period ..... day / ..... month / ..... year

Number of **previous** pregnancies ending: after 20 completed weeks → ..... before 20 completed weeks → .....

Did the mother receive ante-natal care? ◯ No ◯ Don't know ◯ Yes

Delivery ◯ Normal spontaneous vertex ◯ Other → *Specify* ..... (Method) ..... (Presentation)

Causes of Death

(a) Main disease or condition in fetus or infant .....

(b) Other diseases or conditions in fetus or infant .....

.....

(c) Main maternal disease or condition affecting fetus or infant .....

(d) Other maternal diseases or conditions affecting fetus or infant .....

(e) Other relevant circumstances .....

Post-mortem examination ◯ Will be done ◯ Requested — consent not given ◯ Not requested

I certify that the particulars and causes of death shown above are true to the best of my knowledge and belief, and that no relevant information has been omitted and that the death is not required to be reported to a coroner under the Coroners Act 2006. If required by the Director-General, Ministry of Health, I am prepared to provide additional information as to the cause of death, where available, for the purpose of allocating a more precise statistical classification.

..... **Printed name of practitioner** ..... Qualifications

Health Practitioner Index - Common Person Number (HPI-CPN) | | | | | | | |

..... Address ..... Signature ..... / / Date