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STATE FILE NUMBER

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

CERTIFICATE OF LIVE BIRTH

124 -

VS 100C MO 580-0697 (10-2022)

CHILD

1. CHILD'S NAME — FIRST | MIDDLE | LAST | SUFFIX

2. DATE OF BIRTH — MONTH | DAY | YEAR

3. TIME OF BIRTH — ☐ AM ☐ PM ☐ MILITARY ☐ UNKNOWN

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 number and street)*

MOTHER/CO-PARENT

9a. MOTHER'S/CO-PARENT'S NAME PRIOR TO FIRST MARRIAGE — FIRST | MIDDLE | LAST | SUFFIX

9b. DATE OF BIRTH — MONTH | DAY | YEAR

9c. MOTHER'S/CO-PARENT'S CURRENT LEGAL NAME — FIRST | MIDDLE | LAST | SUFFIX

9d. BIRTHPLACE — COUNTRY | STATE, TERRITORY, OR PROVINCE

10a. RESIDENCE OF MOTHER/CO-PARENT — COUNTRY | STATE, TERRITORY, OR PROVINCE

10b. COUNTY

10c. CITY, TOWN, OR LOCATION

10d. NUMBER AND STREET

10e. ZIP CODE

10f. INSIDE CITY LIMITS? ☐ Yes ☐ No ☐ Unknown

11a. MOTHER'S/CO-PARENT'S MAILING ADDRESS
☐ SAME AS RESIDENCE
COUNTRY | STATE, TERRITORY, OR PROVINCE

11b. CITY, TOWN, OR LOCATION

11c. NUMBER AND STREET

11d. ZIP CODE

FATHER/CO-PARENT

12a. FATHER'S/CO-PARENT'S CURRENT LEGAL NAME — FIRST | MIDDLE | LAST | SUFFIX

12b. DATE OF BIRTH — MONTH | DAY | YEAR

12c. BIRTHPLACE — COUNTRY | STATE, TERRITORY, OR PROVINCE

CERTIFIER

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

NAME _____

☐ MD ☐ DO ☐ CNM/CM ☐ CPM ☐ OTHER MIDWIFE

☐ HOSPITAL ADMINISTRATOR ☐ OTHER (Specify) _____

13b. CERTIFIER'S MO LICENSE NUMBER

13c. CERTIFIER'S NPI NUMBER

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

SIGNATURE ▶

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

ATTENDANT

14. ATTENDANT NAME AND TITLE *(Type/Print)*

☐ SAME AS CERTIFIER ABOVE

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

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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 conception, birth, or any time between)*

- ☐ Yes, I was married to the father of this child.
- ☐ Yes, to a male spouse, but not to the father of this child.
- ☐ Yes, to a female spouse.
- ☐ Yes, to a female spouse, but I wish to provide information about the father.
- ☐ Yes, but I refuse to provide spouse's information.
- ☐ No, but I wish to provide information about the father.
- ☐ No, and I do not wish to provide information about the father.
- ☐ Unknown

19. MOTHER'S SOCIAL SECURITY NUMBER

20. FATHER'S/CO-PARENT'S SOCIAL SECURITY NUMBER

MOTHER

21. WHAT IS THE HIGHEST LEVEL OF SCHOOLING THAT YOU WILL HAVE COMPLETED AT THE TIME OF DELIVERY? (CHECK THE BOX THAT BEST DESCRIBES YOUR EDUCATION. IF YOU ARE CURRENTLY ENROLLED, CHECK THE BOX THAT INDICATES THE PREVIOUS GRADE OR HIGHEST DEGREE RECEIVED.)

- ☐ 8th grade or less
- ☐ No diploma, 9th - 12th grade
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate's 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)
- ☐ Unknown

22. ARE YOU SPANISH/HISPANIC/LATINA? IF NOT SPANISH/HISPANIC/LATINA, CHECK THE "NO" BOX. IF YOU ARE SPANISH/HISPANIC/LATINA, CHECK THE APPROPRIATE BOX. **CHECK ONLY ONE BOX.**

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Colombian)
  Specify: _____
- ☐ Unknown

23. WHICH ONE OR MORE OF THE FOLLOWING IS YOUR RACE? **CHECK ALL THAT APPLY.**

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (specify tribe)
  _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify): _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (specify): _____
- ☐ Other (specify) _____
- ☐ Unknown

FATHER/CO-PARENT

24. WHAT IS THE HIGHEST LEVEL OF SCHOOLING THAT THE FATHER/CO-PARENT WILL HAVE COMPLETED AT THE TIME OF DELIVERY? (CHECK THE BOX THAT BEST DESCRIBES LEVEL OF EDUCATION. IF CURRENTLY ENROLLED, CHECK THE BOX THAT INDICATES THE PREVIOUS GRADE OR HIGHEST DEGREE RECEIVED.)

- ☐ 8th grade or less
- ☐ No diploma, 9th - 12th grade
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate's 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)
- ☐ Unknown

25. IS THE FATHER/CO-PARENT SPANISH/HISPANIC/LATINO(A)? IF NOT SPANISH/HISPANIC/LATINO(A), CHECK THE "NO" BOX. IF SPANISH/HISPANIC/LATINO(A), CHECK THE APPROPRIATE BOX. **CHECK ONLY ONE BOX.**

- ☐ No, not Spanish/Hispanic/Latino(a)
- ☐ Yes, Mexican, Mexican American, Chicano(a)
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino(a) (e.g. Spaniard, Salvadoran, Dominican, Colombian)
  Specify: _____
- ☐ Unknown

26. WHICH ONE OR MORE OF THE FOLLOWING IS THE RACE OF THE FATHER/CO-PARENT? **CHECK ALL THAT APPLY.**

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (specify tribe)
  _____
- ☐ 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 ☐ Unknown

34. DID MOTHER PARTICIPATE IN THE FOOD STAMP PROGRAM?

☐ Yes ☐ No ☐ Unknown

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

35a. Now Living
Number _____
☐ None

35b. Now Deceased
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 Trimester of Pregnancy	_____	or	_____
Second Trimester of Pregnancy	_____	or	_____
Third Trimester of Pregnancy	_____	or	_____

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

39. MOTHER'S MEDICAL RECORD NUMBER

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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
☐ Unknown

41. OBSTETRIC PROCEDURES *(Check all that apply)*
- ☐ Cervical cerclage
- ☐ Tocolysis
- ☐ External cephalic version:
  - ☐ Successful
  - ☐ Failed
- ☐ None of the above
- ☐ Unknown

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
- ☐ Unknown

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
- ☐ Unknown

44. METHOD OF DELIVERY

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

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

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

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

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

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
- ☐ Unknown

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
- ☐ Unknown

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
- ☐ Unknown

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)* _____
- ☐ Unknown

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

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

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

59b. NAME OF PROPHYLACTIC DRUG

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

61. IS ADOPTION PENDING? ☐ Yes ☐ No