

State of Idaho
CERTIFICATE OF STILLBIRTH
INSTRUCTIONS FOR THREE-PART FORM

24-HOUR REPORT OF STILLBIRTH (PINK)

1. In every case a Report of Stillbirth must be mailed to (or otherwise filed with) the Local Registrar of the district in which stillbirth occurred within 24 hours after taking possession of the stillborn fetus.

AUTHORIZATION FOR FINAL DISPOSITION - TRANSIT PERMIT (YELLOW)

2. For all cases except cremation, out-of-state transport, or coroner's case, only the mortician's signature is necessary for final disposition.
3. If the stillborn fetus is to be transported out-of-state, is a coroner's case, or is to be cremated (also see #4), the stillbirth certificate and this authorization must be signed by the person responsible for certifying to the cause of stillbirth.
4. If the stillborn fetus is to be cremated, the coroner must give additional authorization on the Final Disposition form only. If the hospital cremates the stillborn fetus, the coroner need not give additional authorization.

CERTIFICATE OF STILLBIRTH (WHITE)

5. A completed stillbirth certificate must be filed with the Local Registrar where stillbirth occurred within five (5) days from the date of stillbirth.

PLEASE DETACH THIS INSTRUCTION SHEET AND COMPLETE FORM AS OUTLINED

IDAHO CODE

39-260. Registration of Deaths and Stillbirths

- (4) Each stillbirth, defined as a spontaneous fetal death of twenty (20) completed weeks gestation or more, based on a clinical estimate of gestation, or a weight of three hundred fifty (350) grams (twelve and thirty-five hundredths (12.35) ounces) or more, which occurs in this state shall be registered on a certificate of stillbirth within five (5) days after delivery with the local registrar of the district in which the stillbirth occurred. All induced terminations of pregnancy shall be reported in the manner prescribed in section 39-261, Idaho Code, and shall not be reported as stillbirths. No certificate shall be deemed complete until every item of information required shall have been provided or its omission satisfactorily accounted for.
 - (a) When a stillbirth occurs in an institution, the person in charge of the institution or a designated representative shall prepare the certificate, obtain the signature of the physician, physician assistant or advanced practice professional nurse in attendance, except as otherwise provided in subsection (5) of this section, who shall provide the medical data, and forward the certificate to the mortician or person acting as such. In the absence of the attending physician, physician assistant or advanced practice professional nurse or with said person's approval the certificate may be completed and signed by said person's associate, who must be a physician, physician assistant or advanced practice professional nurse, the chief medical officer of the institution in which the stillbirth occurred, or the physician who performed an autopsy on the stillborn fetus, provided such individual has access to the medical history of the case and views the fetus at or after stillbirth. The mortician or person acting as such shall provide the disposition information and file the certificate with the local registrar.
 - (b) When a stillbirth occurs outside an institution, the mortician or person acting as such shall complete the certificate, obtain the medical data from and signature of the attendant at the stillbirth, except as otherwise provided in subsection (5) of this section, and file the certificate. If the attendant at or immediately after the stillbirth is not a physician, physician assistant or advanced practice professional nurse, the coroner shall investigate and sign the certificate of stillbirth.
 - (c) When a stillbirth occurs in a moving conveyance in the United States and the stillborn fetus is first removed from the conveyance in this state, the stillbirth shall be registered in this state and the place where the stillborn fetus is first removed shall be considered the place of stillbirth. When a stillbirth occurs in a moving conveyance while in international airspace or in a foreign country or its airspace and the stillborn fetus is first removed from the conveyance in this state, the stillbirth shall be registered in this state but the certificate shall show the actual place of stillbirth insofar as can be determined.
 - (d) When a stillborn fetus is found in this state and the place of stillbirth is unknown, it shall be reported in this state. The place where the stillborn fetus was found shall be considered the place of stillbirth.
 - (e) The name of the father shall be entered on the certificate of stillbirth as provided by section 39-255, Idaho Code.
- (5) The person responsible for the preparation or completion of the stillbirth certificate as stated in subsections (4)(a) and (b) of this section shall refer the following cases to the coroner who shall make an immediate investigation, supply the necessary medical data and certify to the cause of stillbirth:
 - (a) When the circumstances suggest that the stillbirth occurred as a result of other than natural causes, excepting legally induced abortions, as defined by section 39-241, Idaho Code; or
 - (b) When death is due to natural causes and the physician, physician assistant or advanced practice professional nurse in attendance at or immediately after the stillbirth or said person's designated associate is not available or is physically incapable of signing.

DEPARTMENT OF HEALTH AND WELFARE RULES

16.02.08.450. Registration of Deaths and Stillbirths.

03. Signatures Required on Stillbirth Certificates. (12-26-83)
 - a. The mortician's signature must meet the following criteria: (12-26-83)
 - i. The mortician, or person acting as such, must sign the certificate. No stamps or other types of facsimile signatures may be used. (4-2-08)
 - ii. When a hospital disposes of a stillborn fetus, in accordance with Section 39-268(3), Idaho Code, the hospital authority must complete and sign the certificate as mortician. (4-2-08)
 - b. The person responsible according to Section 39-260, Idaho Code, for the attendant or medical certification, must sign the certificate. No stamps or other types of facsimile signatures may be used. (12-26-83)
 - c. The local registrar must sign the certificate. The registrar's signature must be the same as it appears in the notarized certificate of appointment. No stamps or other types of facsimile signatures may be used. (12-26-83)

State of Idaho
CERTIFICATE OF STILLBIRTH

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR WITH THE DEPARTMENT OF HEALTH AND WELFARE RAISED SEAL, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS STILLBIRTH UNDER §39-241(4) AND §39-274, IDAHO CODE

STILLBORN CHILD: 1. CHILD'S NAME, 2. TIME OF DELIVERY, 3. SEX, 4. DATE OF DELIVERY, 5. FACILITY NAME, 6. CITY, TOWN, OR LOCATION OF DELIVERY, 7. COUNTY OF DELIVERY. MOTHER: 8a. MOTHER'S CURRENT LEGAL NAME, 8b. DATE OF BIRTH, 8c. MOTHER'S MAIDEN NAME, 8d. BIRTHPLACE, 9a. RESIDENCE OF MOTHER - STATE, 9b. COUNTY, 9c. CITY, TOWN, OR LOCATION, 9d. STREET AND NUMBER, 9e. APT. NO., 9f. ZIP CODE, 9g. INSIDE CITY LIMITS?. FATHER: 10a. FATHER'S CURRENT LEGAL NAME, 10b. DATE OF BIRTH, 10c. BIRTHPLACE. LOCAL REGISTRAR: 11a. REGISTRAR'S SIGNATURE, 11b. DATE SIGNED. CERTIFIER: 12a. CERTIFIER OF STILLBIRTH, 12b. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER, 12c. CERTIFIER'S LICENSE NUMBER, 12d. DATE SIGNED, 12e. DELIVERY ATTENDANT'S NAME AND TITLE. CORONER: 13a. TO BE COMPLETED BY CORONER ONLY, 13b. DATE SIGNED. DISPOSITION: 14. METHOD OF DISPOSITION, 15. PLACE OF DISPOSITION, 16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY, 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE, 17b. LICENSE NUMBER.

CAUSE/CONDITIONS CONTRIBUTING TO STILLBIRTH

CAUSE OF STILLBIRTH: 18a. INITIATING CAUSE/CONDITION, 18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS, 19. WEIGHT OF FETUS, 20. OBSTETRIC ESTIMATE OF GESTATION, 21. ESTIMATED TIME OF FETAL DEATH, 22. WAS AN AUTOPSY PERFORMED?, 23. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?, 24. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?

* At a minimum, complete items 1; 4; 5; 6; 7; 12b (name) or 13a (name); 16; and 17a for the 24-Hour Report and Authorization for Final Disposition.

MEDICAL AND HEALTH SECTION Complete Each Item	25. MOTHER MARRIED? (at delivery, conception, or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No IF "NO", HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? <input type="checkbox"/> Yes <input type="checkbox"/> No	26. PLACE WHERE DELIVERY OCCURRED (Check one) <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home delivery Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Other (Specify) _____	27. WAS MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", NAME OF FACILITY MOTHER TRANSFERRED FROM: _____
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28. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) 1 <input type="checkbox"/> 8th grade or less (includes none) 2 <input type="checkbox"/> 9th - 12th grade, but no diploma 3 <input type="checkbox"/> High school graduate or GED completed 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree (eg, AA, AS) 6 <input type="checkbox"/> Bachelor's degree (eg, AB, BA, BS) 7 <input type="checkbox"/> Master's degree (eg, MA, MBA, MEd, MEng, MS, MSW) 8 <input type="checkbox"/> Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)	29. MOTHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina) 0 <input type="checkbox"/> No, not Spanish/Hispanic/Latina 1 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana 2 <input type="checkbox"/> Yes, Puerto Rican 3 <input type="checkbox"/> Yes, Cuban 4 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____	30. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be) 01 <input type="checkbox"/> White 02 <input type="checkbox"/> Black or African American 03 <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ 04 <input type="checkbox"/> Asian Indian 05 <input type="checkbox"/> Chinese 06 <input type="checkbox"/> Filipino 07 <input type="checkbox"/> Japanese 08 <input type="checkbox"/> Korean 09 <input type="checkbox"/> Vietnamese 10 <input type="checkbox"/> Other Asian (Specify) _____ 11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro 13 <input type="checkbox"/> Samoan 14 <input type="checkbox"/> Other Pacific Islander (Specify) _____ 15 <input type="checkbox"/> Other (Specify) _____
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31. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) 1 <input type="checkbox"/> 8th grade or less (includes none) 2 <input type="checkbox"/> 9th - 12th grade, but no diploma 3 <input type="checkbox"/> High school graduate or GED completed 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree (eg, AA, AS) 6 <input type="checkbox"/> Bachelor's degree (eg, AB, BA, BS) 7 <input type="checkbox"/> Master's degree (eg, MA, MBA, MEd, MEng, MS, MSW) 8 <input type="checkbox"/> Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)	32. FATHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino) 0 <input type="checkbox"/> No, not Spanish/Hispanic/Latino 1 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano 2 <input type="checkbox"/> Yes, Puerto Rican 3 <input type="checkbox"/> Yes, Cuban 4 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____	33. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be) 01 <input type="checkbox"/> White 02 <input type="checkbox"/> Black or African American 03 <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ 04 <input type="checkbox"/> Asian Indian 05 <input type="checkbox"/> Chinese 06 <input type="checkbox"/> Filipino 07 <input type="checkbox"/> Japanese 08 <input type="checkbox"/> Korean 09 <input type="checkbox"/> Vietnamese 10 <input type="checkbox"/> Other Asian (Specify) _____ 11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro 13 <input type="checkbox"/> Samoan 14 <input type="checkbox"/> Other Pacific Islander (Specify) _____ 15 <input type="checkbox"/> Other (Specify) _____
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34a. DATE OF FIRST PRENATAL CARE VISIT MM / DD / YYYY <input type="checkbox"/> No prenatal care	34b. DATE OF LAST PRENATAL CARE VISIT MM / DD / YYYY <input type="checkbox"/> No prenatal care	35. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ (IF NONE, ENTER "0")	
36. MOTHER'S HEIGHT _____ (feet/inches)	37. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)	38. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)	39. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL AND HEALTH SECTION Complete Each Item	PREGNANCY HISTORY (Complete each section) PREVIOUS LIVE BIRTHS (report live births and their current status by completing items 40a-40c) OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies) Complete items 41a-41b		42. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter 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 three months of pregnancy _____ OR _____ Second three months of pregnancy _____ OR _____ Last three months of pregnancy _____ OR _____	43. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicaid 3 <input type="checkbox"/> Self-pay 4 <input type="checkbox"/> Indian Health Service 5 <input type="checkbox"/> CHAMPUS/TRICARE 6 <input type="checkbox"/> Other government (federal, state, local) 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> None
	40a. Now Living Number _____ <input type="checkbox"/> None	40b. Now Dead Number _____ <input type="checkbox"/> None	41a. Other Outcomes (Do not include this fetus) Number _____ <input type="checkbox"/> None	44. DATE LAST NORMAL MENSES BEGAN MM / DD / YYYY

MEDICAL AND HEALTH SECTION Complete Each Item	46. METHOD OF DELIVERY A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Fetal presentation at delivery (Check one) <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other _____ D. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean, was trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No E. Hysterotomy/Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No	47. PLURALITY (single, twin, triplet, etc.) (Specify) _____ 48. IF NOT SINGLE BIRTH (born first, second, third, etc.) (Specify) _____	52. CONGENITAL ANOMALIES OF THE FETUS (Check all that apply) 01 <input type="checkbox"/> Anencephaly 02 <input type="checkbox"/> Meningocele/Spina bifida 03 <input type="checkbox"/> Cyanotic congenital heart disease 04 <input type="checkbox"/> Congenital diaphragmatic hernia 05 <input type="checkbox"/> Omphalocele 06 <input type="checkbox"/> Gastroschisis 07 <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) 08 <input type="checkbox"/> Cleft lip with or without cleft palate 09 <input type="checkbox"/> Cleft palate alone 10 <input type="checkbox"/> Down syndrome <input type="checkbox"/> Karyotype confirmed 11 <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected other chromosomal disorder 12 <input type="checkbox"/> Karyotype confirmed 13 <input type="checkbox"/> Karyotype pending 14 <input type="checkbox"/> Hypospadias 15 <input type="checkbox"/> Other (Specify) _____ 00 <input type="checkbox"/> None
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MEDICAL AND HEALTH SECTION Complete Each Item	49. RISK FACTORS IN THIS PREGNANCY (Check all that apply) Diabetes 01 <input type="checkbox"/> Prepregnancy (diagnosis prior to this pregnancy) 02 <input type="checkbox"/> Gestational (diagnosis in this pregnancy) Hypertension 03 <input type="checkbox"/> Prepregnancy (chronic) 04 <input type="checkbox"/> Gestational (PIH, preeclampsia, eclampsia) 05 <input type="checkbox"/> Previous preterm birth 06 <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) 07 <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor 08 <input type="checkbox"/> Pregnancy resulted from infertility treatment 09 <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many? _____ 00 <input type="checkbox"/> None of the above	50. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply) 01 <input type="checkbox"/> Gonorrhoea 02 <input type="checkbox"/> Syphilis 03 <input type="checkbox"/> HIV infection 04 <input type="checkbox"/> Herpes Simplex Virus (HSV) 05 <input type="checkbox"/> Chlamydia 06 <input type="checkbox"/> Listeria 07 <input type="checkbox"/> Group B Streptococcus 08 <input type="checkbox"/> Cytomegalovirus 09 <input type="checkbox"/> Parvovirus 10 <input type="checkbox"/> Toxoplasmosis 11 <input type="checkbox"/> Hepatitis B 12 <input type="checkbox"/> Hepatitis C 13 <input type="checkbox"/> Other (Specify) _____ 00 <input type="checkbox"/> None	51. MATERNAL MORBIDITY (complications associated with labor and delivery) (Check all that apply) 1 <input type="checkbox"/> Maternal transfusion 2 <input type="checkbox"/> Third or fourth degree perineal laceration 3 <input type="checkbox"/> Ruptured uterus 4 <input type="checkbox"/> Unplanned hysterectomy 5 <input type="checkbox"/> Admission to intensive care unit 6 <input type="checkbox"/> Unplanned operating room procedure following delivery 0 <input type="checkbox"/> None of the above
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MULTIPLE BIRTHS.
Enter State File Number(s) of mate(s):

LIVE BIRTH(S):

STILLBIRTH(S):

State of Idaho
AUTHORIZATION FOR FINAL DISPOSITION-TRANSIT PERMIT

STILLBORN CHILD	* 1. CHILD'S NAME (First, Middle, Last, Suffix)	2. TIME OF DELIVERY (24hr)	3. SEX	* 4. DATE OF DELIVERY (Mo/Day/Yr)
	* 5. FACILITY NAME (If not facility, give street and number)	* 6. CITY, TOWN, OR LOCATION OF DELIVERY	* 7. COUNTY OF DELIVERY	
MOTHER	8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		8b. DATE OF BIRTH (Mo/Day/Yr)	
	8c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)		8d. BIRTHPLACE (State, Territory, or Foreign Country)	
	9a. RESIDENCE OF MOTHER - STATE	9b. COUNTY	9c. CITY, TOWN, OR LOCATION	
	9d. STREET AND NUMBER	9e. APT. NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER	10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	10b. DATE OF BIRTH (Mo/Day/Yr)	10c. BIRTHPLACE (State, Territory, or Foreign Country)	
LOCAL REGISTRAR	11a. REGISTRAR'S SIGNATURE		11b. DATE SIGNED MM / DD / YYYY	
CERTIFIER'S AUTHORIZATION FOR DISPOSAL	12a. CERTIFIER OF STILLBIRTH (Check only one, based on official capacity for this certificate) <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> ADVANCED PRACTICE PROFESSIONAL NURSE To the best of my knowledge, stillbirth occurred at the time, date, and place, and due to the <i>natural</i> cause(s)/manner stated.		12c. CERTIFIER'S LICENSE NUMBER	
	Certifier's Signature ▶		12d. DATE SIGNED MM / DD / YYYY	
	* 12b. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print)	12e. DELIVERY ATTENDANT'S NAME AND TITLE NAME _____ TITLE <input type="checkbox"/> LM <input type="checkbox"/> CM <input type="checkbox"/> Other (Specify) _____		
CORONER	13a. TO BE COMPLETED BY CORONER ONLY: IF NOT ATTENDED BY PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE PROFESSIONAL NURSE OR IF FROM EXTERNAL CAUSES, CORONER'S SIGNATURE REQUIRED On the basis of examination and/or investigation, in my opinion, stillbirth occurred at the time, date, and place, and due to the cause(s) and manner stated.			
	Coroner's Signature ▶		13b. DATE SIGNED MM / DD / YYYY	
DISPOSITION	14. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Hospital disposition <input type="checkbox"/> Donation <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Other (Specify) _____	15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)	* 16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY	
	* 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH		17b. LICENSE NUMBER (Of licensee)	

CORONER'S AUTHORIZATION FOR CREMATION	INSTRUCTIONS FOR THREE-PART FORM
	<p>24-HOUR REPORT OF STILLBIRTH (PINK) 1. In every case a Report of Stillbirth must be mailed to (or otherwise filed with) the Local Registrar of the district in which stillbirth occurred within 24 hours after taking possession of the stillborn fetus.</p> <p>AUTHORIZATION FOR FINAL DISPOSITION - TRANSIT PERMIT (YELLOW) 2. For all cases except cremation, out-of-state transport, or coroner's case, only the mortician's signature is necessary for final disposition. 3. If the stillborn fetus is to be transported out-of-state, is a coroner's case, or is to be cremated (also see #4), the stillbirth certificate and this authorization must be signed by the person responsible for certifying to the cause of stillbirth. 4. If the stillborn fetus is to be cremated, the coroner must give additional authorization on the Final Disposition form only. If the hospital cremates the stillborn fetus, the coroner need not give additional authorization.</p> <p>CERTIFICATE OF STILLBIRTH (WHITE) 5. A completed stillbirth certificate must be filed with the Local Registrar where stillbirth occurred within five (5) days from the date of stillbirth.</p>
	DATE SIGNED MM / DD / YYYY
MORTICIAN'S RESPONSIBILITY	<p>CORONER'S AUTHORIZATION FOR CREMATION</p> <p>Signature ▶</p> <p>* DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal (out-of-state transport) <input type="checkbox"/> Entombment <input type="checkbox"/> Scientific Use <input type="checkbox"/> Other _____</p> <p style="text-align: center;">I have obtained the signatures required in §39-268, Idaho Code, for Authorization for Final Disposition.</p> <p>_____ Mortician or person acting as mortician (Signature)</p> <p>_____ Person receiving the remains if transferred out-of-state (Signature)</p>

* At a minimum, complete items 1; 4; 5; 6; 7; 12b (name) or 13a (name); 16; and 17a for the 24-Hour Report and Authorization for Final Disposition.
To Crematory Manager: Do not cremate the stillborn fetus without the coroner's signature on this form.
This form must accompany the stillborn fetus to final disposition, including transportation, storage, interment, and cremation.

State of Idaho
24 HOUR REPORT OF STILLBIRTH

Local Reg. No. _____

STILLBORN CHILD	* 1. CHILD'S NAME (First, Middle, Last, Suffix)	2. TIME OF DELIVERY <small>(24hr)</small>	3. SEX	* 4. DATE OF DELIVERY (Mo/Day/Yr)
	* 5. FACILITY NAME (If not facility, give street and number)	* 6. CITY, TOWN, OR LOCATION OF DELIVERY	* 7. COUNTY OF DELIVERY	
MOTHER	8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		8b. DATE OF BIRTH (Mo/Day/Yr)	
	8c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)		8d. BIRTHPLACE (State, Territory, or Foreign Country)	
	9a. RESIDENCE OF MOTHER - STATE	9b. COUNTY	9c. CITY, TOWN, OR LOCATION	
	9d. STREET AND NUMBER	9e. APT. NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER	10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	10b. DATE OF BIRTH (Mo/Day/Yr)	10c. BIRTHPLACE (State, Territory, or Foreign Country)	
LOCAL REGISTRAR	11a. REGISTRAR'S SIGNATURE		11b. DATE SIGNED ____/____/____ MM DD YYYY	
CERTIFIER	12a. CERTIFIER OF STILLBIRTH (Check only one, based on official capacity for this certificate) <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> ADVANCED PRACTICE PROFESSIONAL NURSE To the best of my knowledge, stillbirth occurred at the time, date, and place, and due to the <i>natural</i> cause(s)/manner stated.		12c. CERTIFIER'S LICENSE NUMBER	
	Certifier's Signature ▶ _____		12d. DATE SIGNED ____/____/____ MM DD YYYY	
	* 12b. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print)	12e. DELIVERY ATTENDANT'S NAME AND TITLE NAME _____ TITLE <input type="checkbox"/> LM <input type="checkbox"/> CM <input type="checkbox"/> Other (Specify) _____		
CORONER	13a. TO BE COMPLETED BY CORONER ONLY: IF NOT ATTENDED BY PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE PROFESSIONAL NURSE OR IF FROM EXTERNAL CAUSES, CORONER'S SIGNATURE REQUIRED On the basis of examination and/or investigation, in my opinion, stillbirth occurred at the time, date, and place, and due to the cause(s) and manner stated.			
	Coroner's Signature ▶ _____		13b. DATE SIGNED ____/____/____ MM DD YYYY	
DISPOSITION	14. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Hospital disposition <input type="checkbox"/> Donation <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Other (Specify) _____	15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)	* 16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY	
	* 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	17b. LICENSE NUMBER (Of licensee)		

CAUSE/CONDITIONS CONTRIBUTING TO STILLBIRTH

CAUSE OF STILLBIRTH	18a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE CHECK OR SPECIFY THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS) Maternal Conditions/Diseases (Specify) _____ Complications of Placenta, Cord, or Membranes: <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____ Other Obstetrical or Pregnancy Complications (Specify) _____ Fetal Anomaly (Specify) _____ Fetal Injury (Specify) _____ Fetal Infection (Specify) _____ Other Fetal Conditions/Disorders (Specify) _____ <input type="checkbox"/> Unknown	18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (CHECK AND/OR SPECIFY IN ITEM 18b ALL OTHER CONDITIONS CONTRIBUTING TO DEATH) Maternal Conditions/Diseases (Specify) _____ Complications of Placenta, Cord, or Membranes: <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____ Other Obstetrical or Pregnancy Complications (Specify) _____ Fetal Anomaly (Specify) _____ Fetal Injury (Specify) _____ Fetal Infection (Specify) _____ Other Fetal Conditions/Disorders (Specify) _____ <input type="checkbox"/> Unknown	19. WEIGHT OF FETUS (Check unit, grams preferred) <input type="checkbox"/> grams OR <input type="checkbox"/> lb/oz 20. OBSTETRIC ESTIMATE OF GESTATION _____ (completed weeks) 21. ESTIMATED TIME OF FETAL DEATH (Check one) <input type="checkbox"/> Dead at first assessment, no labor ongoing <input type="checkbox"/> Dead at first assessment, labor ongoing <input type="checkbox"/> Died during labor, after first assessment <input type="checkbox"/> Unknown time of fetal death 22. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned 23. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned 24. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No
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* At a minimum, complete items 1; 4; 5; 6; 7; 12b (name) or 13a (name); 16; and 17a for the 24-Hour Report and Authorization for Final Disposition.

IDAHO CODE

39-268. Authorization For Final Disposition

- (1) The mortician or person acting as such who first assumes possession of a dead body or stillborn fetus shall make a written report to the registrar of the district in which death or stillbirth occurred or in which the body or stillborn fetus was found within twenty-four (24) hours after taking possession of the body or stillborn fetus, on a form prescribed and furnished by the state registrar and in accordance with rules promulgated by the board. Except as specified in subsection (2) of this section, the written report shall serve as permit to transport, bury or entomb the body or stillborn fetus within this state, provided that the mortician or person acting as such shall certify that the physician, physician assistant or advanced practice professional nurse in charge of the patient's care for the illness or condition which resulted in death or stillbirth has been contacted and has affirmatively stated that said physician, physician assistant or advanced practice professional nurse or the designated associate according to section 39-260(1)(b) or (4)(a), Idaho Code, will sign the certificate of death or stillbirth.
- (2) The written report as specified in subsection (1) of this section shall not serve as a permit to:
 - (a) Remove a body or stillborn fetus from this state;
 - (b) Cremate the body or stillborn fetus; or
 - (c) Make disposal or disposition of any body or stillborn fetus in any manner when inquiry is required under chapter 43, title 19, Idaho Code, or section 39-260(2) or (5), Idaho Code.
- (3) In accordance with the provisions of subsection (2) of this section, the mortician or person acting as such who first assumes possession of a dead body or stillborn fetus shall obtain an authorization for final disposition prior to final disposal or removal from the state of the body or stillborn fetus. The physician, physician assistant, advanced practice professional nurse or coroner responsible for signing the death or stillbirth certificate shall authorize final disposition of the body or stillborn fetus, on a form prescribed and furnished by the state registrar. If the body is to be cremated, the coroner must also give additional authorization. In the case of stillbirths, the hospital may dispose of the stillborn fetus if the parent(s) so requests; authorization from the coroner is not necessary unless the coroner is responsible for signing the certificate of stillbirth.
- (4) When a dead body or stillborn fetus is transported into the state, a permit issued in accordance with the law of the state in which the death or stillbirth occurred or in which the body or stillborn fetus was found shall authorize the transportation and final disposition within the state of Idaho.
- (5) A permit for disposal shall not be required in the case of a dead fetus of less than twenty (20) weeks gestation and less than three hundred fifty (350) grams or twelve and thirty-five hundredths (12.35) ounces where disposal of the fetal remains is made within the institution where the delivery of the dead fetus occurred.

DEPARTMENT OF HEALTH AND WELFARE RULES

16.02.08.850. Removal of Dead Body or Fetus From Place of Death or Stillbirth.

Before removing a dead body or fetus from the place of death or stillbirth, the funeral director, or person acting as such, must, in accordance with Section 39-268, Idaho Code:

(4-2-08)

01. **Obtain Assurance That Death is from Natural Causes.** Obtain assurance from the attending physician, physician assistant, advanced practice professional nurse, or his designated associate, responsible for medical certification of the cause of death or stillbirth:
 - a. That the death or stillbirth is from natural causes; and (5-8-09)
 - b. That the attending physician, physician assistant, advanced practice professional nurse, or his designated associate, will assume responsibility for certification of the cause of death or stillbirth; or (4-2-08) (5-8-09)
02. **Notify the Coroner.** Notify the coroner when:
 - a. The case falls within the jurisdiction of the coroner in accordance with Section 39-260, Idaho Code; or (4-2-08)
 - b. The death or stillbirth is due to natural causes; and (4-2-08)
 - i. There was no attending physician, physician assistant, or advanced practice professional nurse during the last illness; or (4-2-08)
 - ii. There was no physician, physician assistant, or advanced practice professional nurse in attendance at the stillbirth; or (4-2-08)
 - iii. When the attending physician, physician assistant, advanced practice professional nurse, or his designated associate, is not available or is physically incapable of providing assurance that the death or stillbirth is from natural causes or providing permission to remove the dead body or fetus from the place of death or stillbirth. (5-8-09)
03. **Receive Permission to Remove the Dead Body or Fetus.** Receive permission to remove the dead body or fetus from the place of death or stillbirth from:
 - a. The attending physician, physician assistant, advanced practice professional nurse, or his designated associate, if the death is from natural causes and all assurances in Subsection 850.01 of this rule have been met; or (4-2-08) (5-8-09)
 - b. The coroner, if the case falls within the jurisdiction of the coroner, in accordance with Section 39-260, Idaho Code, or if the death or stillbirth is due to natural causes and one (1) of the conditions listed in Subsections 850.02.b.i. through 850.02.b.iii, of this rule has been met. (4-2-08)