VSA

State of Maryland
CERTIFICATE OF LIVE BIRTH

STATE REGISTER

BIRTH NUMBER 119-

1. CHILD'S NAME FIRST MIDDLE LAST
2. DATE OF BIRTH (Month, Day, Year)
3. TIME OF BIRTH
4. SEX
5. BIRTH WEIGHT
6. PLURALITY
7. BIRTH ORDER
8. CITY OR TOWN OF BIRTH
9. BALTIMORE CITY OR COUNTY OF BIRTH
10. FACILITY NAME
11. PLACE OF BIRTH
12. ATTENDANT'S NAME, AND TITLE (If Other than Certifier)
13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14. CERTIFIER'S NAME, AND TITLE
15a. I CERTIFY THAT THIS CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED

SIGNATURE ▶

15b. DATE SIGNED (Month, Day, Year)
16. MOTHER'S FULL MAIDEN NAME (First, Middle, Last)
17. DATE OF BIRTH (Mo., Day, Year)
18. AGE
19. BIRTHPLACE
20a. USUAL RESIDENCE OF MOTHER (Number and Street)
20b. CITY OR TOWN
20c. COUNTY
20d. STATE
20e. ZIP CODE
20f. INSIDE CITY LIMITS
21. PARENTS REQUEST SOCIAL SECURITY NUMBER ISSUANCE FOR THIS CHILD
22. CORRECTIONS OR AMENDMENTS
23. FATHER'S NAME (First, Middle, Last)
24. DATE OF BIRTH (Mo., Day, Year)
25. AGE
26. BIRTHPLACE
27. MOTHER'S NAME AND ADDRESS FOR MAILING BIRTH CARD
28. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THIS CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF (Signature of Parent or Other Informant)

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29a. DATE REC'D BY STATE REGISTRAR
29b. STATE REGISTRAR'S SIGNATURE

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SAMPLE

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

30. OF HISPANIC ORIGIN? (Specify No or Yes. If yes, specify Cuban, Mexican, Puerto Rican, etc.)
31a. MOTHER
31b. FATHER
32. RACE - American Indian, Black White, etc. (Specify below)
32a. MOTHER
32b. FATHER

EDUCATION (Specify highest grade completed)

Elem. and Sec. (0-12) College (1 - 5+)

33a. MOTHER
33b. FATHER

34. PREGNANCY HISTORY (Complete this section)

LIVE BIRTHS (Do not include this child)

34a. Now Living
34b. Now Dead
34c. DATE OF LAST LIVE BIRTH (Mo., Year)

OTHER TERMINATIONS (Spontaneous and induced at any time after conception)

34d. NUMBER
34e. DATE OF LAST OTHER TERMINATION
35. MOTHER MARRIED?
36. DATE LAST NORMAL MENSES BEGAN
37. MONTH OF PREGNANCY PRENATAL CARE BEGAN
38. PRENATAL VISITS - Total Number
39. SOURCES OF PRENATAL CARE (List all that apply)
40. CLINICAL ESTIMATE OF GESTATION (WEEKS)
41. MOTHER'S SOCIAL SECURITY NUMBER
42. FATHER'S SOCIAL SECURITY NUMBER

HOSPITAL USE

APGAR SCORE

43a. 1 minute
43b. 5 minutes
44a. MOTHER TRANSFERRED PRIOR TO DELIVERY

If yes, enter name of facility transferred from:

44b. INFANT TRANSFERRED AFTER DELIVERY

If yes, enter name of facility transferred to:

45. METHOD OF DELIVERY (List all that apply)
46. OBSTETRIC PROCEDURES (List all that apply)
47a. MEDICAL FACTORS FOR THIS PREGNANCY (List all that apply)
47b. OTHER FACTORS FOR THIS PREGNANCY

Tobacco use during pregnancy

Average number of cigarettes per day

Alcohol use during pregnancy

Average number of drinks per week

Weight gained during pregnancy

48. COMPLICATIONS OF LABOR OR DELIVERY (List all that apply)
49. ABNORMAL CONDITIONS OF THE NEWBORN EVIDENT AT TIME OF REPORTING (List all that apply)
50. CONGENITAL ANOMALIES OF CHILD EVIDENT AT TIME OF REPORTING (List all that apply)
51. CERTIFIED FOR MEDICAL ASSISTANCE

TO HOSPITAL OR CERTIFIER: THE CERTIFICATE OF LIVE BIRTH SHOULD BE COMPLETE AND ALL SHEETS FILED WITHIN 72 HOURS AFTER THE BIRTH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

EBC 945001