Municipal Form No. 103A
(Revised January 2007)

Republic of the Philippines
OFFICE OF THE CIVIL REGISTRAR GENERAL

(To be accomplished in quadruplicate using black ink)

# CERTIFICATE OF FETAL DEATH

Province: LEYTE
City/Municipality: BAYBAY CITY

Registry No.

**FETUS**

1. NAME — (First) BB BOY — (Middle) DECENA — (Last) DORON

2. SEX (Male/Female/Undetermined): MALE

3. DATE OF DELIVERY — (Day) 05 — (Month) NOVEMBER — (Year) 2024

4. PLACE OF DELIVERY — (Name of Hospital/Clinic/Institution/ House No., St., Barangay): BAYBAY CITY IMMACULATE CONCEPTION HOSPITAL — (City/Municipality): BAYBAY CITY — (Province): LEYTE

5a. TYPE OF DELIVERY (Single, Twin, Triplet, etc.): SINGLE

5b. IF MULTIPLE DELIVERY, FETUS WAS (First, Second, Third, etc.): NOT APPLICABLE

5c. METHOD OF DELIVERY (Normal spontaneous vertex, if others, specify):

5d. BIRTH ORDER (live births and fetal deaths including this delivery) (First, Second, Third, etc.): FOURTH

5e. WEIGHT OF FETUS: _____ grams

**MOTHER**

6. MAIDEN NAME — (First) DIANA — (Middle) PEÑONES — (Last) DECENA

7. CITIZENSHIP: FILIPINO

8. RELIGION/RELIGIOUS SECT: ROMAN CATHOLIC

9. OCCUPATION: HOUSEWIFE

10. AGE at the time of this delivery (completed years): 37

11a. Total number of children born alive: 03

11b. No. of children still living: 03

11c. No. of children born alive but are now dead: 00

12. RESIDENCE — (House No., St., Barangay) (City/Municipality) (Province) (Country): BRGY. PUNTA, BAYBAY CITY, LEYTE

**FATHER**

13. NAME — (First) ARNEL — (Middle) GUARTE — (Last) DORON

14. CITIZENSHIP: FILIPINO

15. RELIGION/RELIGIOUS SECT: ROMAN CATHOLIC

16. OCCUPATION: UTILITY WORKER

17. AGE at the time of this delivery (completed years): 37

**MARRIAGE OF PARENTS**

18a. DATE (Month) (Day) (Year):

18b. PLACE (City/Municipality) (Province) (Country):

**MEDICAL CERTIFICATE**

19. CAUSES OF FETAL DEATH
- a. Main disease/condition of fetus: POSTMATURITY
- b. Other diseases/conditions of the fetus: SEVERE OLIGOHYDRAMNIOS
- c. Main maternal disease/condition affecting fetus: GESTATIONAL HYPERTENSION
- d. Other maternal disease/condition affecting fetus:
- e. Other relevant circumstances:

20. FETUS DIED: _____ 1 Before Labor _____ 2 During labor/delivery _____ 3 Unknown

21. LENGTH OF PREGNANCY (in completed weeks):

22a. ATTENDANT (Physician, Nurse, Midwife, Hilot or Traditional Birth Attendant, none, others (specify)):

22b. CERTIFICATION OF FETAL DEATH

☐ I hereby certify that the foregoing particulars are correct as near as same can be ascertained and I further certify that I ☑ have attended/ ☐ have not attended the death of the fetus at 11:12pm am/pm on the date of delivery specified above.

Signature: [signature]
Name in Print: LUDIVINA D. CAVAL, M.D.
Title or Position: MEDICAL OFFICER III
Address: BCICH, BAYBAY CITY
Date: NOV. 5, 2024

REVIEWED BY:

Signature Over Printed Name of Health Officer

Date

23. CORPSE DISPOSAL (Burial, Cremation, if others, specify):

24. BURIAL/CREMATION PERMIT
Number:
Date Issued:

25. AUTOPSY (Yes /No):

26. NAME AND ADDRESS OF CEMETERY OR CREMATORY: