



**INDIANA STATE - CERTIFICATE OF FETAL DEATH**

State Form : 11410(R5/01-08)

Local No: 256802

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

1. NAME OF FETUS (optional at the discretion of the parents) A [REDACTED]		2. TIME OF DELIVERY 16:00 PM (24hr)		3. SEX (M/F/Unk) FEMALE		4. DATE OF DELIVERY (Mo/Day/Yr) [REDACTED]	
5a. CITY, TOWN, OR LOCATION OF DELIVERY INDIANAPOLIS		7. PLACE WHERE DELIVERY OCCURRED (Check One) <input checked="" type="checkbox"/> Hospital <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):		8. FACILITY NAME (If not institution, give street and number) COMMUNITY HOSPITAL NORTH			
5b. ZIP CODE OF DELIVERY		6. COUNTY OF DELIVERY MARION		9. FACILITY I.D. (NPI)			
10a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) CRYSTAL D. ALLEN				10b. DATE OF BIRTH (Mo/Day/Yr) [REDACTED]			
10c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix) Crystal D. Allen				10d. BIRTH PLACE (State, Territory, or Foreign Country) [REDACTED]			
11a. RESIDENCE OF MOTHER - STATE INDIANA		11b. COUNTY [REDACTED]		11c. CITY, TOWN, OR LOCATION [REDACTED]			
11d. STREET AND NUMBER [REDACTED]		11e. APT#		11f. ZIP CODE [REDACTED]		11g. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
12a. FATHER'S CURRENT LEGAL NAME NOELL F. ALLEN		12b. DATE OF BIRTH (Mo/Day/Yr) [REDACTED]		12c. BIRTH PLACE (State, Territory, or Foreign Country) PENNSYLVANIA			
13. METHOD OF DISPOSITION: <input type="checkbox"/> Donation <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Hospital Disposition <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		14. ATTENDANT'S NAME AND NPI SARAH KERLIN		14a. TITLE: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/OM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify):			
15. NAME OF FUNERAL HOME FEENEY-HORNAK KEYSTONE MORTUARIES		15a. PLACE OF DISPOSITION THE COLUMBUS CREMATORY, COLUMBUS, INDIANA					
15b. SIGNATURE OF INDIANA FUNERAL SERVICE LICENSEE WILLIAM C MINGES by electronic signature				15c. LICENSE NUMBER (OF LICENSEE) FO20200013			
16. SIGNATURE OF LOCAL HEALTH OFFICER VIRGINIA A. CAINE via electronic signature				16a. FILE DATE 12/04/2015			
17. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH							
17a. INITIATING CAUSE/CONDITION Among the choices below, please select the <u>one</u> that most likely began the sequence of events resulting in the death of the fetus, and check the box for the Manner of Death in item 17c. Maternal Condition/Disease (Specify): _____ Complications of Placenta, Cord, or Membranes <input type="checkbox"/> Rupture of membranes prior to onset of labor <input checked="" type="checkbox"/> Chorionmionitis <input type="checkbox"/> Abruptio Placenta <input type="checkbox"/> Placental Insufficiency <input type="checkbox"/> Prolapsed Cord <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				17b. OTHER SIGNIFICANT CAUSES OR CONDITIONS Select Or Specify All other Conditions Contributing To Death Item 17a. Maternal Condition/Disease (Specify): _____ Complications of Placenta, Cord, or Membranes <input type="checkbox"/> Rupture of membranes prior to onset of labor <input checked="" type="checkbox"/> Chorionmionitis <input type="checkbox"/> Abruptio Placenta <input type="checkbox"/> Placental Insufficiency <input type="checkbox"/> Prolapsed Cord <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			
17c. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined check <u>one</u> box		17d. DATE OF INJURY (Mo/Day/Yr)		17e. TIME OF INJURY		17f. DESCRIBE HOW INJURY OCCURRED	
		17g. PLACE OF INJURY -at home, farm, street, factory, etc. Specify:		17h. LOCATION (Street & Number or Rural Route Number, City or Town, State)			
17i. DATE PRONOUNCED DEAD (Mo/Day/Yr) 11/21/2015		17j. MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		17k. IF YES, SPECIFY DRIVER, PASSENGER, PEDESTRIAN, ETC.			
17l. WEIGHT OF FETUS (grams preferred, specify unit) 249 <input checked="" type="checkbox"/> grams <input type="checkbox"/> lb/oz		17m. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY 19 (completed weeks)		17n. ESTIMATED TIME OF FETAL DEATH <input type="checkbox"/> Died at time of first assessment, no labor ongoing <input type="checkbox"/> Died at time of first assessment, labor ongoing <input type="checkbox"/> Died during labor, after assessment <input checked="" type="checkbox"/> Unknown time of fetal death		17o. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Planned	
						17p. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Planned	
						17q. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. SIGNATURE OF PERSON CERTIFYING CAUSE OF DEATH SARAH F. KERLIN by electronic signature				18a. LICENSE NUMBER 01068600A			
18b. NAME, ADDRESS AND ZIP CODE OF PERSON CERTIFYING CAUSE OF DEATH SARAH F. KERLIN, 7150 CLEARVISTA PARKWAY, INDIANAPOLIS, INDIANA, 46256				18c. DATE CERTIFIED (Mo/Day/Yr) 12/04/2015			

**FOR CREMATION PURPOSES ONLY**



INDIANA STATE - CERTIFICATE OF FETAL DEATH  
State Form : 11410(R5/01-08)

**FOR CREMATION PURPOSES ONLY**

Local No: 257047

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

1 NAME OF FETUS (optional at the discretion of the parents) A [REDACTED] B [REDACTED]		2 TIME OF DELIVERY 15.22 PM (24hr)	3 SEX (M/F/UNK) MALE	4 DATE OF DELIVERY (Mo/Day/Yr) [REDACTED]
5a CITY/TOWN/OR LOCATION OF DELIVERY INDIANAPOLIS		7 PLACE WHERE DELIVERY OCCURRED (Check One) <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Free-standing birthing center 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)		8 FACILITY NAME (If not institution, give street and number) COMMUNITY HOSPITAL NORTH
5b ZIP CODE OF DELIVERY MARION		9 FACILITY I.D. (NPI)		
8 COUNTY OF DELIVERY MARION		10a MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) CRYSTAL D. ALLEN		10b DATE OF BIRTH (Mo/Day/Yr) [REDACTED]
10c MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix) Crystal D. Allen		10d BIRTH PLACE (State, Territory, or Foreign Country) [REDACTED]		
11a RESIDENCE OF MOTHER - STATE INDIANA	11b COUNTY [REDACTED]	11c CITY, TOWN, OR LOCATION [REDACTED]		
11d STREET AND NUMBER [REDACTED]		11e APT#	11f ZIP CODE [REDACTED]	11g INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
12a FATHER'S CURRENT LEGAL NAME NCELL ALLEN		12b DATE OF BIRTH (Mo/Day/Yr) [REDACTED]	12c BIRTH PLACE (State, Territory, or Foreign Country) PENNSYLVANIA	
13 METHOD OF DISPOSITION <input type="checkbox"/> Donation <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Hospital Disposition <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)		14 ATTENDENT'S NAME AND NPI SARAH KERLIN		14a. TITLE <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/CNM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify)
15 NAME OF FUNERAL HOME FEENEY-HORNAX KEYSTONE MORTUARIES		15a. PLACE OF DISPOSITION THE COLUMBUS CREMATORY, COLUMBUS, INDIANA		
15b SIGNATURE OF INDIANA FUNERAL SERVICE LICENSEE WILLIAM C MINGES by electronic signature		15c LICENSE NUMBER (OF LICENSES) FD20200015		
16 SIGNATURE OF LOCAL HEALTH OFFICER VIRGINIA A. CAINE via electronic signature		16b FILE DATE 12/04/2015		
17. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH				
17a INITIATING CAUSE/CONDITION Among the choices below, please select the one that most likely began the sequence of events resulting in the death of the fetus, and check one box for the Manner of Death in item 17c. Maternal Condition/Disease (Specify): Complications of Placenta, Cord, or Membranes <input checked="" type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Abruptio Placenta <input type="checkbox"/> Placental Insufficiency <input type="checkbox"/> Prolapsed Cord <input type="checkbox"/> Other (Specify): Other Obstetrical or Pregnancy Complications (Specify): Fetal Anomaly (Specify): Fetal Injury (Specify): Fetal Infection (Specify): Other Fetal Condition/Disorders (Specify): <input type="checkbox"/> Unknown		17b OTHER SIGNIFICANT CAUSES OR CONDITIONS Select Or Specify All other Conditions Contributing To Death from 17a. Maternal Condition/Disease (Specify): Complications of Placenta, Cord, or Membranes <input type="checkbox"/> Rupture of membranes prior to onset of labor <input checked="" type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Abruptio Placenta <input type="checkbox"/> Placental Insufficiency <input type="checkbox"/> Prolapsed Cord <input type="checkbox"/> Other (Specify): Other Obstetrical or Pregnancy Complications (Specify): Fetal Anomaly (Specify): Fetal Injury (Specify): Fetal Infection (Specify): Other Fetal Condition/Disorders (Specify): <input type="checkbox"/> Unknown		
17c MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide check one box <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		17d DATE OF INJURY (Mo/Day/Yr)	17e TIME OF INJURY	17f DESCRIBE HOW INJURY OCCURRED
17g PLACE OF INJURY - not home, farm, street, factory, etc Specify		17h LOCATION (Street & Number or Rural Route Number, City or Town, State)		
17i DATE PRONOUNCED DEAD (Mo/Day/Yr) 11/21/2015		17j MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		17k IF YES, SPECIFY DRIVER, PASSENGER, PEDESTRIAN ETC
17l WEIGHT OF FETUS (grams preferred, specify unit) 251 <input checked="" type="checkbox"/> grams <input type="checkbox"/> lb/oz		17m ESTIMATED TIME OF FETAL DEATH <input type="checkbox"/> Dead at time of first assessment, no labor ongoing <input type="checkbox"/> Dead at time of first assessment, labor ongoing <input type="checkbox"/> Died during labor, after assessment <input checked="" type="checkbox"/> Unknown time of fetal death		17n WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Planned
17o OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY 16 (completed weeks)		17p WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		17q WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Planned
18 SIGNATURE OF PERSON CERTIFYING CAUSE OF DEATH SARAH F. KERLIN by electronic signature		18a. LICENSE NUMBER 01059500A		18c. DATE CERTIFIED (Mo/Day/Yr)
18b. NAME, ADDRESS AND ZIP CODE OF PERSON CERTIFYING CAUSE OF DEATH SARAH F. KERLIN 7150 CLEARVISTA PARKWAY INDIANAPOLIS, INDIANA 46256				

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