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] D[redacted] 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) [X] Hospital [ ] Freestanding birthing center Home Delivery,Planned to deliver at home? [ ] Yes [ ] No [ ] Clinic/Doctor's Office [ ] Other (Specify):	8. FACILITY NAME (If not institution, give street and number) COMMUNITY HOSPITAL NORTH	
5b. ZIP CODE OF DELIVERY		9. FACILITY I.D. (NPI)	
6. 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 [X] No [ ]
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: [ ] Donation [ ] Burial [X] Cremation [ ] Hospital Disposition [ ] Removal From State [ ] Other (Specify):	14. ATTENDENT'S NAME AND NPI SARAH KERLIN	14a. TITLE: [X] MD [ ] DO [ ] CNM/CM [ ] OTHER MIDWIFE [ ] 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) FD20200013	
16. SIGNATURE OF LOCAL HEALTH OFFICER VIRIGINIA 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 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 Conditions/Diseases (Specify):

Complications of Placenta, Cord, or Membranes

- [ ] Rupture of membranes prior to onset of labor
- [X] Chorioamnionitis
- [ ] Abruptio Placenta
- [ ] Placental Insufficiency
- [ ] Prolapsed Cord
- [ ] Other (Specify):

Other Obstetrical or Pregnancy Complications (Specify):

Fetal Anomaly (Specify):

Fetal Injury (Specify):

Fetal Infection (Specify):

Other Fetal Conditions/Disorders (Specify):

- [ ] Unknown

17b. OTHER SIGNIFICANT CAUSES OR CONDITIONS

Select Or Specify All other Conditions Contributing To Death from 17a.

Maternal Conditions/Diseases (Specify):

Complications of Placenta, Cord, or Membranes

- [ ] Rupture of membranes prior to onset of labor
- [X] Chorioamnionitis
- [ ] Abruptio Placenta
- [ ] Placental Insufficiency
- [ ] Prolapsed Cord
- [ ] Other (Specify):

Other Obstetrical or Pregnancy Complications (Specify):

Fetal Anomaly (Specify):

Fetal Injury (Specify):

Fetal Infection (Specify):

Other Fetal Conditions/Disorders (Specify):

- [ ] Unknown

17c. MANNER OF DEATH [X] Natural [ ] Accident [ ] Homicide [ ] Pending Investigation [ ] Could not be determined (check one 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? [ ] Yes [ ] No		17k IF YES, SPECIFY DIVER, PASSENGER, PEDESTRAIN, ETC.
17l WEIGHT OF FETUS (grams preferred, specify unit) 249 [X] grams [ ] lb/oz	17n ESTIMATED TIME OF FETAL DEATH [ ] Dead at time of first assessment, no labor ongoing [ ] Dead at time of first assessment, labor ongoing [ ] Died during labor, after assessment [X] Unknown time of fetal death		17o WAS AN AUTOPSY PERFORMED? [ ] Yes [X] No [ ] Planned
17m OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY 19 (completed weeks)			17p WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? [ ] Yes [X] No [ ] Planned
	17q WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? [ ] Yes [ ] No		
18. SIGNATURE OF PERSON CERTIFYING CAUSE OF DEATH SARAH F. KERLIN by electronic signature			18a. LICENSE NUMBER 01056500A
18b. NAME, ADDRESS AND ZIP CODE OF PERSON CERTIFYING CAUSE OF DEATH SARAH F. KERLIN ,7150 CLEARVISTA PARKWAY, INDIANAPOLIS, INDIANA, 46256	FOR CREMATION PURPOSES ONLY		18c. DATE CERTIFIED (Mo/Day/Yr) 12/04/2015

INDIANA STATE - CERTIFICATE OF FETAL DEATH

State Form : 11410(R5/01-08)

Local No: 257047

FOR CREMATION PURPOSES ONLY

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] C [redacted] A [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

5b. ZIP CODE OF DELIVERY

6. COUNTY OF DELIVERY
MARION

7. PLACE WHERE DELIVERY OCCURRED (Check One)
[X] Hospital [ ] Freestanding birthing center
Home Delivery, Planned to deliver at home? [ ] Yes [ ] No
[ ] Clinic/Doctor's Office [ ] Other (Specify)

8. FACILITY NAME (If not institution, give street and number)
COMMUNITY HOSPITAL NORTH

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 [X] No [ ]

12a. FATHER'S CURRENT LEGAL NAME
NOELL ALLEN

12b. DATE OF BIRTH (Mo/Day/Yr)
[redacted]

12c. BIRTH PLACE (State, Territory, or Foreign Country)
PENNSYLVANIA

13. METHOD OF DISPOSITION
[ ] Donation [ ] Burial
[X] Cremation [ ] Hospital Disposition [ ] Removal From State
[ ] Other (Specify)

14. ATTENDENTS NAME AND NPI
SARAH KERLIN

14a. TITLE: [X] MD [ ] DO [ ] CNM/CM [ ] OTHER MIDWIFE [ ] 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)
FD20200015

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 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 Conditions/Diseases (Specify):

Complications of Placenta, Cord, or Membranes
[X] Rupture of membranes prior to onset of labor [ ] Chorioamnionitis
[ ] Abruptio Placenta
[ ] Placental Insufficiency
[ ] Prolapsed Cord
[ ] Other (Specify)

Other Obstetrical or Pregnancy Complications (Specify)

Fetal Anomaly (Specify):

Fetal Injury (Specify):

Fetal Infection (Specify)

Other Fetal Conditions/Disorders (Specify)

[ ] Unknown

17b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
Select Or Specify All other Conditions Contributing To Death Item 17a.

Maternal Conditions/Diseases (Specify):

Complications of Placenta, Cord, or Membranes
[ ] Rupture of membranes prior to onset of labor [X] Chorioamnionitis
[ ] Abruptio Placenta
[ ] Placental Insufficiency
[ ] Prolapsed Cord
[ ] Other (Specify)

Other Obstetrical or Pregnancy Complications (Specify):

Fetal Anomaly (Specify):

Fetal Injury (Specify):

Fetal Infection (Specify):

Other Fetal Conditions/Disorders (Specify):

[ ] Unknown

17c. MANNER OF DEATH [X] Natural [ ] Accident [ ] Homicide [ ] Pending Investigation [ ] Could not be determined
check one box

17d. DATE OF INJURY (Mo/Day/Yr)

17e. TIME OF INJURY

17f. DESCRIBE HOW INJURY OCCURED

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? [ ] Yes [ ] No

17k. IF YES, SPECIFY DRIVER, PASSENGER, PEDESTRAIN ETC

17l. WEIGHT OF FETUS (grams preferred, specify unit)
251 [X] grams [ ] lb/oz

17m. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY
19 (completed weeks)

17n. ESTIMATED TIME OF FETAL DEATH
[ ] Dead at time of first assessment, no labor ongoing
[ ] Dead at time of first assessment, labor ongoing
[ ] Died during labor, after assessment
[X] Unknown time of fetal death

17o. WAS AN AUTOPSY PERFORMED?
[ ] Yes [X] No [ ] Planned

17p. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?
[ ] Yes [X] No [ ] Planned

17q. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?
[ ] Yes [ ] No

18. SIGNATURE OF PERSON CERTIFYING CAUSE OF DEATH
SARAH F KERLIN by electronic signature

18a. LICENSE NUMBER
01059500A

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)

FOR CREMATION PURPOSES ONLY