SOUTHWESTERN
INSTITUTE OF FORENSIC SCIENCES
AT DALLAS

OFFICE OF THE MEDICAL EXAMINER

DECEASED INFANT/CHILD BODY DISPOSITION REQUEST AND WAIVER

I, (X) _____, do hereby certify that I have the right to control the disposition of the remains of (X) _____ as specified in Section 711.002 of the Health and Safety Code, and I further attest that ☐ I do not have financial resources sufficient to accept responsibility for the disposition of the remains OR ☐ I am refusing to accept responsibility for disposition of the remains. Therefore, I am requesting that the Dallas County Office of the Medical Examiner (OME) take responsibility for the disposition of the remains as specified in Sections 691.023 and 694.002 of the Health and Safety Code*. I understand that the remains will be cremated, as allowed by State law.

By this request, I relinquish all rights and claims regarding hereon described decedent, by any person whatsoever, and direct that in accepting the responsibility for disposition of the remains that the OME shall not incur any liability, and that no claim shall arise against that institution in any manner.

**Section 694.002(b) of the Health and Safety Code states that "the commissioners court shall consider any information, including the religious affiliation of the deceased pauper, provided by a person listed in Section 711.002 (a)" of the Health and Safety Code. I hereby that I acknowledge that I have been informed of my right to provide information for consideration by the commissioners court, and I make the following choice in this regard:*

☐ *I wish to provide information for consideration by the Commissioners Court (attach Deceased Pauper Information Form)*

☐ *I decline my right to provide information for consideration by the Commissioners Court.*

X _____ X _____
Printed Name - Legal Next of Kin Relationship to Decedent

X _____ X _____
Signature – Legal Next of Kin Date

Witnessed by: _____
Field Agent

(F-46) 12/03

STATE OF TEXAS — CERTIFICATE OF FETAL DEATH — STATE FILE NUMBER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES – VITAL STATISTICS UNIT

1. Name (Optional - at the discretion of the parents)	2. Date of Delivery (mm/dd/yyyy)	3. Time of Delivery	4. Sex

5. Place of Delivery - County	6a. City or Town (If outside city limits, give precinct no.)	6b. Zip Code	7a. Plurality – Single, Twin, Triplet, etc.	7b. If Plural, Delivered 1st, 2nd, 3rd, etc.

8a. Place of Delivery ☐ Hospital ☐ Licensed Birthing Center ☐ Clinic/Doctor's Office
☐ Home Delivery (Planned to deliver at home? ☐ Yes ☐ No)
☐ Other (Specify):

8b. Name of Hospital or Birthing Center (If not institution, give street address)
Facility NPI:

9. Mother's Current Legal Name First	Middle	Last	10. Mother's Date of Birth

11. Mother's Name Prior to First Marriage First	Middle	Last	12. Birthplace (State, Territory or Foreign Country)

13a. Mother's Residence - State	13b. County	13c. City, Town, or Location

13d. Street Address or Rural Location	13e. Apt No.	13f. Zip Code	13g. Inside City Limits? ☐ Yes ☐ No

14. Father's Name First	Middle	Last	Suffix	15. Father's Date of Birth	16. Birthplace (State, Territory or Foreign Country)

17a. Attendant's Name and Mailing Address
NPI:

18a. Certifier – *To the best of my knowledge, the fetus was delivered at the time, date, and place as shown and fetal death was due to the cause(s) as stated.*
Signature and Title — Date Signed

17b. ☐ MD ☐ DO ☐ CNM ☐ Midwife ☐ Other (Specify):

18b. ☐ Certifying Physician ☐ Medical Examiner/Justice of the Peace

19. Method of Disposition
☐ Burial ☐ Cremation ☐ Donation
☐ Entombment ☐ Removal From State
☐ Other (Specify)

20. Signature and License Number of Funeral Director or Person Acting as Such

21. ☐ Unknown
Section
Block
Lot
Space

22. Place of Disposition (Name of cemetery, crematory, other place)

23. Location (City/Town and State)

24. Name of Funeral Facility

25. Complete Address of Funeral Facility (Street and Number, City, State, Zip Code)

26a. INITIATING CAUSE/CONDITION CONTRIBUTING TO FETAL DEATH

(Among the choices below, please select 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
☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta
☐ Placental insufficiency ☐ Prolapsed cord
☐ Chorioamnionitis
☐ Other (Specify)

Other Obstetrical or Pregnancy Complications (Specify)

Fetal Anomaly (Specify)

Fetal Injury (Specify)

Fetal Infection (Specify)

Other Fetal Conditions/Disorders (Specify)

☐ Unknown

26b. OTHER SIGNIFICANT CAUSES OR CONDITIONS CONTRIBUTING TO FETAL DEATH

(Select or specify all other conditions contributing to death in item 26b)

Maternal Conditions/Diseases (Specify)

Complications of Placenta, Cord, or Membranes
☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta
☐ Placental insufficiency ☐ Prolapsed cord
☐ Chorioamnionitis
☐ Other (Specify)

Other Obstetrical or Pregnancy Complications (Specify)

Fetal Anomaly (Specify)

Fetal Injury (Specify)

Fetal Infection (Specify)

Other Fetal Conditions/Disorders (Specify)

☐ Unknown

27. Weight of Fetus (Grams Preferred, Specify Units)
☐ Grams ☐ Pounds/Ounces

28. Obstetric Estimate of Gestation at Delivery
(Completed Weeks)

29. 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 first assessment
☐ Unknown time of fetal death

30. Was an Autopsy Performed?
☐ Yes ☐ No ☐ Planned

31. Was a Histological Placental Examination Performed?
☐ Yes ☐ No ☐ Planned

32. Were Autopsy or Histological Placental Examination Results Used in Determining the Cause of Death?
☐ Yes ☐ No

33a. Local File Number	33b. Date Received by Local Registrar	33c. Signature of Local Registrar

WARNING
The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine of up to $10,000. (Health and Safety Code, Sec. 195, 1989)

VS-113 REV 1/2006

THE BACK OF THIS FORM MUST ALSO BE COMPLETED

CONFIDENTIAL INFORMATION FOR MEDICAL AND PUBLIC HEALTH USE – THE FOLLOWING INFORMATION WILL NOT BE SHOWN ON CERTIFIED COPIES

34. Mother's Education (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- ☐ 8th grade or less
- ☐ 9th – 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

35. Mother of Hispanic Origin? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if decedent is not Spanish/Hispanic/Latina)

- ☐ No, not Spanish, Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina

(Specify) _____

36. Mother's Race (Check one or more races to indicate what the mother considers herself to be)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
  (Name of the enrolled or principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify) _____

PREGNANCY HISTORY

LIVE BIRTHS		OTHER PREGNANCY OUTCOMES
37a. Now Living	37b. Now Dead	37d.
Number _____ ☐ None	Number _____ ☐ None	Number _____ ☐ None
37c. Date of Last Live Birth (mm/yyyy)		37e. Date Last Other Pregnancy Ended (mm/yyyy)

39. Source of Prenatal Care (Check all that apply)

- ☐ Hospital Clinic
- ☐ Public Health Clinic
- ☐ Private Physician
- ☐ Midwife
- ☐ None
- ☐ Unknown
- ☐ Other (Specify):

40. Mother's Height (feet/inches)

41. Mother's Prepregnancy weight (pounds)

42. Mother's Weight at Delivery (pounds)

PRENATAL CARE ☐ No Prenatal Care

43a. Date of First Visit (mm/dd/yyyy) _____

43b. Date of Last Visit (mm/dd/yyyy) _____

43c. Number of Prenatal Visits _____

38. 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	_____
Third trimester of pregnancy	_____	OR	_____

44. Date Last Normal Menses Began (mm/dd/yyyy)

45. Did mother get WIC food for herself during this pregnancy? ☐ Yes ☐ No

46. Mother Married? (At delivery, conception, or anytime between) ☐ Yes ☐ No

47. Mother transferred for maternal medical or fetal indications for this delivery? ☐ Yes ☐ No

If Yes, enter the name of facility mother transferred from: _____

48. Risk Factors In This Pregnancy (Check all that apply)

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

☐ Previous preterm birth

☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment – If yes, check all that apply:
- ☐ Fertility-enhancing drugs, artificial insemination, or intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))

☐ Mother had previous cesarean delivery
If yes, how many _____

☐ Antiretrovirals administered during pregnancy or at delivery

☐ None of the above

49. Infections Present and/or Treated During This Pregnancy (Check all that apply)

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Listeria
- ☐ Group B Streptococcus
- ☐ Cytomegalovirus
- ☐ Parvovirus
- ☐ Toxoplasmosis
- ☐ None of the above
- ☐ Other (Specify) _____

50a. HIV Test Done Prenatally ☐ Yes ☐ No

50b. HIV Test Done at Delivery ☐ Yes ☐ No

51. Method Of Delivery

A. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No

C. Fetal presentation at birth
- ☐ Cephalic
- ☐ Breech
- ☐ Other

D. Final route and method of delivery (Check one)
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
- ☐ Cesarean
  If cesarean, was a trial of labor attempted?
  - ☐ Yes
  - ☐ No

E. Hysterotomy/Hysterectomy ☐ Yes ☐ No

52. Maternal Morbidity – Complications associated with labor and delivery (Check all that apply)

- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☐ None of the above

53. Congenital Anomalies Of The Newborn (Check all that apply)

- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Cleft lip with or without cleft palate
- ☐ Cleft palate alone
- ☐ Down syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the anomalies listed above