

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)	
Province _____				Registry No. _____	
City/Municipality _____					
F E T U S	1. NAME (First) _____		(Middle) _____		(Last) _____
	2. SEX (Male/Female/Undetermined)		3. DATE OF DELIVERY (Day) _____		(Month) _____ (Year) _____
	4. PLACE OF DELIVERY (Name of Hospital/Clinic/Institution/ House No., St., Barangay) _____		(City/Municipality) _____		(Province) _____
	5a. TYPE OF DELIVERY (Single, Twin, Triplet, etc.) _____		5b. IF MULTIPLE DELIVERY, FETUS WAS (First, Second, Third, etc.) _____		
	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.) _____		5e. WEIGHT OF FETUS _____ grams
M O T H E R	6. MAIDEN NAME (First) _____		(Middle) _____		(Last) _____
	7. CITIZENSHIP _____	8. RELIGION/RELIGIOUS SECT _____	9. OCCUPATION _____		10. AGE at the time of this delivery (completed years) _____
	11a. Total number of children born alive _____		11b. No. of children still living _____		11c. No. of children born alive but are now dead _____
	12. RESIDENCE (House No., St., Barangay) _____		(City/Municipality) _____		(Province) _____ (Country) _____
F A T H E R	13. NAME (First) _____		(Middle) _____		(Last) _____
	14. CITIZENSHIP _____	15. RELIGION/RELIGIOUS SECT _____	16. OCCUPATION _____		17. AGE at the time of this delivery (completed years) _____
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 _____					
b. Other diseases/conditions of the fetus _____					
c. Main maternal disease/condition affecting fetus _____					
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					
<input type="checkbox"/> I hereby certify that the foregoing particulars are correct as near as same can be ascertained and I further certify that I <input type="checkbox"/> have attended/ have not attended the death of the fetus at _____ am/pm on the date of delivery specified above.					
Signature _____			REVIEWED BY: Signature Over Printed Name of Health Officer _____ Date _____		
Name in Print _____					
Title or Position _____					
Address _____					
Date _____					
23. CORPSE DISPOSAL (Burial, Cremation, if others, specify) _____		24. BURIAL/CREMATION PERMIT		25. AUTOPSY (Yes /No)	
		Number _____			
		Date Issued _____			
26. NAME AND ADDRESS OF CEMETERY OR CREMATORY _____					
27. CERTIFICATION OF INFORMANT			28. PREPARED BY		
I hereby certify that all information supplied are true and correct to my own knowledge and belief.					
Signature _____			Signature _____		
Name in Print _____			Name in Print _____		
Relationship to the Deceased _____			Title or Position _____		
Address _____			Date _____		
Date _____					
29. RECEIVED BY			30. REGISTERED BY THE CIVIL REGISTRAR		
Signature _____			Signature _____		
Name in Print _____			Name in Print _____		
Title or Position _____			Title or Position _____		
Date _____			Date _____		
REMARKS/ANNOTATIONS (For LCRO/OCRG Use Only)					
TO BE FILLED-UP AT THE OFFICE OF THE CIVIL REGISTRAR					
7 8 9 12 14 15					
16 19a 19c					

POSTMORTEM CERTIFICATE OF FETAL DEATH

I HEREBY CERTIFY that I have performed an autopsy upon the body of the deceased this _____ day of _____ and that the cause of death was as follows _____

Signature _____ Title/Designation _____
Name in Print _____ Address _____
Date _____

CERTIFICATION OF EMBALMER

I HEREBY CERTIFY that I have embalmed _____ following all the regulations prescribed by the Department of Health.

Signature _____ Title/Designation _____
Name in Print _____ License No. _____
Address _____ Issued on _____ at _____
Expiry Date _____

AFFIDAVIT FOR DELAYED REGISTRATION OF FETAL DEATH

I, _____, of legal age, single/married/divorced/widow/widower, with residence and postal address _____, after being duly sworn in accordance with law, do hereby depose and say:

1. That _____ died on _____ in _____ and was buried/cremated in _____ on _____.
2. That the fetus at the time of his/her death:
- ☐ was attended by _____.
- ☐ was not attended.
3. That the cause of death of the fetus was _____.
4. That the reason for the delay in registering this fetal death was due to _____.
5. That I am executing this affidavit to attest to the truthfulness of the foregoing statements for all legal intents and purposes.

In truth whereof, I have affixed my signature below this _____ day of _____, _____ at _____, Philippines.

(Signature Over Printed Name of Affiant)

SUBSCRIBED AND SWORN to before me this _____ day of _____, _____ at _____, Philippines, affiant who exhibited to me his Community Tax Cert. _____ issued on _____ at _____.

Signature of the Administering Officer _____ Position / Title / Designation _____
Name in Print _____ Address _____