

SUMMARY OF VITAL STATISTICS
2013
THE CITY OF NEW YORK
Appendix B

**Technical Notes and
New York City Vital Event Certificates**



POPULATION

CITYWIDE POPULATION

The 2013 NYC population estimates used in tables and figures are based on the US Census Bureau 2013 Vintage population estimate as extracted from <http://www.census.gov/popest/data/counties/asrh/2013/CC-EST2013-ALLDATA.html>. The 2013 US Census population estimate for New York City (NYC) is 8,405,8374. (See table on next page for 2013 NYC population estimates by age, race/ethnicity and sex). Population data used to compute rate trends (2004-2013), regardless of NYC geography presented, was estimated by DOHMH, Epidemiology Services, using the methodology found below under Community District Population Estimates.

RACE/ETHNICITY CATEGORIES

Beginning with the 2000 Census, respondents could describe themselves and household members as being of more than one race, selecting at least one of six race categories: white, black, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, and some other race(s). These categories yield 63 possible combinations. Respondents also were asked if they were of Hispanic origin. The resulting responses could be organized into 64 groups. New York City's Department of City Planning collapses these groups into seven categories: (1) Hispanic origin, (2) non-Hispanic white, (3) non-Hispanic black, (4) non-Hispanic Asian or Pacific Islander, (5) non-Hispanic American Indian and Alaska Native, (6) non-Hispanic of some other race, and (7) non-Hispanic of two or more races, which the Department of City Planning refers to as "mutually exclusive race and Hispanic categories. The first four of these categories are reflected in the Vital Statistics Summary variable "ethnic group" with a 5th that combines non-Hispanic American Indian and Alaska Native, non-Hispanic of some other race, non-Hispanic of two or more races and other or multiple race. For more information, see "Race, Ancestry, and Ethnic Group."

COMMUNITY DISTRICT POPULATION ESTIMATES

Community districts were established by City Charter in 1969 for the delivery of city services. Population figures for these districts are compiled by Department of City Planning from census tract and census block data. The sum of the community district populations in each borough may not equal the borough population or the citywide population because community districts may cross borough boundaries.

2013 Community District estimates

The 2013 Community District estimates were calculated based on the Census postcensal estimate for 2013 released in May 2014 (See Historical Technical Notes for previous years' methods).

LIFE EXPECTANCY

For life expectancy computations, single-year age group populations were based on decennial census counts. Life expectancies for 2001-2009 have been updated from the previous Summary using linear interpolation of single-year age group populations based on 2000 and 2010 census counts. Life expectancies for 2010 are calculated based on 2010 census population. Population data for life expectancies for 2011-2012 were extrapolated based on single-year age groups of Census population, 2000 and 2010. Life expectancy for Asians and Pacific Islanders is not displayed because the required single year of age population denominators are too small to produce reliable estimates. Also See Technical Notes: Deaths, Life Expectancy

AGE CATEGORIES

Since 2010, rates of teen events (ages 15-17, 18-19) require population data with 22 age groups as opposed to the standard 18 provided by the census. As a result, 22-age group population estimates are calculated and provided by Bureau of Epidemiology Services based on Census Bureau's estimates.

DEMOGRAPHICS/CHARACTERISTICS OF VITAL EVENTS

AGE AT DEATH

For ages greater than one year, decedent's age is based on age at last birthday. Unknown ages are not recoded.

RACE, ANCESTRY, AND ETHNIC GROUP

Race and ancestry are two separate items on the certificates. A relative of the decedent usually reports this information to the funeral director for the death certificate. As of 2003 and 2008, the death and birth certificates respectively allow for the selection of multiple races. Responses are coded following rules from the National Center for Health Statistics (NCHS). The ordered selection rules for defining ethnic group first assign Puerto Rican or other Hispanic ethnicities based on ancestry, regardless of race. Then, those of other or unknown ancestries are classified by race as Asian and Pacific Islander, non-Hispanic white, non-Hispanic black, or other/multiple race/unknown.

NCHS defines ancestry as the nationality, lineage, or country where the subject's ancestors were born before their arrival in the United States. If a religious group is reported, NCHS instructions are to ask for the country of origin or nationality. New York City receives enough certificates reporting Jewish or Hebrew ancestry to warrant inclusion in these tables, notwithstanding the religious meaning of the terms. Persons whose race is black and whose ancestry is American are classified as being of African American ancestry.

Population Estimates by Age, Mutually Exclusive Race and Hispanic Origin, and Sex, New York City, 2013

Age in Years	All			Hispanic			Non-Hispanic White			Non-Hispanic Black			Asian and Pacific Islander			Other or Multiple Races		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
	All Ages	8,405,837	4,010,373	4,395,464	2,428,759	1,180,660	1,248,099	2,767,831	1,346,072	1,421,759	1,902,565	858,184	1,044,381	1,154,506	554,074	600,432	152,176	71,383
Under 5	555,929	284,703	271,226	195,185	99,531	95,654	152,625	78,410	74,215	120,771	61,563	59,208	66,249	34,395	31,854	21,099	10,804	10,295
5-9	482,699	246,388	236,311	170,052	86,799	83,253	129,183	66,205	62,978	112,256	56,918	55,338	57,562	29,636	27,926	13,646	6,830	6,816
10-14	463,561	236,701	226,860	164,131	83,879	80,252	112,845	58,247	54,598	119,371	59,988	59,383	56,228	28,954	27,274	10,986	5,633	5,353
15-19	481,409	242,967	238,442	174,164	88,850	85,314	111,564	56,077	55,487	126,357	63,043	63,314	59,136	30,078	29,058	10,188	4,919	5,269
20-24	631,907	309,172	322,735	212,872	109,321	103,551	168,660	79,209	89,451	153,176	74,308	78,868	85,305	40,808	44,497	11,894	5,526	6,368
25-29	768,622	371,029	397,593	212,707	109,704	103,003	284,961	134,880	150,081	144,531	67,676	76,855	112,441	52,645	59,796	13,982	6,124	7,858
30-34	710,767	345,787	364,980	201,789	102,355	99,434	254,565	127,534	127,031	133,770	60,444	73,326	108,343	49,948	58,395	12,300	5,506	6,794
35-39	599,648	292,353	307,295	175,826	87,789	88,037	198,879	102,697	96,182	121,144	53,445	67,699	94,060	44,007	50,053	9,739	4,415	5,324
40-44	571,888	278,333	293,555	166,129	81,860	84,269	180,541	94,565	85,976	126,756	55,597	71,159	89,389	42,106	47,283	9,073	4,205	4,868
45-49	557,970	268,995	288,975	160,172	76,641	83,531	166,928	87,387	79,541	139,576	61,410	78,166	82,576	39,448	43,128	8,718	4,109	4,609
50-54	554,523	263,080	291,443	146,908	67,895	79,013	174,775	89,310	85,465	142,064	62,382	79,682	82,679	39,817	42,862	8,097	3,676	4,421
55-59	512,957	238,124	274,833	124,760	55,954	68,806	178,330	87,295	91,035	125,346	53,839	71,507	77,565	37,828	39,737	6,956	3,208	3,748
60-64	439,771	199,060	240,711	100,472	43,622	56,850	170,599	80,653	89,946	101,723	42,808	58,915	61,792	29,685	32,107	5,185	2,292	2,893
65-69	342,523	150,331	192,192	76,176	32,166	44,010	141,892	65,328	76,564	78,026	31,124	46,902	42,702	20,108	22,594	3,727	1,605	2,122
70-74	250,234	105,263	144,971	55,801	22,414	33,387	103,560	45,984	57,576	58,822	22,097	36,725	29,525	13,704	15,821	2,526	1,064	1,462
75-79	188,125	76,797	111,328	40,423	15,431	24,992	82,153	35,607	46,546	41,805	15,007	26,798	21,929	10,042	11,887	1,815	710	1,105
80-84	139,034	52,491	86,543	27,184	9,401	17,783	68,892	27,809	41,083	27,635	8,814	18,821	14,283	6,080	8,203	1,040	387	653
85 & Over	154,270	48,799	105,471	24,008	7,048	16,960	86,879	28,875	58,004	29,436	7,721	21,715	12,742	4,785	7,957	1,205	370	835

Data Source: US Census Bureau, population estimates, 2013.

Infant Mortality

Infant’s ethnic group is determined from mother’s ancestry and race reported on the infant’s birth certificate. In the absence of corresponding birth certificate for an infant death, the infant’s race and ancestry information on the infant’s death certificate is used to assign an ethnic group.

When rates are computed by infant characteristics (e.g. sex of infant or hospital/location of death), such characteristics are drawn from the death certificate, except for those characteristics that are either not indicated on the death certificate or only available on the child’s birth certificate (e.g. mother’s prenatal care, infant’s birth weight, and gestational age). Those are drawn from the child’s birth certificate. In the absence of a birth certificate, demographics are limited to those available on the death certificate. Infants who died in New York City who were born elsewhere are classified as unmatched in Appendix A: Table IM2.

GEOGRAPHICAL UNITS

RESIDENCY STATUS IN DATA PRESENTATION

Community districts were established by City Charter in 1969 for the delivery of city services. Population figures for these districts are compiled by Department of City Planning from census tract and census block data. The sum of the community district populations in each borough may not equal the borough population or the citywide population because community districts may cross borough boundaries.

Tables that stratify by location of residence (e.g., borough) separate data for nonresidents and residence-unknown categories. See Appendix A, Table M1 as an example. Tables that do not stratify by location of residence combine all deaths registered in New York City, regardless of residence.

Vital events that occurred to New York City residents while outside of New York City are not included in this report, with the exception of Life Expectancy (Report: Figures 4 and 5; Appendix A Tables M24, M25). Life expectancy calculations use national data from the NCHS, including deaths to New York City residents that occurred outside of New York City. For more information see Life Expectancy.

BIRTHPLACE PRESENTATION

Mortality Data

Decedent’s birthplace is reported by country. American Samoa, Northern Mariana Islands, US Virgin Islands and Guam are included in United States.

Mother’s Birthplace (used for births and infant mortality data)

Starting in 2007, mother’s birthplace is categorized as: “United States, including its territories” (Puerto Rico, the US Virgin Islands, American Samoa, Northern Marianas Islands, and Guam), “Foreign,” and “Not Stated.” When mother’s birthplace is classified by country-specific categories, Puerto Rico is categorized apart from the United States.

BOROUGH OF RESIDENCE

Borough of residence and other geographic classifications are based on the usual residence reported on the certificate.

COMMUNITY DISTRICT (CD)

Since 1985, assignments to geographic areas smaller than borough, such as community district, are made through the Geosupport Program, which is developed and maintained by the Department of City Planning. Additional information on community district geography can be found at www.nyc.gov/dcp.

NEIGHBORHOOD POVERTY INDICATOR

Neighborhood poverty disparities continue to be presented in the summary of vital statistics since 2012. The neighborhood poverty indicator is the agency-recommended indicator for monitoring socioeconomic health disparities. The summary reports poverty at the census tract level. Each census tract is assigned to a neighborhood poverty category based on the percent of the census tract population living below the federal poverty level. The four neighborhood poverty categories are:

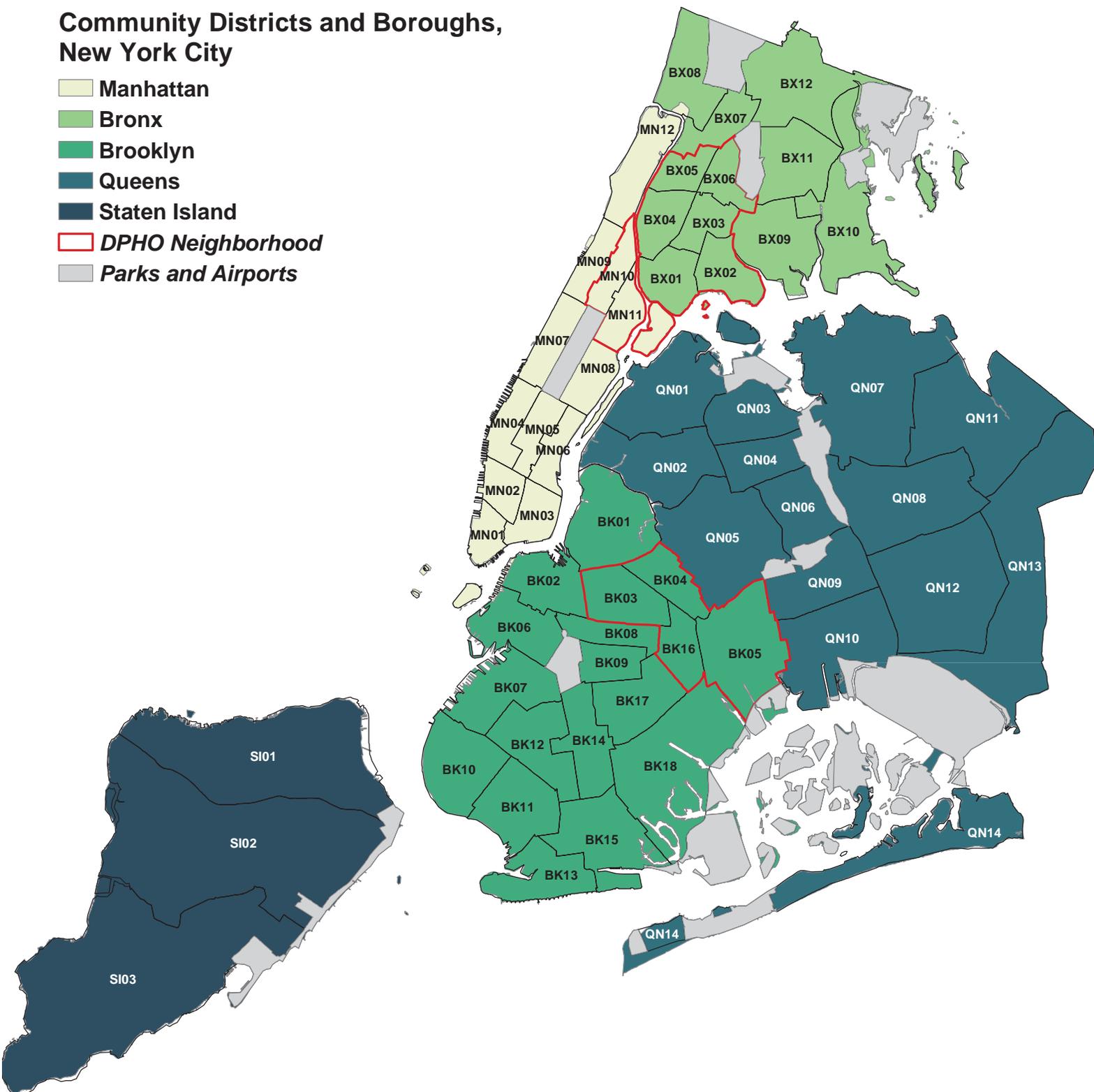
Low: < 10% of the population below poverty	Medium: 10-19% of the population below poverty	High: 20-29% of the population below poverty	Very High: ≥ 30% of the population below poverty
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The denominator of any rate by neighborhood poverty category contains the combined populations of census tracts falling within a category. The numerator contains the summed number of vital events occurring to residents of the census tracts falling within a category. Additional information on poverty indicator can be found at <http://www.hsph.harvard.edu/thegeocodingproject/>.

Community Districts and Boroughs, New York City

Community Districts and Boroughs,
New York City

- Manhattan
- Bronx
- Brooklyn
- Queens
- Staten Island
- DPHO Neighborhood*
- Parks and Airports*



VITAL EVENT RATES

DEATH RATES

Death Rate, all causes per 1,000 population	Death Rate, specified causes per 100,000 population
$\frac{\text{Deaths All Causes}}{\text{Population}} \times 1,000$	$\frac{\text{Deaths due to Specific Cause (specified ICD10 codes)}}{\text{Population}} \times 100,000$
Death Rate, age and sex specific per 1,000 population	Death Rate, age, sex and race-adjusted per 100,000
$\frac{\text{Deaths to persons of specified age group and sex}}{\text{Population, specified age group and sex}} \times 1,000$	The number of deaths per 100,000 US standard population. Age, sex and race/ethnicity specific death rates are applied to a standard population age distribution eliminating the effect of differences in population age composition, and allowing comparisons over time and between geographic areas.
Maternal Mortality Ratio – World Health Organization Definition (Appendix M13)	
$\frac{\text{Deaths due to complications of pregnancy, childbirth and the puerperium occurring within 42 days of delivery}^*}{\text{Live births}} \times 100,000$	
*Deaths of a woman while pregnancy or within 42 days of termination of pregnancy from any cause related to or aggravated by pregnancy or its management (ICD10 codes: O00-O95, O98-O99, A34)	
Perinatal Mortality Ratio	
$\frac{\text{Fetal Deaths 28 Weeks and Over} + \text{Infant Deaths Under 7 days}}{\text{Fetal Deaths 28 Weeks and Over} + \text{Live Births}} \times 1,000$	

INFANT MORTALITY RATES

Infant Mortality Rate	Neonatal Mortality Rate
$\frac{\text{Deaths to infants} < 1 \text{ year old}}{\text{Number of live births}} \times 1,000$	$\frac{\text{Deaths to infants} < 28 \text{ days of life}}{\text{Number of live births}} \times 1,000$
Early Neonatal Mortality Rate	Late Neonatal Mortality Rate
$\frac{\text{Deaths to infants} < 7 \text{ days of life}}{\text{Number of live births}} \times 1,000$	$\frac{\text{Deaths to infants } 7 - 27 \text{ days of life}}{\text{Number of live births}} \times 1,000$

Infant deaths counted in the numerator and live births counted in the denominator are defined by the same calendar year. Some infants counted in the numerator were born in the preceding year and some counted in the denominator may die in the following year.

PREGNANCY OUTCOME RATES

<u>FERTILITY RATE</u>	<u>PREGNANCY RATE</u>
$\frac{\text{Live births}}{\text{Female population aged 15 – 44 years}} \times 1,000$	$\frac{\Sigma (\text{Births, Spontaneous, Induced Terminations})}{\text{Female population of specific age group}} \times 1,000$

<u>BIRTH RATES</u>	
<u>Total birth rate</u>	<u>Age-specific birth rate</u>
$\frac{\text{Total births}}{\text{Total population regardless of age or sex}} \times 1,000$	$\frac{\text{Births among specific age group}}{\text{Female population of specific age group}} \times 1,000$

<u>Total spontaneous termination rate</u>	<u>Age-specific spontaneous termination rate</u>
$\frac{\text{Total spontaneous terminations}}{\text{Female population ages 15 to 44}} \times 1,000$	$\frac{\text{Spontaneous terminations among specific aged females}}{\text{Female population of specified age group}} \times 1,000$

<u>Total induced termination of pregnancy rate</u>	<u>Age-specific induced termination of pregnancy rate</u>
$\frac{\text{Total induced terminations}}{\text{Female population ages 15 to 44}} \times 1,000$	$\frac{\text{Induced terminations among specific aged females}}{\text{Female population of specified age group}} \times 1,000$

*Pregnancy Outcome Counts and Rates

Pregnancy outcome (birth, spontaneous termination, or induced termination) counts and rate numerators use the number of events to women of all ages. For example, the birth rate includes all births in a population, regardless of the mother's age. The denominator for these rates differs by event, consistent with national standards. The birth rate denominator is the number of males and females of all ages. The denominator for spontaneous or induced termination rates is the number of females ages 15-44. The counts and numerator used in age-specific pregnancy outcome rates for the youngest age category (teens 15-19), is the number of events to women in the population under age 20, relative to the denominator of women in the population ages 15 to 19 (Table 1. Pregnancy Outcomes Report). Similarly, the numerator of the oldest age category (40-49) includes events to all women in the population over the age of 40, relative to the denominator of women in the population ages 40-49. NYC first reported these age-specific rates in the 2011 Pregnancy Outcomes Report and applied a denominator of women in the population ages 40-49 as opposed to 40-44 due to the increased number of events occurring among women ages 45-49. The numerator used for the youngest age category for teen pregnancy outcomes (15-17 in Table PO10 Appendix B) is the number of events to women in the population under age 17, relative to the denominator or women in the population ages 15-17.

DEATHS

DEATH CERTIFICATE (see copies in back of Appendix B)

There are two forms, one for natural causes and one for medical examiner cases. The current revisions of the death certificate, implemented in 2003, is based on the recommended 2003 US Standard Certificate of Death <http://www.cdc.gov/nchs/data/dvs/DEATH11-03final-ACC.pdf>

- Natural cause practitioner certificates – Most deaths are due to natural causes.
- Medical examiner certificate of death – When the cause of death is an accident, homicide, suicide, or is unattended or due to certain other circumstances (approximately 15% of deaths), the New York City Office of the Chief Medical Examiner (OCME) completes the medical examiner certificate of death and supplementary report.

For natural cause certificates, the Electronic Vital Events Registration System’s (EVERS) Electronic Death Registration System (EDRS) became available for voluntary use by hospitals in 2005. In January 2010, EDRS reporting became mandatory for medical examiner certificates. In April 2010, EDRS reporting became mandatory for hospitals reporting > 25 deaths/year.

The two forms are similar. Both collect important information pertaining to the fact of death (person, place, and time of death). Both collect “personal particulars” which include items such as decedent’s Social Security number, address, birth place, education, marital status, informant’s information, and place of disposition. The personal particulars are typically provided by a family member of the decedent through the funeral home. Both collect cause of death, which is completed by the physician or a medical examiner. On the natural cause certificate, the cause of death is entered on the confidential medical report, the OCME certificate and on the death certificate itself. In addition to cause of death, the OCME certificate collects information on the circumstances of external causes of death. The OCME certificate indicates manner of death: natural, accident, homicide, suicide, or undetermined. The confidential medical report information is for the compilation of public health statistics and scientific purposes only.

DEATH REPORTING

The death events reported are based on certificates filed with the New York City Department of Health and Mental Hygiene (DOHMH) for vital events occurring in or in-route to New York City, regardless of individual residency status, in a particular year. Any events registered after file closure (typically occurring within 5 months of year-end) are excluded from this report. Such late registrations are rare.

Death certificates must be filed within 72 hours of death or finding the body. During 2013, 93% of death certificates were filed electronically using the Electronic Vital Events Registration System (EVERS). Additional information on EVERS is available at: www.nyc.gov/evers. Since the June 1993 revision of the death certificate, decedent race and ancestry information is reported by funeral directors.

DEATH RATES

See Vital Event Rates

TYPE OF PLACE OF DEATH

“Hospital” includes residential units and other special facilities within the hospital. “Nursing home” includes only sites licensed as Extended Care Facilities by New York State. “Home” refers to the decedent’s residence, and includes private houses and apartments, group quarters for special populations, homes for adults, and other long-term residential sites.

CAUSE OF DEATH REPORTING

The cause of death on the death certificate is completed by a physician, medical examiner or, as of January 16, 2012, by a nurse practitioner. The clinician is required to provide the complete sequence of events and/or medical conditions leading to the death. These include the following:

immediate cause – the specific condition that directly preceded the death.

intermediate cause(s) – the significant condition(s) that preceded and gave rise to the immediate cause of death.

underlying cause – the disease or condition that set off the chain of events leading to death.

For further information on how cause of death should be documented, visit www.nyc.gov/EVERS.

CAUSE OF DEATH-QUALITY IMPROVEMENT INITIATIVE

The Office of Vital Statistics initiated a program to improve quality of cause of death data in 2009, affecting mortality trends. See the NYC Summary of Vital Statistics 2010, Special Section, for more information.

CAUSE OF DEATH CODING

Since 2008, the reported causes of death are coded using the NCHS automated coding software package SuperMICAR, which classifies conditions according to the International Classification of Diseases (ICD) published by the World Health Organization. A single underlying cause is assigned based on the reported chain of events leading to death. Standardized codes allow for national and international comparisons. Causes of death that cannot be coded by SuperMICAR are investigated and coded by nosologists.

Prior to 2007, a large proportion of accidental drug related deaths (X40-X42, X44) were miscoded as chronic drug use (F11-F16, F18-F19). For a full explanation, see the 2007 Annual Summary of Vital Statistics-Special Report: NYC Changes from Manual to Automated Cause of Death Coding, pg. 73-75.

Table M1 is based on the NCHS List of 113 Selected Causes of Death. Some causes have been added to or dropped from these tables based on their number and importance in New York City.

Death trends across ICD code revision years may change as an artifact of the change in ICD codes and coding rules. These should be interpreted with caution.

COMPARABILITY RATIO

National comparability ratios, last updated in 2003, reflect discontinuities in trends for the cause of death when a new version of the ICD is implemented. They are presented in the Appendix A Table M1 to explain changes in following the implementation of the ICD-10 coding system in January 1999.

Comparability ratios measure the net effect of ICD-10 on each cause of death. NCHS determined the causes of death under ICD-10 and ICD-9 for more than 2.3 million 1996 US mortality records and calculated the ratio:

$$\frac{\text{Deaths from cause } \downarrow \text{ICD} - 10}{\text{Deaths from cause } \downarrow \text{ICD} - 9}$$

More information on the ICD-10/ICD-9 comparability ratio can be found at http://www.cdc.gov/nchs/nvss/mortality/comparability_icd.htm

ALCOHOL-RELATED DEATHS

Alcohol-Related Deaths (2013 Mortality Figure 38) Following an increasing deaths due to binge drinking, the ICD codes for alcohol-related deaths were reevaluated by the World Health Organization’s Mortality Reference Group and a coding change was implemented in 2008. Core changes included recoding acute alcoholism, previously coded as F10.2, to X45 (alcohol poisoning) and retiring F100 and going forward coding such cases as X45. This resulted in an increase in alcohol liver disease and alcohol poisoning and a decrease in alcohol dependence syndrome. A subsequent decrease in alcohol liver disease between 2008 and 2009 is, in part, a result of further corrections to coding applied in 2009. Similar changes are seen in US data.

Alcohol-Attributable Mortality (Appendix A Table M14) Alcohol-attributable deaths in Appendix A Table M14 represent the number of New York City deaths attributed to alcohol. Alcohol-attributable mortality (AAM) was calculated using the Alcohol-Related Disease Impact (ARDI) program using an alcohol-attributable fraction (AAF). For conditions that, by definition, are caused by alcohol use, the AAF was set equal to 1.0. For other conditions, especially injuries, ARDI directly estimated the AAF based on direct observations about the relationship between alcohol and a given health outcome. For most chronic conditions, the AAF was indirectly estimated using New York City alcohol prevalence data from the CHS combined with pooled risk estimates from large meta-analyses using the following formula:

$$AAF = [p(RR - 1)] / [1 + (p(RR - 1))]$$

where p is the percentage of New York City men and women age 20 years and older who consume alcohol at a specified level of average daily alcohol consumption within a given year, and RR is the likelihood of death from a particular condition at a specified level of average daily alcohol consumption. To estimate AAM, AAFs were multiplied by the number of New York City deaths for specific causes defined by

the CDC's National Center for Chronic Disease Prevention and Health Promotion. Detailed description of the methodology is available at <http://apps.nccd.cdc.gov/ardi/HomePage.aspx>.

COMPLICATIONS OF MEDICAL AND SURGICAL CARE (Appendix A Table M22)

With the 10th revision of the ICD coding system, complications of medical and surgical care are no longer classified as accidents and are now shown separately from accidents.

DRUG-RELATED DEATHS

Two definitions of drug-related deaths are presented in this report. The first, "Mental and behavioral disorders due to the use of or poisoning by psychoactive substance excluding alcohol and tobacco" is based on NCHS standard cause of death definitions using underlying causes as a basis for categorizing deaths and presented among the leading causes of death. The second definition, "Accidental/unintentional Drug-related Overdose Deaths" is presented in the Executive Summaries of Summary of Vital Statistics, starting in 2009 and in 2012 Mortality Report.

Mental and behavioral disorders due to use of or accidental poisoning by psychoactive substance excluding alcohol and tobacco (2013 Mortality Tables 1-5, Figures 13-16, Appendix A Tables M1, M7-M12 and M26): also called "Use of or poisoning by psychoactive substance" or "Drug Use/Poisoning" combines underlying chronic drug-use ICD codes (F11-F16, F18-F19) and accidental (unintentional) drug-poisoning ICD-10 codes (X40-X42, X44) to estimate overall drug-related deaths. This definition is found in Mortality Tables 1-5 Figures 9-12, Appendix A Tables M1, M7-M12 and M26. "Accidental poisoning by psychoactive substances, excluding alcohol and tobacco," the "accidental" subset of underlying codes (X40-X42, X44) are reported in Appendix A Tables M1 and M18. "Mental and behavioral disorders due to the use of psychoactive substance excluding alcohol and tobacco," the "chronic" subset of underlying codes (F11-F16, F18-F19) is found in Appendix A Table M1. However, please use "accidental" (unintentional) and "chronic" subset trend data with caution as changes from manual to automated ICD coding resulted in a redistribution of chronic causes to acute in 2007 and going forward. For more information on coding error, please see Cause of Death Coding.

Unintentional Drug-related Deaths (2013 Mortality: Figure 44) is the definition used in Take Care New York (TCNY). Reported in the Summary since 2008, the definition has changed. Starting in 2011 Summary, the definition of Unintentional Drug-related Deaths has 2 modifications from "Drug Use/Poisoning": (i) restricted to deaths among individuals ages 15 ≤ 84; (ii) restricted to deaths confirmed by medical examiner to be accidental. This definition has changed since 2008 after extensive review of drug related death case files.

Deaths due to alcohol are reported separately. See Alcohol-Related Deaths above.

EXTERNAL CAUSES OF DEATH (2013 Mortality Figures 40-45; Appendix A Tables M18-M23)

External causes of death include accidents, suicide, assault, legal intervention, events of undetermined intent, operations of war and their sequelae, and complications of medical and surgical care. The Office of Chief Medical Examiner determines the cause and manner of death in such cases. For the purpose of statistical analysis, whether a cause is defined as external depends on the ICD code assigned as the underlying cause of death and may not agree with the manner of death reported.

Sometimes a cause of death has not been established when the statistical file is closed. Such deaths are classified as "pending final determination" and may later be classified.

Deaths classified as "events of undetermined intent" are considered due to external causes for the purpose of statistical analysis.

Information on errors in coding external causes of death prior to 2007 are described above: Cause of Death Coding.

FATAL OCCUPATIONAL INJURIES (2013 Mortality Figure 39, Table 6; Appendix A Table M17 and Figure M12)

Appendix A, Table M17 and Figure M12 are based on US Department of Labor's Bureau of Labor Statistics. These deaths, unlike NYC Vital statistics, are based on the location of the injury, regardless of the residence of the decedents or location of the death. Note that these deaths may or may not occur at the time of injury, they can occur subsequently. The industry in which the decedent worked and was injured is coded based on the North American Industry Classification System (NAICS). Comparisons by industry before and after 2003 are discouraged because of the substantial coding differences.

For all NYC occurring deaths due to external causes, the Bureau of Vital Statistics (BVS) reviews autopsy and other reports to determine if the injury occurred at work. Definitions and terminology are based on US Department of Labor's Bureau of Labor Statistics, which may differ from other definitions used in vital statistics.

Heart Disease Deaths: See 2010 Mortality – Special Section: *Cause of Death Quality Improvement Initiative* for information on the initiative's impact on cause of death reporting, particularly heart disease reporting.

HIV AND AIDS MORTALITY (2013 Mortality Tables 1-5; Figures 34-36; Appendix M16)

Beginning 1999, with the 10th revision of the ICD code, deaths due to HIV disease (ICD-10 codes B20-B24) are characterized by the resulting disease or condition, replacing AIDS and other HIV infections in ICD 9th revision.

HOMICIDE (2013 Mortality Figure 45; Appendix A Table M20)

A homicide is defined as the action of one person causing the death of another regardless of intent (e.g., whether self-defense or justifiable legal intervention). Annual counts of homicides reported by the New York City Police Department (NYPD) differ from those of the Bureau of Vital Statistics (BVS) for a number of reasons outlined below. Nonetheless, reported trends are similar. All homicides are medical examiner (ME) cases.

NYPD reports homicides as counts of Murder and Non-Negligent Manslaughter using rules and procedures from the Federal Bureau of Investigation's Uniform Crime Reporting System (UCR). The count includes deaths determined to be both criminal and satisfying the UCR guidelines. NYPD judges some homicides as justifiable and reports these separately to the FBI. BVS reports a death as a homicide based on the ICD-10 system. ICD-10 defines legal intervention as "including injuries inflicted by police or other law-enforcing agents ... in the course of arresting or attempting to arrest ... and other legal action." Since 2003, deaths from legal intervention have been reported separately in Appendix A Tables M1 and M20 and are excluded from the homicide counts in Tables M11 and M12.

NYPD Murder and Non-Negligent Manslaughter statistics count all murder crimes known to have been committed in New York City regardless of where the death occurred. Note, the crime may or may not have occurred at the time of death; death can occur subsequently and therefore potentially in a different jurisdiction than the murder crime. BVS reports all homicide deaths known to have occurred in New York City regardless of where the crime was committed.

In its annual count, the NYPD includes homicides known to have occurred within that calendar year by the second week of January of the following year. Any death determined to be a criminal murder outside of that period will be counted in the year that the determination is made. BVS reports homicide by the date of the death and the annual count includes any cases reported until the file closes for the year (approximately 5 months after the end of the year).

Sometimes death results from a crime many years after the crime was committed. Other times, a death may be determined a crime years after the death. In either situation, the ME may determine the death a homicide. If classified as a criminal homicide, NYPD will count the death in the year that the determination is made. However BVS will report the homicide by the date of death. In cases where a death is reclassified a homicide after the file closes, the death will be recorded as a homicide on the death certificate, but this change will not be reflected in any counts of homicides for the year of death or any other years.

LIFE EXPECTANCY (2013 Mortality Figures 1, 2; Appendix A Tables M24, M25)

Life expectancy tables summarize the effect of mortality rates prevailing at a specific time on persons being born or living at that time. Tables may be computed for population subgroups, most often males, females, and race groups. The calculation requires counts and mortality figures for the desired subgroups. Life expectancy is estimated by ethnic group instead of race to ascertain differences among Hispanics, non-Hispanic whites and non-Hispanic blacks. Life expectancy tables by race/ethnicity for New York City are generally presented for census years when accurate population data are available. The mortality experience for the census year, the year before, and the year after is used to smooth statistical variation (Table M24). Life expectancy trends are presented by single year of data. Number of Asian and Pacific Islander deaths is too small to generate reliable life expectancies and therefore are not presented either in Mortality Figure 2 or Appendix A. Table M24.

The World Trade Center disaster deaths are not included in calculation of life expectancy.

Appendix A, Table M25 presents annual life expectancy by age and sex providing trend information. Annual life expectancy is estimated using single-year death data. Table M25 does not include life expectancy for 2013 because national data on deaths to New York City residents occurring outside of New York City are required and not yet available.

Historical Hispanic ancestry data and life expectancy estimates should be interpreted with caution. In addition to changes in collection of Hispanic ancestry information, Hispanic immigration patterns may result in overestimated life expectancy if Hispanics move out of the US before death at a greater rate than other ethnic groups. The Hispanic population tends to be younger than other ethnic groups, which may lead to underestimates of Hispanic death rates and overestimates of Hispanic life expectancy.

MATERNAL DEATH AND MATERNAL MORTALITY (Appendix A M13)

Deaths due to "Maternal Causes" meet the World Health Organization's definition of maternal mortality: "death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management" With the 10th revision of the ICD coding system, this category includes codes O00-O95, O98-O99 and A34 (obstetrical tetanus). "Pregnancy, childbirth and the puerperium" (O00-O99) includes deaths to women that occur outside of the time limitation defined by the World Health Organization (WHO).

MOTOR VEHICLE DEATHS

The Bureau of Vital Statistics (BVS) methodology for counting Motor Vehicle Deaths differs from that of the Department of Transportation (DOT) and NYPD in two ways. First, DOT and NYPD do not include deaths resulting from illness while operating a motor vehicle in their traffic fatality count, while BVS does, as this is the standardized NCHS approach. Second, in cases where serious injury suffered during a motor vehicle accident results in subsequent death (e.g., one month later) the fatality will be counted by DOT and NYPD for the month in which the accident occurred. However, BVS reports deaths by date of death.

PREMATURE DEATHS (2013 Mortality: Figures 3, 5, 6, 8, 13-15, Table 4; Appendix A M13)

Premature deaths are deaths that occur before a person reaches an expected age, for instance, age 65 or age 75. Premature death rates in the NYC Annual Summary of Vital Statistics use 65 as the expected age. The number of deaths or deaths by select cause(es) relative to the ≤ 65 population in the same geographic area result in the rate of premature deaths. Also see Years of Potential Life Lost (YPLL).

SMOKING-ATTRIBUTABLE MORTALITY (SAM)

Single year Smoking Attributable Mortality is presented in Appendix A, Table M15. Please see Historic Technical Notes, Deaths, Smoking-Attributable Mortality for information on this computation. World Trade Center (WTC) Deaths

Since 2008, any deaths during the reporting year identified as late-effect WTC deaths are counted in the year of the confirmed death report and in Appendix A, Table M1 under Assault (homicide): ICD-10 Code U02. The total number of WTC deaths is 2,752. The number does not include 3 deaths that occurred outside of NYC. Unless otherwise specified, WTC deaths occurring in 2001 are generally not included in Summary tables and figures due to the effect this large number would have on year-to-year trends.

YEARS OF POTENTIAL LIFE LOST (2013 Mortality Figure 16, Table 5; Appendix A Table M26)

Years of potential life lost (YPLL) measures years lost due to premature death. In contrast to mortality measures, YPLL emphasizes the effect of premature mortality on a population. YPLL is often calculated using a cutoff age, 65 or 75, as follows:

$$YPLL = \sum [(cutoff\ age - i) \times d_i]$$

where i is the midpoint of the grouped year of age at death and d_i is the number of deaths at grouped year of age i . YPLL can be calculated for specified causes of death. In Table M26, age 75 is used as the cut off age and single year of age is used in calculation. Therefore i is single year of age younger than 75. See also Premature Deaths.

PREGNANCY OUTCOMES

BIRTHS

BIRTH CERTIFICATE (see copy in back of Appendix B)

The birth certificate comprises two parts: the certificate of birth and the confidential medical report of birth. The current revision of the birth certificate, implemented in 2008, is based on the recommended 2003 US Standard Certificate of Live Birth <http://www.cdc.gov/nchs/data/dvs/birth11-03final-ACC.pdf>. The 2008 revision coincided with the January 2008 electronic filing requirement.

The certificate of birth is the legal record. Each certificate is authenticated by the medical provider (physician or midwife) or his or her representative and filed with the New York City Department of Health and Mental Hygiene.

The confidential medical report, used for the compilation of public health statistics and scientific purposes, includes parents' demographic information, mother's prenatal history and care, information on financial coverage, maternal morbidity, labor and delivery, and condition and treatment of the infant during, and immediately after, birth. These data are collected from the mother, the mother's and infant's medical records, and medical providers.

BIRTH REPORTING

The birth events reported are based on certificates filed with the New York City Department of Health and Mental Hygiene (DOHMH) for vital events occurring in or in-route to New York City, regardless of individual residency status, in a particular year. Births must be filed within five business days of the event. Birth data are generally collected using two worksheets: mother/parent and facility worksheets. Guides for the completion of the birth certificate and data entry can be found at <http://www.nyc.gov/EVERS>. Effective January 2008, BVS requires all hospitals registering more than 100 births per year to use the Electronic Vital Events Registration System (EVERS). In 2013, more than 99% of all births were registered electronically through the Electronic Vital Events Registration System (EVERS). Any events registered after file closure (typically occurring within 5 months of year-end) are excluded from this report. Such late registrations are rare.

BIRTH RATES

See Vital Event Rates

DATA PRESENTATION

Starting with the 2007 summary, items with unknown/not stated values are excluded from the denominator when calculating percentages. This affects Appendix A Tables PO6, PO7, PO11, PO12 and Maps: PO1, PO2, PO3, and PO4.

BREAST FEEDING

Breast feeding has been reported on the birth certificate since 2008. It includes infant feeding practices through the first 5 days of life. New York City births must be filed with the Department within five business days of the event.

PLACE OF BIRTH

Since 1996, home births in Appendix A Tables PO4 and PO5 include all events for which "Home" was selected as the "Type of Place" regardless of whether the certificate was filed through a hospital. Home births in Table PO1 include events for which "home" was selected as "Type of Place" and the certificate was not filed by an institution; typically, these events were filed by the person who attended to the birth at home.

Appendix A: Table PO1 describes the live births according to the borough in which the birth occurred. Prior to 2010, Table PO1 reported births according to the borough in which the reporting office was located. This primarily affects the frequency of "places other than a hospital or home" and "home births," which occur citywide but are frequently reported by the Bureau of Vital Statistics in Manhattan.

MOTHER'S MARITAL STATUS

The New York City DOHMH is prohibited by local law from recording mother's marital status on the record or report of birth. As a result, marital status is estimated and should be interpreted with caution. Since 1997, marital status is computed using the following algorithm: certificates without the father's name and those with the father's name that are accompanied by an Acknowledgment of Paternity are categorized as non-married; all others are categorized as married. Married parents have a right to have both their names on their child's birth certificate. This applies equally to married opposite-sex parents and same-sex parents. Some hospitals require proof of marriage. If the mother is not married, a father's name may be added through an Acknowledgment of Paternity or court order.

TEEN BIRTHS

See Age-specific birth rate under VITAL EVENT RATES, above.

GESTATIONAL AGE

Gestational age, or clinical estimate of gestation, is defined as the best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of gestation. Characteristics of live births and/or infant deaths in the Appendix A, Tables PO4-PO7, PO11, PO12, and Figure PO4, respectively, include either gestational age categories or a dichotomous indicator of preterm (< 37 weeks gestation) birth.

Beginning 2007, the range for valid gestational age was changed from 20-44 weeks to 17-47 weeks.

SPONTANEOUS AND INDUCED TERMINATIONS OF PREGNANCY REPORTING

SPONTANEOUS TERMINATION OF PREGNANCY CERTIFICATE (see copy in back of Appendix B)

Like the birth certificate, the spontaneous termination of pregnancy certificate has two parts, the certificate and the confidential medical report. The certificate is available to the mother. The confidential medical report information is collected for the compilation of public health statistics and scientific purpose.

INDUCED TERMINATION OF PREGNANCY CERTIFICATE (see copy in back of Appendix B)

Induced termination of pregnancy certificates are not issued. Data are collected for the compilation of public health statistics and scientific purpose.

The spontaneous and induced termination of pregnancy events reported are based on certificates filed with the New York City Department of Health and Mental Hygiene (DOHMH) for vital events occurring in or in-route to New York City, regardless of individual residency status, in a particular year. By law, all terminations of pregnancy are to be reported within 5 business days of the event, unless a permit to dispose of the conceptus is required (≥ 24 week gestation) or requested (any gestational age). In such a case, the event must be reported within 24 hours. However, the number of induced and spontaneous terminations filed depends to some extent on the outreach conducted by BVS. Effective January 1, 2011, all facilities that report births electronically to the Department pursuant to Public Health Law 203, are required to report spontaneous terminations electronically via the Electronic Vital Events Registration System (EVERS); the Chief Medical Examiner and all facilities reporting 100 or more induced terminations of pregnancy per year also are required to file electronically via EVER; all facilities that have commenced reporting electronically, regardless of number of events reported are required to do so electronically. In 2011, 99.8% of induced terminations of pregnancy and 99.7% of spontaneous terminations of pregnancy were filed electronically. Otherwise, paper forms, authorized by the department may be used for reporting such events.

SPONTANEOUS AND INDUCED TERMINATION OF PREGNANCY RATES

See Vital Event Rates

HISTORICAL TECHNICAL NOTES

POPULATION		
Technical Note Section	Description	Summary Year Affected
	Tables and figures with 2001-2012 data use intercensal population estimates determined by Census Bureau released as of September 2012	2011, 2012
	Tables and figures with single-year data use 2010 Census population count. Tables and figures with 2001-2010 data use intercensal population estimates determined by NYC Department of City Planning as of July 1, 2010.	2010
	The 2007-2009 Annual Summaries used the respective year's pre-challenged US Census Bureau's population estimates. As a result, city and borough-wide estimates overall and by age, ethnicity and sex may vary from those presented in prior summaries.	2007-2009
	The 2005-2006 Annual Summaries used post 2000 census estimates for citywide, county (borough), 5-year age group, ethnic group and sex population counts. The Summary year population counts used pre-challenged census estimates; prior year population counts presented in the Summaries used post-challenged census estimates in addition to Census 2000 data.	2005-2006
	Population counts used US Census citywide decennial population counts.	2000-2004
	Intercensal counts were estimated using an exponential formula, which assumes that the growth rate was the same throughout the decade: $\frac{pop(t1)}{pop(t0)} = e^{rt}$ (where r is a constant growth rate and t is the time interval).	Intercensal years between 1990 and 2000
	Intercensal counts were estimated using a linear interpolation.	Intercensal years through 1989
	The population counts for years 1960, 1970, 1980, 1990 and 2000 were US Census counts.	1960, 1970, 1980, 1990, 2000
Community District	Community District population estimates for the years 2000 through 2010 are based on population estimates from Census 2000 and Census 2010 and the official Census intercensal estimates by county, age, race, and sex. The 2010 number is adjusted to account for undercount in Brooklyn and Queens as documented by the Department of City Planning. To calculate individual year's Community District estimates beginning with July 1 st , 2000, an interpolation by Community District, age, race, and sex was adjusted to the county, age, race, and sex numbers using an iterative proportional fitting procedure. Each year through 2009 was constructed from an interpolation based on the previous year, the modified Census 2010, and the intercensal numbers for that year. The July 1 st , 2010 numbers were then extrapolated using July 1 st , 2009 and Census 2010 and then adjusted to the July 1 st intercensal numbers. These estimates differ from the 2001-2011 estimates used in the 2010 and 2011 Summary because the 2010 and 2011 Summary estimates were adjusted to official intercensal estimates consistent with Census 2010 released in October 2012.	2012

TECHNICAL NOTES, 2013

	<p>Community District population estimates for the years 2000-2010 use population estimates from Census 2000 and Census 2010 and the official Census intercensal estimates by county, age, race, and sex. To calculate individual year's Community District estimates beginning with July 1st, 2000, an interpolation by Community District, age, race, and sex was adjusted to the county, age, race, and sex numbers using an iterative proportional fitting procedure. Each year through 2009 was constructed from an interpolation based on the previous year and Census 2010. The July 1st, 2010 numbers were then extrapolated using July 1st, 2009 and Census 2010 and then adjusted to the July 1st intercensal numbers. These estimates differ from the 2000-2010 estimates used in the 2010 Summary because they are adjusted to official intercensal estimates consistent with Census 2010 released in October 2012.</p>	2011
	<p>Community district population estimates by sex and 18 age groups were derived by the New York City Department of City Planning. For community district data by race/ethnicity and 22 age groups for the same period, DOHMH Bureau of Epi Services constructed estimates from the Department of City Planning data and available Census 2000 and</p> <p>2010 data, ensuring consistency with marginal totals from the Census Intercensal Estimates program. Postcensal estimates as well as the official 2010 modified race summary files were used. Because the 2010 modified race summary file was not available from the Census for single-year age by modified race groups, DOHMH used Census summary file 1 and adjusted the dataset to match the Census modified race summary file. To create the modified race groups, the "some other race" group was removed and race is imputed. While the modified race summary file created by the Census used information from other members of the same household, the DOHMH used race information from the corresponding Census tract. The race distribution was then modified to match the 2010 modified race summary file.</p>	2010
	<p>Community District population estimates for intercensal years use United States Census Bureau Population Estimate Program and housing unit data from the New York City Department of City Planning. The "housing unit method" of estimation allocates the population to Community Districts. The method multiplies the estimated number of households in a given area by an estimate of the population per household. In the intercensal context, housing unit growth, measured by housing permit data, determines the locations of growth. Because these estimates are calibrated to equal United States Census-borough-specific population totals, the borough population per household is fixed. New population estimates are derived using the iterative proportional fitting procedure (IPFP) implemented in SAS® Version 9.2. The validity of these estimates depends on vacancy rates, housing unit loss rates, percentage of permits actually constructed, and time to complete construction, which are assumed consistent at the borough level and thus have no effect on the allocation of growth. The method is sensitive to the quality of the housing permit data, which does not identify residential conversions to multiple units. Demographic characteristics are allocated assuming those at the location of growth. Therefore, this approach does not capture intercensal demographic changes at the neighborhood level including change due to migration.</p>	2008-2009
Health Center District	<p>Year 2000 census counts were used for defining smaller geographic units such as Community Districts or single-year age groups.</p>	2005-2006

TECHNICAL NOTES, 2013

	Population estimates for Health Center District (HCD) were not computed in time for the release of 2008 report and have not been presented since 2007. As a result, Health Center District tables were either replaced (Table 7) or did not present rates (Table 34).	Through 2007
Race/Ethnic Group	Health Center district data were presented in Summary Reports. Populations for geographic area smaller than borough were based on decennial census data.	Through 2007
	Census data were used to define race and ethnic distribution; in 2002, the Census Bureau issued the modified Race File resulting in a 65% reduction in Other and Multiple Race, a 6% increase in Asian and Pacific Islander, and 3% increases for non-Hispanic white and non-Hispanic black. There was no change for Hispanic population.	2000-2001
DEMOGRAPHIC CHARACTERISTICS OF VITAL EVENTS		
Race, Ancestry and Ethnic Group	The death certificate allowed the selection of one race category	Through 2002
	The birth certificate allowed the selection of one race category.	Through 2007
	The meaning of ancestry was clarified with hospitals, resulting in a notable increase in Hebrew and Jewish ancestry and a decrease in American ancestry.	1999
	Mother's birthplace was reported in four categories: United States other than Puerto Rico, Puerto Rico, Foreign and Not Stated. US Virgin Islands and Guam are included in the "Foreign" category.	1991-2006
Birthplace	Decedent's birthplace was first reported by country in 2000. US Virgin Islands and Guam were included in the "Other" category.	2000 - 2006
GEOGRAPHICAL UNITS		
Community District	Community districts were referred to by number through 2002 and by name after.	Prior to 2003
Place of Birth	Through 1995, all reports of home births included only events filed outside the hospital.	Through 1995
DEATHS		
Death Reporting	Medical certifier provided race and ancestry information.	Through 1992

TECHNICAL NOTES, 2013

Race/Ethnicity	The death certificate was revised in June 1993 to require funeral directors to provide ancestry information, presumably from decedents' family members.	1993 - present
	Medical certifier provided ancestry information.	Through 1992
Cause of Death Coding	ICD-coding was conducted manually by an NCHS certified nosologist.	Through 2006
Alcohol-related Deaths: ICD Coding	Following increasing deaths due to binge drinking, the ICD codes for alcohol-related deaths were reevaluated by the World Health Organization's Mortality Reference Group and coding was implemented in 2008. Core changes included recoding acute alcoholism, previously coded as F10.2, to X45 (alcohol poisoning) and retiring F100 and going forward coding such cases as X45. This resulted in an increase in alcohol liver disease and alcohol poisoning and a decrease in alcohol dependence syndrome. A subsequent decrease in alcohol liver disease between 2008 and 2009 is, in part, a result of further corrections to coding applied in 2009. Similar changes are seen in US data.	2008 - present
HIV and AIDS	In 1987, NCHS introduced code 042 for AIDS and 043-044 for other HIV disease deaths. Additional information on historical HIV coding can be found in the 1997 and 1998 Annual Summaries.	1987 to 1999
	AIDS was recognized as a cause of death and coded as ICD-9 code 279.1.	1983 to 1986
External Causes	External Causes were not shown separately.	Through 1999
Drug-related Deaths: ICD Coding	Through 2006, a large proportion of accidental drug related deaths (X40-X42, X44) were miscoded as chronic drug use (F11-F16, F18- F19). For a full explanation, please see the 2007 Annual Summary of Vital Statistics-Special Report: NYC Changes from Manual to Automated Cause of death Coding, pg 73-75. NCHS coded data is often substituted when presenting external causes of death trends that span 2006 to 2007.	Through 2006
Maternal Deaths and Maternal Mortality	Currently labeled "Maternal deaths" were "Complications of pregnancy, childbirth and the puerperium" through 1998.	Through 1998
Accidents (Unintentional)	The site of accidents (home and public place) has been dropped due to unreliable reporting.	Through 1998
	Complications of medical care and surgical care were classified as accidents per ICD-9.	Through 1999

Smoking-Attributable Mortality (SAM)	<p>SAM was calculated using CDC's Adult SAMMEC (Smoking-Attributable Mortality, Morbidity, and Economic Costs) program using an attributable fraction formula. New York City sex-specific smoking prevalence was estimated from the New York City DOHMH Community Health Survey (CHS) and computed by the Bureau of Epidemiology. The relative risks (RR) of death for current and former smokers ≥ 35 years of age for 19 smoking-related diseases were estimated from the American Cancer Society's Cancer Prevention Study. The smoking-attributable fraction (SAF) for each smoking-related disease and sex is calculated using the following formula:</p> $\text{SAF} = \frac{[p_0 + p_1(\text{RR}_1) + p_2(\text{RR}_2)] - 1}{[p_0 + p_1(\text{RR}_1) + p_2(\text{RR}_2)]}$ <p>Where p_0 is the percentage of adult never-smokers in New York City; p_1 is the percentage of adult current smokers in New York City; p_2 is the percentage of adult former smokers in New York City; RR_1 is the relative risk of death for adult current smokers relative to adult never-smokers; and the RR_2 is the relative risk of death for adult former-smokers relative to adult never-smokers.</p> <p>To estimate the SAM, the age- and sex-specific SAFs are multiplied by the number of deaths for each smoking-related disease. Specifically, the number of deaths for each sex and 5-year age category was multiplied by the SAF:</p> $\text{SAM} = \text{Number of deaths} \times \text{SAF}$ <p>Summing across age categories provides the sex-specific estimate of SAM for each disease. Total SAM is the sum of the sex-specific SAM estimates. A detailed description of the methodology is available at http://apps.nccd.cdc.gov/sammecc.</p>	Through 2010
World Trade Center Deaths	See Technical Notes, 2009 regarding late effect WTC-deaths.	2008-present
	<p>In 2007, a 2002 death was reclassified as a WTC death.</p> <p>In 2008, a 2001 death was reclassified as a 2001 WTC death.</p> <p>In 2008, a missing person was classified as a 2001 WTC death per New York State Supreme Court.</p>	2007, 2008
	In 2002, the number of WTC deaths included in 2001 deaths was updated from 2,740 to 2,749. This new number included six additional death certificates filed through October 31, 2003 and three deaths that occurred outside of New York City (See 2002 Special Section for details).	2002
Fatal Occupational Injuries	The industry in which the decedent worked and was injured was coded based on the Standard Industrial Classification (SIC).	Through 2002
World Trade Center Deaths and Life Expectancy	Impact of World Trade Center deaths on life expectancy.	2002 (Special Section)

BIRTHS		
Age-specific Birth Rates	Until, 2011, youngest and oldest age-specific birth rates included events within the specific age range (e.g. age-specific birth rates to females 15 to 19 include births to females in that age group. Age-specific births to females 15-17 include births to females in that age group. See current technical notes for change in 2011.	Through 2010
Age-specific Birth Rates	Until 2011, the oldest age-specific birth rate presented was 40 to 44. See current technical notes for change in 2011	Through 2010
Trimester of First Prenatal Care Visit (Late or no Prenatal care).	Following the 2008 transition to EVERS, the magnitude of births registered without information used to calculate Trimester of First Prenatal Care Visit was great and data were suppressed. By 2010 reporting improved such that data could be released and included in the Summary.	2008-2009
Ancestry, Other	Following the 2008 transition to EVERS, the number of births registered with an "other" or unknown ancestry increased.	2008-2010
Mother's Marital Status	Mother's Marital Status was computed using an algorithm developed by NCHS. A 1996 review of marital status indicated that the number of non-marital births was being overestimated. See Special Note on Mother's Marital Status in the 1997 Annual Summary for details.	Through 1996
2008 Revised NYC Birth Certificate	For comprehensive information on the 2008 revision of the NYC birth certificate, please see the Technical Notes from the 2008 Summary of Vital Statistics http://www.nyc.gov/html/doh/downloads/pdf/vs/2008sum.pdf .	2008
INDUCED AND SPONTANEOUS TERMINATION OF PREGNANCY		
Reporting	Induced and spontaneous terminations of pregnancies registered after the annual file closed were added to the following year's data.	Through 2007

DATE FILED

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF BIRTH

CERTIFICATE NO.

THIS CERTIFICATE NOT VALID UNLESS FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 Typewrite or print with black fine point ink. Certificates containing alterations or omissions are unacceptable.

Please complete the following:

Has parent approved assignment of SSN for child? YES NO

Mother/Parent's SSN: _____

Father/Parent's SSN: _____

Cert. No. _____

Place: _____

Died: Date: _____

1. NAME OF CHILD (First, Middle, Last)					
2. SEX	3a. NUMBER DELIVERED of this pregnancy	4a. DATE OF CHILD'S BIRTH (Month) (Day) (Year - yyyy)	4b. TIME <input type="checkbox"/> AM <input type="checkbox"/> PM		
	3b. If more than one, number of this child in order of delivery				
5. PLACE OF BIRTH	5a. NEW YORK CITY BOROUGH	5b. Name of Hospital or other facility (if not facility, street address)			
5c. TYPE OF PLACE	<input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Delivery: Planned to deliver at home?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
	Other-specify: _____				
6a. MOTHER/PARENT'S NAME (Prior to first marriage) (First, Middle, Last) SEX ___M ___F		6b. MOTHER/PARENT'S DATE OF BIRTH (Month) (Day) (Year - yyyy)		6c. MOTHER/PARENT'S BIRTHPLACE City & State or foreign country	
7. MOTHER/PARENT'S USUAL RESIDENCE		7c. City or town	7d. Street and number	Apt. No.	ZIP Code
a. State	b. County	7e. Inside city limits of 7c? Yes <input type="checkbox"/> No <input type="checkbox"/>			
8a. FATHER/PARENT'S NAME (Prior to first marriage) (First, Middle, Last) SEX ___M ___F		8b. FATHER/PARENT'S DATE OF BIRTH (Month) (Day) (Year - yyyy)		8c. FATHER/PARENT'S BIRTHPLACE City & State or foreign country	
9a. NAME OF ATTENDANT AT DELIVERY		<input type="checkbox"/> M.D. <input type="checkbox"/> RPA <input type="checkbox"/> D.O. <input type="checkbox"/> R.N. <input type="checkbox"/> Lic. Midwife <input type="checkbox"/> Other-Specify _____			
9b. I CERTIFY THAT THIS CHILD WAS BORN ALIVE AT THE PLACE, DATE AND TIME GIVEN		<input type="checkbox"/> M.D. <input type="checkbox"/> RPA <input type="checkbox"/> D.O. <input type="checkbox"/> R.N. <input type="checkbox"/> Hosp. Admin. <input type="checkbox"/> Lic. Midwife <input type="checkbox"/> Other-Specify _____			
Signed _____					
Name of Signer _____ (Type or Print)					
Address _____					
Date Signed _____, Year - yyyy _____					
Mother/Parent's Current (First, Middle, Last) Legal Name _____ Address _____ Apt. _____ City _____ State _____ ZIP _____					

CONFIDENTIAL MEDICAL REPORT OF BIRTH (1 of 2)

Only for scientific purposes approved by the Commissioner. Not open to inspection or subject to compelled disclosure.

NAME OF CHILD _____ CHILD'S MEDICAL RECORD NO. _____ CERTIFICATE NO. _____

MOTHER'S/PARENT'S MEDICAL RECORD NO. _____ MOTHER'S/PARENT'S TELEPHONE NUMBERS: Day () _____ Evening () _____

10. PARENT'S RACE

Race as defined by the U.S. Census (Check **one or more** to indicate what the parent considers her/himself to be)

a. Mother/Parent **b. Father/Parent**

White

Black or African American

American Indian or Alaska Native

Name of enrolled or principal tribe _____

(Mother/Parent) (Father/Parent)

Asian Indian

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Asian

Specify _____

(Mother/Parent) (Father/Parent)

Native Hawaiian

Guamanian or Chamorro

Samoan

Other Pacific Islander

Specify _____

(Mother/Parent) (Father/Parent)

Other

Specify _____

(Mother/Parent) (Father/Parent)

11. PARENT'S ANCESTRY

(Check **one** box and specify what the parent considers her/himself to be)

a. Mother/Parent **b. Father/Parent**

Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.)

Specify _____

(Mother/Parent) (Father/Parent)

NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.)

Specify _____

(Mother/Parent) (Father/Parent)

12. PARENT'S LENGTH OF TIME IN US

a. Mother/Parent: If born outside of the United States, how long lived in U.S.?
years _____ or if < 1 yr, months _____

b. Father/Parent: If born outside of the United States, how long lived in U.S.?
years _____ or if < 1 yr, months _____

13. PARENT'S EDUCATION

(Check the box that best describes the highest degree or level of school completed at time of delivery)

a. Mother/Parent **b. Father/Parent**

8th grade or less; none

9th-12th grade, no diploma

High school graduate or GED

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)

14. PARENT'S OCCUPATION

Yes No

a. Was mother/parent employed during pregnancy?

	1. Current/most recent occupation	2. Kind of business or industry
b. Mother/Parent		
c. Father/Parent		

15. PRENATAL HISTORY

a. 1. Total Number of Previous Live Births _____ None

2. Number Born Alive and Now Living _____ None

3. Number Born Alive and Now Dead _____ None

b. Those born alive may have been Preterm, Low Birth Weight or both. Please indicate:

1. Number Preterm (< 37 wks.) _____ None

2. Number Low Birth Weight (< 2500 grams or 5 lbs. 8 oz.) _____ None

c. 1. Total Number of other Pregnancy Outcomes (Spontaneous or Induced Terminations): _____ None

2. Number of Spontaneous Terminations of Pregnancy less than 20 Weeks _____ None

3. Number of Spontaneous Terminations of Pregnancy 20 Weeks or More _____ None

4. Number of Induced Terminations of Pregnancy _____ None

d. Date of First Live Birth (mm/yyyy) ____/____/____

e. Date of Last Live Birth (mm/yyyy) ____/____/____

f. Date of Last other Pregnancy Outcome (mm/yyyy) ____/____/____

g. Date Last Normal Menses began (mm/dd/yyyy) ____/____/____

16. PRENATAL CARE

a. Total Number of Prenatal Visits for this Pregnancy _____
 None

b. Date of First Prenatal Care Visit (mm/dd/yyyy) ____/____/____

c. Date of Last Prenatal Care Visit (mm/dd/yyyy) ____/____/____

d. Primary Prenatal Care Provider Type (Check one)

MD/DO No Provider

C(N)/M/NP/PA/Other Midwife No Information

Clinic Other

e. Risk Factors in this Pregnancy (Check all that apply)

Pre-pregnancy diabetes

Gestational diabetes

Pre-pregnancy hypertension

Gestational hypertension

Cardiac disease:

Structural defect

Functional defect

Other serious chronic illness

Anemia (Hct.<30/Hgb.<10)

Asthma/Acute or chronic lung disease

Rh sensitization

Polyhydramnios

Oligohydramnios

Hemoglobinopathy

Abruptio placenta

Eclampsia

Other previous poor pregnancy outcome

Prelabor referral for high risk care

Other vaginal bleeding

Previous cesarean section: Number _____

Infertility treatment:

Fertility drugs, artificial/intrauterine insemination

Assisted reproductive technology (e.g., IVF, GIFT)

Number of embryos implanted (if applicable) _____

Fetal reduction

None of the above

17. FINANCIAL COVERAGE

a. Primary Payor (Check one)

Medicaid/Family Health Plus Other

Private Insurance Self-pay

Other govt/CHPlusB Unknown

CHAMPUS/TRICARE

b. Is the mother/parent enrolled in an HMO or other managed care plan?

Yes No

c. Did mother/parent participate in WIC?

Yes No

18. MATERNAL MORBIDITY

(Check all that apply)

Maternal transfusion

Perineal laceration (3rd or 4th degree)

Ruptured uterus

Unplanned hysterectomy

Admit to ICU

Unplanned operating room procedure following delivery

Hemorrhage

Postpartum transfer to a higher level of care

None of the above

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

Gonorrhea Hepatitis C

Syphilis Tuberculosis

Herpes Simplex (HSV) Rubella

Chlamydia Bacterial Vaginosis

Hepatitis B None of the above

g. 1. Cigarette Smoking in the 3 Months Before or During Pregnancy?

Yes No

If Yes, Average Number of Cigarettes or Packs/Day (enter 0 if None)

Cigarettes or Packs/Day

2. 3 mo. before pregnancy _____ or _____

3. First 3 mo. of pregnancy _____ or _____

4. Second 3 mo. of pregnancy _____ or _____

5. Third trimester of pregnancy _____ or _____

h. Alcohol Use During This Pregnancy?

Yes No

i. Illicit and other Drugs Used During This Pregnancy?

Yes No

If yes, check all that apply

Heroin Marijuana

Cocaine Sedatives

Methadone Tranquilizers

Methamphetamine Anticonvulsants

j. Mother/Parent Pre-Pregnancy Weight _____ pounds

k. Mother/Parent Height _____ feet _____ inches

l. Obstetric Procedures (Check all that apply)

Cervical cerclage Fetal genetic testing

Tocolysis None of the above

External cephalic version:

Successful

Failed

m. If woman was 35 or over, was fetal genetic testing offered?

Yes No, Too Late No, Other Reason

CONFIDENTIAL MEDICAL REPORT OF BIRTH (2 of 2)

Only for scientific purposes approved by the Commissioner. Not open to inspection or subject to compelled disclosure.

NAME OF CHILD _____

CERTIFICATE NO. _____

19. LABOR AND DELIVERY	
a. If birth occurred in hospital, was mother/parent transferred in before giving birth? If yes, name of facility transferred from _____ <input type="checkbox"/> Yes _____ <input type="checkbox"/> No	
b. Mother/Parent Weight at Delivery _____ pounds	
c. Onset of Labor (Check all that apply) <input type="checkbox"/> Prolonged rupture of membranes (12 hours or more) <input type="checkbox"/> Prolonged labor (20 hours or more) <input type="checkbox"/> Premature rupture of membranes (prior to labor) <input type="checkbox"/> None of the above <input type="checkbox"/> Precipitous labor (less than 3 hours)	
d. Characteristics of Labor & Delivery (Check all that apply) <input type="checkbox"/> Induction of Labor-AROM <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Induction of Labor-Medicinal <input type="checkbox"/> Febrile (>100.4F or 38C) <input type="checkbox"/> Augmentation of Labor <input type="checkbox"/> Meconium staining <input type="checkbox"/> Placenta previa <input type="checkbox"/> Fetal intolerance <input type="checkbox"/> Other excessive bleeding <input type="checkbox"/> External electronic fetal monitor <input type="checkbox"/> Steroids <input type="checkbox"/> Internal electronic fetal monitor <input type="checkbox"/> Antibiotics <input type="checkbox"/> None of the above	

e. 1. Anesthesia (Check all that apply) <input type="checkbox"/> Epidural <input type="checkbox"/> Paracervical <input type="checkbox"/> General inhalation <input type="checkbox"/> Pudendal <input type="checkbox"/> General intravenous <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> None of the above	
2. Complications from any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Method of Delivery f. Fetal Presentation at Birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Other <input type="checkbox"/> Breech	
g. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Cesarean	
1. If cesarean, was trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Indications for C-Section <input type="checkbox"/> Unknown (Select all that apply) <input type="checkbox"/> Maternal condition-not pregnancy related <input type="checkbox"/> Failure to progress <input type="checkbox"/> Maternal condition-pregnancy related <input type="checkbox"/> Malpresentation <input type="checkbox"/> Refused VBAC <input type="checkbox"/> Previous C-Section <input type="checkbox"/> Elective <input type="checkbox"/> Fetus at risk/NFS <input type="checkbox"/> Other	
3. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Indications for Forceps <input type="checkbox"/> Unknown (Select all that apply) <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Failure to progress <input type="checkbox"/> Other	
5. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Indications for Vacuum <input type="checkbox"/> Unknown (Select all that apply) <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Failure to progress <input type="checkbox"/> Other	
h. Other Procedures Performed at Delivery (Check all that apply) <input type="checkbox"/> Episiotomy & repair <input type="checkbox"/> Repair of lacerations <input type="checkbox"/> Sterilization <input type="checkbox"/> None of the above	

20. INFANT	
a. Birthweight _____ Pounds _____ Ounces or _____ Grams	
b. If birth weight < 1250 grams (2 lbs. 12 oz.), reason(s) for delivery at a less than level III hospital: (Only if applicable) <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time (Select all that apply) <input type="checkbox"/> Rapid/Advanced Labor <input type="checkbox"/> Severe pre-eclampsia <input type="checkbox"/> Bleeding <input type="checkbox"/> Woman Refused Transfer <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Other-specify _____	
c. Apgar Score at 1. 1 minute 2. 5 minutes 3. 10 minutes _____ _____ _____	
d. Clinical Estimate of Gestation Completed Weeks: _____	
e. Infant Transferred Within 24 hours of Delivery After 24 hours Not Transferred <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
f. If transferred, name of facility transferred to: _____	
g. Abnormal Conditions of the Newborn (Check all that apply) <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above	
h. Hepatitis B Inoculation 1. Immunization administered? <input type="checkbox"/> Yes Date: (mm/dd/yyyy) ____/____/____ <input type="checkbox"/> No 2. Immungoglobulin administered? <input type="checkbox"/> Yes Date: (mm/dd/yyyy) ____/____/____ <input type="checkbox"/> No	
i. Is infant living at time of report? <input type="checkbox"/> Yes <input type="checkbox"/> No	
j. How is infant being fed? (Check one) <input type="checkbox"/> Breast milk <input type="checkbox"/> Both <input type="checkbox"/> Formula <input type="checkbox"/> Neither	

Congenital Anomalies		
k. Select all that apply	l. Diagnosed Prenatally?	m. If Yes, please indicate all methods used:
1. Anencephaly Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP/Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
2. Meningomyelocele/ Spina Bifida Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP/Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
3. Cyanotic Congenital Heart Disease Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
4. Congenital Diaphragmatic Hernia Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
5. Omphalocele Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
6. Gastroschisis Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
7. Limb Reduction Defect Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
8. Cleft lip with or without Cleft Palate Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
9. Cleft Palate alone Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
10. Down Syndrome Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP/Triple Screen <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> CVS <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Other <input type="checkbox"/> Unknown
11. Other Chromosomal Disorder Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP/Triple Screen <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> CVS <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Other <input type="checkbox"/> Unknown
12. Hypospadias Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
13. None of those listed above <input type="checkbox"/>		

CERTIFICATE OF DEATH Certificate No. _____

1. DECEDENT'S LEGAL NAME _____
(First, Middle, Last)

MEDICAL CERTIFICATE OF DEATH (To be filled in by the Physician)	Place Of Death	2a. New York City 2b. Borough	2c. Type of Place 1 <input type="checkbox"/> Hospital Inpatient 2 <input type="checkbox"/> Emergency Dept./Outpatient 3 <input type="checkbox"/> Dead on Arrival	4 <input type="checkbox"/> Nursing Home/Long Term Care Facility 5 <input type="checkbox"/> Hospice Facility 6 <input type="checkbox"/> Decedent's Residence 7 <input type="checkbox"/> Other Specify _____	2d. Any Hospice care in last 30 days 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	2e. Name of hospital or other facility (if not facility, street address)		
	Date and Time of Death	3a. (Month) (Day) (Year-yyyy)	3b. Time <input type="checkbox"/> AM <input type="checkbox"/> PM	4. Sex	5. Date last attended by a Physician mm dd yyyy			
6. Certifier: I certify that death occurred at the time, date and place indicated and that to the best of my knowledge traumatic injury or poisoning DID NOT play any part in causing death, and that death did not occur in any unusual manner and was due entirely to NATURAL CAUSES. See instructions on reverse of certificate.								
Name of Physician _____ (Type or Print)			Signature _____		D.O. M.D.			
Address _____			License No. _____		Date _____			
PERSONAL PARTICULARS (To be filled in by Funeral Director or, in case of City Burial, by Physician)	7a. Usual Residence State	7b. County	7c. City or Town	7d. Street and Number	Apt. No.	ZIP Code		
	8. Date of Birth (Month) (Day) (Year-yyyy)		9. Age at last birthday (years)	Under 1 Year Months Days		Under 1 Day Hours Minutes	7e. Inside City Limits? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	11a. Usual Occupation (Type of work done during most of working life. Do not use "retired")		11b. Kind of business or industry	12. Aliases or AKAs				
	13. Birthplace (City & State or Foreign Country)		14. Education (Check the box that best describes the highest degree or level of school completed at the time of death) 1 <input type="checkbox"/> 8th grade or less; none 2 <input type="checkbox"/> 9th – 12th grade; no diploma 3 <input type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree (e.g., AA, AS) 6 <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) 7 <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) 8 <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)				10. Social Security No.	
	15. Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	16. Marital/Partnership Status at time of death 1 <input type="checkbox"/> Married 2 <input type="checkbox"/> Domestic Partnership 3 <input type="checkbox"/> Divorced 4 <input type="checkbox"/> Married, but separated 5 <input type="checkbox"/> Never Married 6 <input type="checkbox"/> Widowed 7 <input type="checkbox"/> Other, Specify _____ 8 <input type="checkbox"/> Unknown		17. Surviving Spouse's/Partner's Name (If wife, name prior to first marriage)(First, Middle, Last)				
	18. Father's Name (First, Middle, Last)			19. Mother's Maiden Name (Prior to first marriage) (First, Middle, Last)				
	20a. Informant's Name		20b. Relationship to Decedent	20c. Address (Street and Number Apt. No. City & State ZIP Code)				
	21a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Entombment 4 <input type="checkbox"/> City Cemetery 5 <input type="checkbox"/> Other Specify _____			21b. Place of Disposition (Name of cemetery, crematory, other place)				
	21c. Location of Disposition (City & State or Foreign Country)					21d. Date of Disposition mm dd yyyy		
	22a. Funeral Establishment			22b. Address (Street and Number City & State ZIP Code)				

**THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CONFIDENTIAL MEDICAL REPORT**

VR 15 (Rev. 01/09)

Certificate No. _____

To be filled in by FUNERAL DIRECTOR or, in case of City Burial, by Physician		Certificate No. _____								
23. Ancestry (Check one box and specify) <input type="checkbox"/> Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify _____ <input type="checkbox"/> NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) Specify _____	24. Race as defined by the U.S. Census (Check one or more to indicate what the decedent considered himself or herself to be) 01 <input type="checkbox"/> White 02 <input type="checkbox"/> Black or African American 03 <input type="checkbox"/> American Indian or Alaska Native (Name of enrolled or principal tribe) _____ 04 <input type="checkbox"/> Asian Indian 05 <input type="checkbox"/> Chinese 06 <input type="checkbox"/> Filipino 07 <input type="checkbox"/> Japanese 08 <input type="checkbox"/> Korean 09 <input type="checkbox"/> Vietnamese 10 <input type="checkbox"/> Other Asian—Specify _____ 11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro 13 <input type="checkbox"/> Samoan 14 <input type="checkbox"/> Other Pacific Islander—Specify _____ 15 <input type="checkbox"/> Other—Specify _____	DECEDENT'S LEGAL NAME (Type or Print) _____								
25. CAUSE OF DEATH – List only one cause on each line. DO NOT ABBREVIATE.										
PART I	a.	IMMEDIATE CAUSE	APPROXIMATE INTERVAL: ONSET TO DEATH							
	b.	DUE TO OR AS A CONSEQUENCE OF								
	c.	DUE TO OR AS A CONSEQUENCE OF								
	d.	DUE TO OR AS A CONSEQUENCE OF								
PART II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not resulting in the underlying cause given in Part I. Include operation information.									
26a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	27a. If Female 1 <input type="checkbox"/> Not pregnant within 1 year of death 2 <input type="checkbox"/> Pregnant at time of death 3 <input type="checkbox"/> Not pregnant at death, but pregnant within 42 days of death 4 <input type="checkbox"/> Not pregnant at death, but pregnant 43 days to 1 year before death 5 <input type="checkbox"/> Unknown if pregnant within 1 year of death	27b. If pregnant within one year of death, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Spontaneous Termination/Ectopic Pregnancy 3 <input type="checkbox"/> Induced Termination 4 <input type="checkbox"/> None	27c. Date of Outcome <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width:33%;">mm</td> <td style="width:33%;">dd</td> <td style="width:33%;">yyyy</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	mm	dd	yyyy				28. Was this case referred to OCME? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
mm	dd	yyyy								
29. Did tobacco use contribute to death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	30. For infant under one year: Name and address of hospital or other place of birth _____									
I am submitting herewith a confidential report of the cause of death.										
SIGNATURE _____	D.O. M.D.	ADDRESS _____	LICENSE NO. _____							

CAUSE OF DEATH—Enter the chain of events—diseases, complications or abnormalities—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology.

IMMEDIATE CAUSE → FINAL disease or condition resulting in death.

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease that initiated the events resulting in death) LAST.

OPERATION—Enter in Part II information on operation or procedure related to disease or conditions listed in Part I.

SUBSTANCE USE Include the use of tobacco, alcohol or other substance if this caused or contributed to death. SPECIFY IN PART I or PART II.

CERTIFICATE OF DEATH Certificate No. _____

- New
- Corr/Amend
- Replacement

**DOHMH
USE ONLY**

**1. DECEDENT'S
LEGAL NAME** _____
(First, Middle, Last)

THIS CERTIFICATE NOT VALID UNLESS FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOR
INST
MANNER
RESIDENCE
CODE
BP
LDIS
H
ANC
NH
ANC
ICD
AUT

MEDICAL CERTIFICATE OF DEATH (To be filled in by the OCME)	Place Of Death	2a. New York City 2b. Borough	2c. Type of Place 1 <input type="checkbox"/> Hospital Inpatient 2 <input type="checkbox"/> Emergency Dept./Outpatient 3 <input type="checkbox"/> Dead on Arrival	4 <input type="checkbox"/> Nursing Home/Long Term Care Facility 5 <input type="checkbox"/> Hospice Facility 6 <input type="checkbox"/> Decedent's Residence 7 <input type="checkbox"/> Other Specify _____	2d. Any Hospice care in last 30 days 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	2e. Name of hospital or other facility (if not facility, street address)		
	Date and Time of Death or Found Dead	3a. (Month) (Day) (Year-yyyy)	3b. Time <input type="checkbox"/> AM <input type="checkbox"/> PM	4. Sex	5. OCME Case No.			
	6. CAUSE OF DEATH	PART I	a. Immediate cause					APPROXIMATE INTERVAL ONSET TO DEATH
			b. Due to or as a consequence of					
	c. Due to or as a consequence of							
	PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Include operation information.							
	7a. Injury Date (mm dd yyyy)	7b. Time <input type="checkbox"/> AM <input type="checkbox"/> PM	7c. At Work 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	7d. Place of Injury – At home, factory, street, etc. 7e. Location				
	7f. How Injury Occurred							
	7g. If Transportation Injury Specify <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other Specify _____		8. Manner of Death <input type="checkbox"/> Pending further study <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined		9. Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Autopsy Pursuant to Law <input type="checkbox"/> No Autopsy		10. On the basis of examination and/or investigation, in my opinion, death occurred due to the causes and manner as stated: Certifier Signature _____ D.O. M.D. Date _____ Certifier Name (Print) _____ (Medical Investigator) (Deputy Chief) (Chief) (Medical Examiner)	
	11a. Usual Residence State	11b. County	11c. City or Town	11d. Street and Number	Apt. No.	ZIP Code	11e. Inside City Limits? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
12. Date of Birth (Month) (Day) (Year-yyyy)		13. Age at last birthday (years)		Under 1 Year Months Days	Under 1 Day Hours Minutes	14. Social Security No.		
15a. Usual Occupation (Type of work done during most of working life. Do not use "retired")			15b. Kind of business or industry		16. Aliases or AKAs			
17. Birthplace (City & State or Foreign Country)		18. Education (Check the box that best describes the highest degree or level of school completed at the time of death) 1 <input type="checkbox"/> 8th grade or less; none 2 <input type="checkbox"/> 9th – 12th grade; no diploma 3 <input type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree (e.g., AA, AS) 6 <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) 7 <input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MSW, MBA) 8 <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)						
19. Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		20. Marital/Partnership Status at time of death 1 <input type="checkbox"/> Married 2 <input type="checkbox"/> Domestic Partnership 3 <input type="checkbox"/> Divorced 4 <input type="checkbox"/> Married, but separated 5 <input type="checkbox"/> Never Married 6 <input type="checkbox"/> Widowed 7 <input type="checkbox"/> Other, Specify _____ 8 <input type="checkbox"/> Unknown		21. Surviving Spouse's/Partner's Name (If wife, name prior to first marriage)(First, Middle, Last)				
22. Father's Name (First, Middle, Last)			23. Mother's Maiden Name (Prior to first marriage) (First, Middle, Last)					
24a. Informant's Name		24b. Relationship to Decedent		24c. Address (Street and Number Apt. No. City & State ZIP Code)				
25a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Entombment 4 <input type="checkbox"/> City Cemetery 5 <input type="checkbox"/> Other Specify _____			25b. Place of Disposition (Name of cemetery, crematory, other place)					
25c. Location of Disposition (City & State or Foreign Country)				25d. Date of Disposition mm dd yyyy				
26a. Funeral Establishment			26b. Address (Street and Number City & State ZIP Code)					

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S SUPPLEMENTARY REPORT

VR 16 (Rev. 01/09)

Certificate No. _____

To be filled in by FUNERAL DIRECTOR or, in case of City Burial, by OCME	
27. Ancestry (Check one box and specify) <input type="checkbox"/> Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify _____ <input type="checkbox"/> NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) Specify _____	28. Race as defined by the U.S. Census (Check one or more to indicate what the decedent considered himself or herself to be) 01 <input type="checkbox"/> White 02 <input type="checkbox"/> Black or African American 03 <input type="checkbox"/> American Indian or Alaska Native (Name of enrolled or principal tribe) _____ 04 <input type="checkbox"/> Asian Indian 05 <input type="checkbox"/> Chinese 06 <input type="checkbox"/> Filipino 07 <input type="checkbox"/> Japanese 08 <input type="checkbox"/> Korean 09 <input type="checkbox"/> Vietnamese 10 <input type="checkbox"/> Other Asian—Specify _____ 11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro 13 <input type="checkbox"/> Samoan 14 <input type="checkbox"/> Other Pacific Islander—Specify _____ 15 <input type="checkbox"/> Other—Specify _____

DECEDENT'S LEGAL NAME (Type or Print) _____

29a. If Female 1 <input type="checkbox"/> Not pregnant within 1 year of death 2 <input type="checkbox"/> Pregnant at time of death 3 <input type="checkbox"/> Not pregnant at death, but pregnant within 42 days of death 4 <input type="checkbox"/> Not pregnant at death, but pregnant 43 days to 1 year before death 5 <input type="checkbox"/> Unknown if pregnant within 1 year of death	29b. If pregnant within one year of death, outcome of pregnancy 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Spontaneous Termination / Ectopic Pregnancy 3 <input type="checkbox"/> Induced Termination 4 <input type="checkbox"/> None	29c. Date of Outcome <table border="1"> <tr> <td style="width: 30px; text-align: center;">mm</td> <td style="width: 30px; text-align: center;">dd</td> <td style="width: 30px; text-align: center;">yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	mm	dd	yyyy			
mm	dd	yyyy						

30. Did tobacco use contribute to death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	31. For infant under one year: Name and address of hospital or other place of birth _____ _____
--	---

**Cleared For Cremation
 If Family Requests**

M.E. Signature

I certify that I personally examined the body on _____ at _____
 (Date) (Location)

SIGNATURE: _____
 (Medical Investigator) (Deputy Chief) (Chief) (Medical Examiner)

or

I did not personally examine the body after death.

SIGNATURE: _____
 (Deputy Chief) (Chief) (Medical Examiner)

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF SPONTANEOUS TERMINATION OF PREGNANCY

VR-17
 (REV. 01/10)

CERTIFICATE NO. _____

THIS CERTIFICATE NOT VALID UNLESS FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. Typewrite or print with black fine point ink.
 2. Certificates containing alterations or omissions are unacceptable.
 3. Items "Date filed," "Certificate No.," and this space, reserved for the Department of Health and Mental Hygiene use only.
- I CERTIFY THAT I HAVE IN MY POSSESSION AN AFFIDAVIT OF AUTHORIZATION FOR CREMATION

FD Initials _____

Did heart beat after delivery? _____ Was there movement of voluntary muscle? _____		If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.			
FETUS	1. NAME (Optional): (First, Middle, Last, Suffix) _____	2a. DATE OF DELIVERY (Month) (Day) (Year-yyyy)	2b. TIME _____ AM _____ PM <input type="checkbox"/> Unknown	3. SEX <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female	
	4. OBSTETRIC ESTIMATE OF GESTATION # of weeks _____	5a. NUMBER DELIVERED THIS PREGNANCY _____	IF MORE THAN ONE 5b. Number in order of delivery _____ 5c. Number born alive _____		
FETUS Place of Delivery	6a. TYPE OF PLACE <input type="checkbox"/> Hospital – ER/ED <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Hospital – Amb. Surg. <input type="checkbox"/> Home <input type="checkbox"/> Hospital – Labor/Labor and Delivery <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Hospital – Other <input type="checkbox"/> Other, Specify _____ <input type="checkbox"/> Unknown		6b. FACILITY NAME/ADDRESS If not in facility, street address: (Street Number and Name, City or Town, County, State, Country, Zip Code)		
	7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix) _____		9. DATE OF BIRTH (Month) (Day) (Year-yyyy)	12. BIRTHPLACE City _____ State _____	
MOTHER/PARENT	8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix) _____	10. AGE _____	11. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Country _____	
	13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code) _____			14. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	
FATHER/PARENT	15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix) _____		16. DATE OF BIRTH (Month) (Day) (Year-yyyy)	19. BIRTHPLACE City _____ State _____	
			17. AGE _____	18. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Country _____
ATTENDANT/CERTIFIER	20. ATTENDANT NAME AT DELIVERY: _____ (First, Middle, Last, Suffix)		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> LIC. Midwife <input type="checkbox"/> RPA <input type="checkbox"/> Other, (specify) _____		
	21. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.		<input type="checkbox"/> MD <input type="checkbox"/> DO		
	Signature of Physician Certifier _____ Name of Physician Certifier _____ Address _____ License No. _____ / _____ / _____ Date				
FUNERAL DIRECTOR'S CERTIFICATE	FUNERAL DIRECTOR'S CERTIFICATE				
	I hereby certify that I have been employed as Funeral Director by _____ (Name of person in control of disposition)				
	of _____ (Address) . This statement is made to obtain a disposition permit for this fetus _____ (Signature of Funeral Director) (License No.)				
Funeral Establishment _____		Business Registration No. _____			
Address _____					
NAME OF CEMETERY OR CREMATORY (OR DESTINATION)		CITY OR COUNTY AND STATE		DATE OF DISPOSITION (Month) (Day) (Year-yyyy)	

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CONFIDENTIAL MEDICAL REPORT OF SPONTANEOUS TERMINATION OF PREGNANCY (1 of 2)

Only for scientific purposes approved by the Commissioner. Not subject to compelled disclosure.

Mother/Parent Medical Record No. _____

CERTIFICATE NO. _____

22. Date Last Normal Menses Began: ____/____/____
mm dd yyyy

23. PARENT'S EDUCATION
(Check the box that best describes the highest degree or level of school completed at time of delivery)
a. Mother/Parent b. Father/Parent
8th grade or less; none.....
9th-12th grade, no diploma.....
High school graduate or GED.....
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, MEd, MSW, MBA).....
Doctorate (e.g., PhD, EdD).....
or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
Unknown.....

24. PARENT'S OCCUPATION
Yes No
a. Was mother/parent employed during pregnancy?
1. Current/most recent occupation 2. Kind of business or industry
b. Mother/Parent
c. Father/Parent

25. PARENT'S ANCESTRY
(Check one box and specify what the parent considers her/himself to be)
a. Mother/Parent b. Father/Parent
Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.)

Specify
(Mother/Parent) (Father/Parent)
NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.)

Specify
(Mother/Parent) (Father/Parent)
Unknown.....

26. PARENT'S RACE
Race as defined by the U.S. Census
(Check one or more to indicate what the parent considers her/himself to be)
a. Mother/Parent b. Father/Parent
White.....
Black or African American.....
American Indian or Alaska Native.....
Name of enrolled or principal tribe
(Mother/Parent) (Father/Parent)
Asian Indian.....
Chinese.....
Filipino.....
Japanese.....
Korean.....
Vietnamese.....
Other Asian.....
Specify
(Mother/Parent) (Father/Parent)
Native Hawaiian.....
Guamanian or Chamorro.....
Samoan.....
Other Pacific Islander.....
Specify
(Mother/Parent) (Father/Parent)
Other.....
Specify
(Mother/Parent) (Father/Parent)
Unknown.....

27. PARENT'S LENGTH OF TIME IN U.S.
a. Mother/Parent b. Father/Parent
Never lived in United States.....
If born outside of the United States, how long lived in U.S.?
years
(Mother/Parent) (Father/Parent)
or if <1 yr, months
(Mother/Parent) (Father/Parent)

28. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH
a. 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).
 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 (Please consult with OCME) _____
 Fetal Infection (Specify) _____
 Other Fetal Conditions/Disorders (Specify) _____
 Unknown
b. Other Significant Causes or Conditions
(Select or specify all other conditions contributing to death).
 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 (Please consult with OCME) _____
 Fetal Infection (Specify) _____
 Other Fetal Conditions/Disorders (Specify) _____
 Unknown

c. Was this case referred to OCME? Yes No Unknown If yes, ME Case Number: _____

FOR GESTATION OF 20 WEEKS OR MORE: ALL ITEMS BELOW MUST BE COMPLETED (except OCME cases).

29. PRENATAL
a. Primary Payor (Check one)
 Medicaid Self-pay
 Other govt. insurance None
 Private insurance Unknown
b. Total Number of Prenatal Visits for this Pregnancy
 None _____
c. Date of First Prenatal Care Visit
(mm/dd/yyyy) ____/____/____
d. Date of Last Prenatal Care Visit
(mm/dd/yyyy) ____/____/____
e. Previous Live Births
1. Total Number of Previous Live Births _____ None
2. Number Born Alive and Now Living _____ None
3. Number Born Alive and Now Dead _____ None

f. Date of First Live Birth (mm/yyyy) ____/____
g. Date of Last Live Birth (mm/yyyy) ____/____
h. Total Number of Other Pregnancy Outcomes _____ None
(Spontaneous or Induced losses or ectopic pregnancies)
Do not include this fetus
i. Date of Last Other Pregnancy Outcome
(mm/yyyy) ____/____

30. MOTHER/PARENT HEALTH
a. Height _____ feet _____ inches
b. Pre-Pregnancy Weight _____ pounds
c. Weight Immediately Prior to Event _____ pounds

d. Cigarette Smoking
1. Cigarette smoking in the 3 months before or during pregnancy?
 Yes No Unknown
If yes, average number of cigarettes or packs/day (enter 0 if None)
Cigarettes or Packs/Day
2. 3 mo. before pregnancy _____ or _____
3. First 3 mo. of pregnancy _____ or _____
4. Second 3 mo. of pregnancy _____ or _____
5. Third trimester of pregnancy _____ or _____
e. Alcohol use during this pregnancy?
 Yes No Unknown
f. Illicit and other drugs used during this pregnancy?
 Yes No Unknown
If yes, check all that apply
 Heroin Sedatives
 Cocaine Tranquilizers
 Methadone Anticonvulsants
 Methamphetamine Other
 Marijuana Unknown

31. PREGNANCY FACTORS
a. Risk Factors in this Pregnancy
(Check all that apply)
 Diabetes – Prepregnancy
 Diabetes – Gestational
 Hypertension – Pre-pregnancy
 Hypertension – Gestational
 Hypertension – Eclampsia
 Previous Preterm Birth
 Other previous poor pregnancy outcome
 Infertility Treatment – Fertility-enhancing drugs, Artificial/Intrauterine insemination
 Infertility Treatment – Assisted Reproductive Technology
 Mother had a Previous Cesarean Delivery
 Other If yes, how many? _____
 None
 Unknown

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE (Each question MUST be answered)
CONFIDENTIAL MEDICAL REPORT OF SPONTANEOUS TERMINATION OF PREGNANCY (2 of 2)

Only for scientific purposes approved by the Commissioner. Not subject to compelled disclosure.

Mother/Parent Medical Record No. _____

CERTIFICATE NO. _____

FOR GESTATION OF 20 WEEKS OR MORE: ALL ITEMS BELOW MUST BE COMPLETED (except OCME cases).

31. PREGNANCY FACTORS (cont.)																		
<p>b. Infection Present and/or Treated During Pregnancy (Check all that apply)</p> <table border="0"> <tr> <td><input type="checkbox"/> Gonorrhea</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Syphilis</td> <td><input type="checkbox"/> Rubella</td> </tr> <tr> <td><input type="checkbox"/> Herpes Simplex (HSV)</td> <td><input type="checkbox"/> Cytomegalovirus</td> </tr> <tr> <td><input type="checkbox"/> Chlamydia</td> <td><input type="checkbox"/> Parvovirus</td> </tr> <tr> <td><input type="checkbox"/> Bacterial Vaginosis</td> <td><input type="checkbox"/> Toxoplasmosis</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis B</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis C</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Listeria</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Group B Strep</td> <td></td> </tr> </table>	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Rubella	<input type="checkbox"/> Herpes Simplex (HSV)	<input type="checkbox"/> Cytomegalovirus	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Parvovirus	<input type="checkbox"/> Bacterial Vaginosis	<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Other	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> None	<input type="checkbox"/> Listeria	<input type="checkbox"/> Unknown	<input type="checkbox"/> Group B Strep	
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Tuberculosis																	
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<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Other																	
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> None																	
<input type="checkbox"/> Listeria	<input type="checkbox"/> Unknown																	
<input type="checkbox"/> Group B Strep																		
32. DELIVERY																		
<p>a. Method of Delivery</p> <p>1. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Attempted and successful <input type="checkbox"/> Attempted and unsuccessful <input type="checkbox"/> Forceps were not used <input type="checkbox"/> Unknown</p> <p>2. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Attempted and successful <input type="checkbox"/> Attempted and unsuccessful <input type="checkbox"/> Vacuum extraction was not used <input type="checkbox"/> Unknown</p> <p>3. Fetal presentation at delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p> <p>4. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum Vaginal delivery after a previous C-section? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Primary Cesarean <input type="checkbox"/> Repeat Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>5. Hysterotomy/Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																		

<p>b. Maternal Morbidity (Check all that apply) (Complications associated with labor and delivery)</p> <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Postpartum transfer to a higher level of care <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown
<p>c. Was mother transferred for maternal medical or fetal indication prior to delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, name of facility transferred from: _____</p>
33. FETAL ATTRIBUTES
<p>a. Weight of Fetus (grams preferred, specify unit)</p> <p style="text-align: center;">_____ _____ <input type="checkbox"/> lb/oz <input type="checkbox"/> grams</p>
<p>b. Estimated Time of Fetal Death</p> <input type="checkbox"/> Death at time of first assessment, no labor ongoing <input type="checkbox"/> Death at time of first assessment, labor ongoing <input type="checkbox"/> Died during labor, after first assessment <input type="checkbox"/> Unknown time of fetal death
<p>c. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned</p>
<p>d. Was a histological placental examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned</p>

<p>e. Were autopsy or histological placental examination results used in determining the cause of fetal death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>f. Congenital Anomalies of the Fetus (Check all that apply)</p> <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft lip with or without cleft palate <input type="checkbox"/> Cleft palate alone <input type="checkbox"/> Down syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Unknown

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF INDUCED TERMINATION OF PREGNANCY

Use this form *ONLY* for induced terminations whether surgical or medical.
Only for scientific purposes approved by the Commissioner; not subject to compelled disclosure.

CERTIFICATE NO.
(For Health Dept. Use Only)

FACILITY	1. DATE OF PROCEDURE FOR TERMINATION (Month) (Day) (Year-yyyy)		2. FACILITY TYPE		
	3A. FACILITY NAME		<input type="checkbox"/> Hospital <input type="checkbox"/> Shared Facility <input type="checkbox"/> Clinic (Article 28) <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Clinic (non-Article 28) <input type="checkbox"/> Unknown <input type="checkbox"/> Other type _____		
	3B. FACILITY ADDRESS Street Number and Name		4. PRIMARY FINANCIAL COVERAGE THIS TERMINATION		
	City or Town _____ County _____ State _____ Country _____ ZIP Code _____		<input type="checkbox"/> Medicaid <input type="checkbox"/> Self Pay <input type="checkbox"/> Other Govt. Insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Private Insurance		
INST.	5. PATIENT'S LEGAL NAME First Name _____ Last Name _____ (First two letters) (First two letters)		6. PATIENT'S DATE OF BIRTH (Month) (Day) (Year-yyyy)		
B	8. NEVER LIVED IN UNITED STATES <input type="checkbox"/> If born outside of the United States, how long lived in U.S.? _____ (years)		9. PATIENT'S USUAL RESIDENCE (COMPLETE ONLY ONE)		
R			<input type="checkbox"/> New York City ZIP Code _____ <input type="checkbox"/> Outside NYS <input type="checkbox"/> Manhattan <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island <input type="checkbox"/> Unknown (U.S. State)		
A	10. EDUCATION		11. ANCESTRY (CHECK ONE BOX AND SPECIFY)		
E	<input type="checkbox"/> 8th grade or less; none <input type="checkbox"/> Associate degree <input type="checkbox"/> 9th–12th grade, no diploma <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Master's degree <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Doctorate or Professional degree <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown		<input type="checkbox"/> Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify _____ <input type="checkbox"/> NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) Specify _____ <input type="checkbox"/> Unknown		
PATIENT ATTRIBUTES		12. RACE Race as defined by the U.S. Census. (Check one or more to indicate what the patient considers herself to be.)		13. MARITAL/PARTNERSHIP STATUS	
		<input type="checkbox"/> White <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Black or African American <input type="checkbox"/> Filipino _____ <input type="checkbox"/> American Indian or Alaska Native (specify tribe) <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Guamanian or Chamorro _____ <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Unknown		<input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Married, but separated <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other, Specify _____ <input type="checkbox"/> Unknown	
MEDICAL		14. DATE LAST NORMAL MENSES BEGAN (Month) (Day) (Year-yyyy)	15. OBSTETRIC ESTIMATE OF GESTATION _____ completed weeks	16. PREVIOUS PREGNANCIES	
				a. Total Number of Previous Live Births _____ <input type="checkbox"/> None b. Born Alive Now Living _____ <input type="checkbox"/> None c. Born Alive Now Dead _____ <input type="checkbox"/> None d. Total Number Other Pregnancy Outcomes _____ <input type="checkbox"/> None (Spontaneous or Induced losses or ectopic pregnancies) Do not include this termination.	
MEDICAL		17A. PRIMARY PROCEDURE (CHECK ONLY ONE)		17B. ADDITIONAL PROCEDURES (CHECK ALL THAT APPLY)	
		<input type="checkbox"/> Suction Curettage <input type="checkbox"/> Mifepristone and Misoprostol <input type="checkbox"/> Sharp Curettage (D&C) <input type="checkbox"/> Methotrexate and Misoprostol <input type="checkbox"/> Dilatation and Evacuation (D&E) <input type="checkbox"/> Other Medical (nonsurgical) <input type="checkbox"/> Intra-Uterine Instillation Specify Medications _____ <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Misoprostol <input type="checkbox"/> Other, Specify _____		<input type="checkbox"/> None <input type="checkbox"/> Mifepristone and Misoprostol <input type="checkbox"/> Suction Curettage <input type="checkbox"/> Methotrexate and Misoprostol <input type="checkbox"/> Sharp Curettage (D&C) <input type="checkbox"/> Other Medical (nonsurgical) <input type="checkbox"/> Dilatation and Evacuation (D&E) Specify Medications _____ <input type="checkbox"/> Intra-Uterine Instillation <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Misoprostol <input type="checkbox"/> Other, Specify _____	
ATTENDANT/CERTIFIER		18. CONTRACEPTIVE METHOD PRESCRIBED AND/OR DISPENSED AFTER THIS PROCEDURE (Check all that apply)			
		<input type="checkbox"/> None Offered <input type="checkbox"/> Oral Contraceptive Pills <input type="checkbox"/> Injection <input type="checkbox"/> Contraceptive Patch <input type="checkbox"/> Diaphragm <input type="checkbox"/> Emergency Contraception <input type="checkbox"/> Offered but Declined <input type="checkbox"/> Condoms <input type="checkbox"/> Contraceptive Implant <input type="checkbox"/> Cervical Vaginal Ring <input type="checkbox"/> IUD <input type="checkbox"/> Other, Specify _____			
ATTENDANT/CERTIFIER		19. ATTENDANT NAME AT TERMINATION: _____		<input type="checkbox"/> MD <input type="checkbox"/> DO (First, Middle, Last, Suffix)	
		20. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.			
ATTENDANT/CERTIFIER		Signature of Physician Certifier _____		<input type="checkbox"/> MD <input type="checkbox"/> DO	
		Name of Physician Certifier _____			
		Address _____			
		License No. _____ / _____ / _____ Date			