HEALTH FACILITY -MATERNITY WARD DEATH REPORT FORM

This is to certify that the stillbirth/neonate, of Mrs /Ms…………………………………………and Mr………………………………………………………of ……………………………………………………, occurred at …………………………………on the day………………month…………………year………………

Cause of death (neonate)…………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………

Name of DR/Midwife/ Nurse
…………………………………………Signature………………………………

Health facility………………………… Region…………………………date……………………
………………………………………………………………………………………………………………………………………………………………

Variables
‘Foetus/ neonatal death/ still birth/ abortion, Sex, Date of death, Place of death, Name of mother, Name of father, Cause of death (event)’