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www.nlchi.nl.ca
### Mortality Data User Document
#### Document Control Record

<table>
<thead>
<tr>
<th>Version</th>
<th>Author</th>
<th>Date</th>
<th>Change(s) Made</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 v.1.0</td>
<td>Rosalie Haire and Michele Bishop</td>
<td>March 30, 2012</td>
<td>Annual Updates</td>
</tr>
<tr>
<td>2012 v.1.1</td>
<td>Michele Bishop</td>
<td>June 12, 2013</td>
<td>Annual Updates</td>
</tr>
<tr>
<td>2013 V.1.0</td>
<td>Rosalie Haire</td>
<td>March 22, 2014</td>
<td>Annual Updates</td>
</tr>
<tr>
<td>2016 V.1.0</td>
<td>Beatrice Pittman and Lisa McKenzie</td>
<td>August 14, 2017</td>
<td>Annual Updates</td>
</tr>
</tbody>
</table>
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1. **NLCHI Mortality System - Introduction**

1.1 **Overview**

This internal document is considered the primary reference for Centre staff working with the NLCHI Mortality System. It is intended to provide staff with information related to the collection, processing, storage, use and disclosure of information contained within this key provincial health information system.

The content of this document provides detailed guidance for staff in the day-to-day data management tasks of the NLCHI Mortality System, fulfilling the role of a procedure manual.

This document is reviewed annually and revised as needed to ensure it remains current and useful. Feedback from readers is welcomed. Suggestions for future updates can be sent to:

Manager Clinical Standards and Information  
Newfoundland and Labrador Centre for Health Information  
70 O’Leary Avenue  
St. John’s, NL A1B 2C7  
Phone 709 752-6014

1.2 **Purpose of Dataset**

This dataset is used primarily for research regarding deaths which occur within the province of Newfoundland & Labrador and to provide aggregate statistical information. It is also used to cross reference other datasets for quality assurance and verification purposes.

The Research and Evaluation Department (R&E) at the Newfoundland and Labrador Centre for Health Information (the Centre) provides mortality statistical information and reports to government agencies, health care managers, clinicians, etc. to assist in making evidence-based decisions.

1.3 **Population Reference Coverage**

Under the Vital Statistics Act (2009) all deaths occurring within the province of Newfoundland and Labrador must be reported to Vital Statistics, by the funeral home, within a 5 day period. All funeral homes in Newfoundland and Labrador submit Registration of Death (RD) forms to Vital Statistics in compliance with the Act.
1.4 Reporting Period
The reporting period for deaths is the calendar year, January 1st to December 31st.

1.5 Years Available
Data is available for the years 1991-2016.

1.6 Management Responsibility
The Manager Clinical Standards and Information is responsible for managing the NLCHI Mortality System, ensuring the system is of the highest quality attainable and available to stakeholders for use.

The NLCHI Live Birth/Mortality Systems Advisory Committee is comprised of internal and external stakeholders. This committee’s mandate is to advise the Manager, Clinical Standards and Information on stakeholder information needs, data collection and other relevant issues. One of this committee’s responsibilities is to perform an annual review of the RD form and make recommendations regarding data collection requirements.

2. Description of Database

2.1 Description
This dataset has 46 data elements that contain demographic, administrative and clinical data related to all deaths that occur in the province, both resident and non-resident.

The Registration of Death form contains multiple sections. Responsibility for completion of the sections varies as noted in the table below:

<table>
<thead>
<tr>
<th>Section</th>
<th>Responsibility for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration</td>
<td>Vital Statistics</td>
</tr>
<tr>
<td>Information on Deceased</td>
<td>Health Care Professional /Funeral Home</td>
</tr>
<tr>
<td>Parental Information</td>
<td>Health Care Professional/Funeral Home</td>
</tr>
<tr>
<td>Informant</td>
<td>Health Care Professional/Funeral Home</td>
</tr>
<tr>
<td>Place of Death</td>
<td>Health Care Professional</td>
</tr>
<tr>
<td>Medical Certification</td>
<td>Health Care Professional</td>
</tr>
<tr>
<td>Disposition</td>
<td>Funeral Home</td>
</tr>
<tr>
<td>Office Use</td>
<td>Vital Statistics</td>
</tr>
</tbody>
</table>

Data are retained in a longitudinal file to facilitate efficient retrieval and creation of statistical data and research reports. The longitudinal file is updated annually with previous year’s data.
2.2 **Data Dictionary/Elements**

Data elements on the RD form are those identified by the Live Birth/Mortality Systems Advisory Committee as required data by one or more of the stakeholders. Of all the elements on the RD form, a minimum data set is entered into the system. The Mortality System Data Dictionary (Appendix 1) contains the list of data elements, element details and the reference year.

Estimated Date of Death Data Element: When a range of dates is documented, the last date listed in the range is entered as the estimated date of death.

2.3 **Reference Materials**

Reference materials available from the Data Quality and Standards Department (DQS) include:

- The Guide to the Completion of Registration of Death and Registration of Stillbirth. This document is produced by Vital Statistics as a reference document for those responsible for completing the registration form.

3. **Data Source(s)**

3.1 **Origin of Data**

Data originates at the funeral home responsible for the disposition of the remains.

Origin of death data can vary:
- If death occurs in a health care facility, the data originates from the facility.
- If the death is suspicious or undergoes an autopsy the data originates from a medical examiner.
- If an expected death occurs at home, the data originates from the last attending health care provider.

No matter where the data originates, the funeral home director is responsible for obtaining the RD prior to accepting the remains for disposal.

3.2 **Flow of Data**

The RD forms are initiated by the medical professional responsible for certifying the death. The funeral home staff obtains both the Vital Statistics and the Centre’s copy when they accept the remains, completes demographic and disposition data and forwards both copies to Vital Statistics. Vital Statistics adds administrative data before forwarding a copy to the Centre’s Data Quality and Standards Department.

The RD forms are received from Vital Statistics, via courier, on a weekly basis. Accompanying the forms is a Records Transfer Sheet, on which Vital Statistics records
which type of form is enclosed (Live Birth, Registration of Death, Registration of Stillbirth, Revisions, etc.) as well as the registration numbers. Upon receipt of the documents, the HIM analyst or Data Entry Operator will check each batch of forms to ensure all registration numbers recorded on the transfer sheet have been received. Once verified, the transfer sheet is dated and signed by the Health Information Management (HIM) analyst and emailed to Vital Statistics as confirmation of receipt of the documents.

The Centre’s HIM analyst assigns the medical codes. Medical codes are based upon the ICD-10-CA/CCI as of January 1, 2003; prior to 2003, ICD-9/CCI classification system was used. The forms are forwarded to the data entry operator for demographic coding and data entry. The demographic coding includes Standard Geographical Code (SGC) and institution code for location of death.

DQS staff completes internal edits and correction process after all known RDs have been received, coded and entered into the database. Once closed, the file is added to the longitudinal dataset and is ready for use by stakeholders.

### 3.3 Data Collection and Processing Time Lines

- **Daily:** Funeral homes are legally required to report deaths to Vital Statistics within 5 days after death.
- **Weekly:** Vital Statistics completes the administrative section of the form and forwards a copy to the Centre.
- **Monthly:** Forms requiring revisions and/or coding queries are completed.
- **Annually:** All RD forms are received at the Centre by mid-April for the previous calendar year.
- **April 30, YYYY:** The annual cycle of demographic and medical coding, data entry and corrections for the previous data year is scheduled for completion.
- **May 31, YYYY:** The mortality longitudinal file is scheduled to be uploaded with the previous calendar edited year data.

### 4. Data Quality Processes

#### 4.1 Edit and Correction Process

The NLCHI Mortality System contains a series of edit checks which have been designed to automatically flag data elements that are incomplete, illegible or contain incorrect data.

Mortality edits are internal only and are performed in mid-March. The edit process consists of logic and classification edits. These include edits such as; date of death must
be greater than the date of birth and sorting files within the applicable regional health authority.

After all edits and corrections are completed a validation of MCP numbers is performed. The correction process is scheduled to be completed by May 31, YYYY for the previous year’s data. If Vital Statistics indicates that all deaths have not been reported in a timely manner, there may be a delay in meeting the May 31, YYYY target.

Appendix 3 lists the mortality edits.

4.2 Data Quality Results

The table below displays the annual results of data quality measures for the NLCHI Mortality database. As per the Data Quality Assessment tool, the Outstanding Error Rate is calculated thusly:

Total number of errors that cannot be resolved ÷ total number of errors triggered x 100

<table>
<thead>
<tr>
<th>Year</th>
<th>Total # Records Edited*</th>
<th>Total # Errors Identified</th>
<th>Total # Corrections Using Internal Resources</th>
<th>Total # Corrections Using External Resources**</th>
<th>Total # Outstanding Errors After Corrections</th>
<th>Outstanding Error Rate</th>
<th>Number of Records with one or more outstanding errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>4481</td>
<td>601</td>
<td>372</td>
<td>N/A</td>
<td>229</td>
<td>38%</td>
<td>N/A***</td>
</tr>
<tr>
<td>2011</td>
<td>4521</td>
<td>308</td>
<td>238</td>
<td>N/A</td>
<td>70</td>
<td>22%</td>
<td>70</td>
</tr>
<tr>
<td>2012</td>
<td>4623</td>
<td>224</td>
<td>198</td>
<td>N/A</td>
<td>26</td>
<td>11%</td>
<td>26</td>
</tr>
<tr>
<td>2013</td>
<td>4859</td>
<td>205</td>
<td>152</td>
<td>N/A</td>
<td>53</td>
<td>26%</td>
<td>53</td>
</tr>
<tr>
<td>2014</td>
<td>4987</td>
<td>260</td>
<td>218</td>
<td>N/A</td>
<td>42</td>
<td>16%</td>
<td>42</td>
</tr>
<tr>
<td>2015</td>
<td>5224</td>
<td>438</td>
<td>402</td>
<td>N/A</td>
<td>36</td>
<td>8%</td>
<td>36</td>
</tr>
<tr>
<td>2016</td>
<td>5003</td>
<td>420</td>
<td>389</td>
<td>N/A</td>
<td>31</td>
<td>7%</td>
<td>31</td>
</tr>
</tbody>
</table>

*The total number of records edited may not always reflect the total number of records received each year due to late receipt of records after the file has been closed.  
**Currently, edits to the Mortality database are performed on an internal basis only.  
***Capture of the number of records containing errors was not begun until 2011.

4.3 Maintenance Procedure

The Live Birth/Mortality Advisory Committee members are responsible for bringing forward issues or concerns from their respective organizations, providing key expertise, seeking input and circulating decisions made by the committee.

This is a dynamic dataset therefore users should be aware of past data element changes and that changes are likely to occur in the future. Due to these ongoing changes data elements have been added, revised or classified as inactive. Data elements that are
deemed inactive are no longer entered into the dataset. However for historical purposes these data elements and their values remain in the dataset (for the applicable years).

Whenever it is discovered that Vital Statistics inadvertently omitted a form or a funeral home failed to report a death, these revisions are retrospectively added to the longitudinal file.

When corrections are required after the year-end file is closed, the revisions are made and the changes are documented, including the rationale for the changes.

The revised mortality dataset is renamed, assigning a new version number and date to ensure accurate identification of the most recent data.

In 2008 data entry screens were redesigned and standardized to assist with data quality on input. For example, the date format validation as mm/dd/yyyy was implemented.

End users of mortality data may identify data quality issues. When an issue is reported to DQS staff, corrective and/or preventative action is taken.

<table>
<thead>
<tr>
<th>Registration of Death</th>
<th>Process</th>
<th>Position Responsible</th>
<th>Start Timeframe</th>
<th>Start Date</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medical Coding</td>
<td>HIM Analyst</td>
<td>Within 10 days after receiving from Vital Statistics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Coding</td>
<td>Data Entry Operator</td>
<td>Within 5 days after receiving from HIM Analyst</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Keying</td>
<td>Data Entry Operator</td>
<td>Within 10 days after social coding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIM Analyst</td>
<td>April</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MCP Verification and Annual Database Import</td>
<td>Database Analyst</td>
<td>Within 15 days after Edit Process</td>
</tr>
</tbody>
</table>
5. **Significant Data Quality History**

5.1 **Methodological/Revision Changes**

There have been no significant changes to the dataset structure since its inception.

From 1991 to 1999 Vital Statistics began their registration numbers with 1001. Since 2000 the numbering system was changed to begin with number 1.

Prior to 1990 Newfoundland and Labrador was assigned code 12 by Statistics Canada, in June 1990 the code was changed to 10.

In 2003, the RD form underwent significant changes to the format and data elements collected. Documentation related to changes and general information on the Mortality System prior to 2003 is minimal.

Appendix 5 lists all mandatory, revised, and inactive data elements for each year and accepted values from 2003 onwards.

In 2008 the responsibility of the Mortality System was transferred from the R&E Department to DQS.

6. **Data Quality Limitations**

6.1 **Contributors Impact on Data Quality**

Historically, the only reference source available to assist with quality assurance activities was the Vital Statistics paper form, which is also the source of origin.

Since 2009, the DQS staff has been authorized to access the provincial Client Registry and the MCP Beneficiary Registration Database to cross reference key administrative and demographic data elements to improve data quality.

Rarely will a funeral home refuse to comply with submission of RD forms; however it is not uncommon for a late response thus delaying the completion timeframe of March 31st.

Due to significant investments in quality assurance processes in recent years, the file years of 2003-current are more accurate than those of previous years.
7. Data Access, Storage, Retrieval and Privacy

7.1 Access
Access by Centre staff to this database is granted when R&E and/or DQS directors or managers grant permission on an individual basis, based on job responsibilities. Authorized users will be required to use a unique user name and password in order to access the file, which is housed in the NLCHI Information Management Solutions (NIMS) secure environment.

Positions that have access to the dataset:
- Manager, Clinical Standards and Information, HAES
- Health Information Management Analyst, HAES
- Data Entry Operator, HAES
- Database Analyst, HAES
- Health Data Consultant, HAES
- Epidemiologists, HAES
- Research Analysts, HAES

7.2 Storage/Retrieval
Source documents used to create the dataset are kept indefinitely until such time as the Centre implements a new retention policy.

The electronic dataset is maintained indefinitely and is stored on a secure server at the Centre.

Only the Infrastructure Department’s staff has access to the backup files. The Centre uses the Grandfather-Father-Son (GFS) method to backup data. The backups are organized into Daily, Weekly, and Monthly files. The Daily tapes are retained for 1 week. Weekly tapes are retained for 5 weeks, and Monthly tapes are retained for 1 year. The Centre also performs an annual backup with no specified retention period. The annual tapes are archived and are not reused.

The Mortality System data has a standardized naming convention to provide easy identification and prompt retrieval of data. The naming convention rules can be found in Appendix 5.

7.3 Privacy
The Centre has a Secondary Uses Committee that reviews applications for the use of death data for research and data quality purposes. A strong component of this committee is adherence to privacy and confidentiality legislation.
It is the responsibility of all users of death data to ensure complete confidentiality of the information. It is expected that all users adhere to policies outlined by the Centre.

Researchers will be granted access to de-identification data only, unless their research specifically requires identifiable data.

8. **Comparisons to Other Holdings**

8.1 **Centre Holdings**

Comparability across the years in the Mortality System and with other Centre datasets is possible using static elements such as the mother’s MCP number. In CDMS, the mother’s MCP number provides access to other identifiers such as chart number that can be used to link to the infant.

8.2 **Other Holdings**

Comparability between Statistics Canada and Vital Statistics mortality databases is possible using the registration number.
# Appendix 1: NLCHI Mortality System Data Dictionary

*Note: Areas in grey are variables which are no longer collected and/or valid.

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
<th>Value/Example</th>
<th>Type</th>
<th>Length</th>
<th>Applicable Year(s)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>regisnum</td>
<td>Registration Number</td>
<td>Year-Provience - Accession Number YYYYY/NL/1234... 10 = Newfoundland and Labrador</td>
<td>Numeric</td>
<td>11</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>year</td>
<td>Year of Death</td>
<td>Value: YYYY</td>
<td>Numeric</td>
<td>4</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>sex</td>
<td>Sex</td>
<td>1=Male 2=Female 3=Unknown</td>
<td>String</td>
<td>1</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>deadname</td>
<td>Name of Deceased (Surname, Given Names)</td>
<td>None</td>
<td>String</td>
<td>40</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>dob</td>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>None</td>
<td>Date</td>
<td>10</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>dob_derivd</td>
<td>Date of Birth derived from validated MCP number</td>
<td>None</td>
<td>Date</td>
<td>10</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>age_yrs</td>
<td>Age (Years)</td>
<td>None</td>
<td>Numeric</td>
<td>3</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>age_yrsDerived</td>
<td>Age (Years) derived from derived dob</td>
<td>None</td>
<td>Numeric</td>
<td>3</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>dod</td>
<td>Date of Death (mm/dd/yyyy)</td>
<td>None</td>
<td>Date</td>
<td>10</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>age_mths</td>
<td>Age (Months)</td>
<td>For deaths under 1 year of age</td>
<td>Numeric</td>
<td>2</td>
<td>1991-2006 2010-2016</td>
<td>When a range of dates is documented, the last date listed in the range is entered as the estimated date of death.</td>
</tr>
<tr>
<td>age_days</td>
<td>Age (Days)</td>
<td>For deaths under 1 year of age</td>
<td>Numeric</td>
<td>2</td>
<td>1991-2006 2010-2016</td>
<td></td>
</tr>
<tr>
<td>age_hrs</td>
<td>Age (Hours)</td>
<td>For deaths under 24 hours</td>
<td>Numeric</td>
<td>2</td>
<td>1991-2006 2010-2016</td>
<td></td>
</tr>
<tr>
<td>age_mins</td>
<td>Age (Minutes)</td>
<td>For deaths under 24 hours</td>
<td>Numeric</td>
<td>2</td>
<td>1991-2006 2010-2016</td>
<td></td>
</tr>
<tr>
<td>time_dth</td>
<td>Time of Death</td>
<td>For deaths ≤ 1 year of age (24 hr clock)</td>
<td>Numeric</td>
<td>4</td>
<td>2010-2016</td>
<td>To only be used for deaths ≤ 1 year of age</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
<td>Value/Example</td>
<td>Type</td>
<td>Length</td>
<td>Applicable Year(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>---------------</td>
<td>------</td>
<td>--------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>marsta</td>
<td>Current Legal Marital Status</td>
<td>1=Never Married 2=Legally Married and not Separated 3=Legally Married but Separated 4=Divorced 5=Widowed 6=Unknown 9=System Missing</td>
<td>Numeric</td>
<td>4</td>
<td>2007-2016</td>
<td></td>
</tr>
<tr>
<td>mcp</td>
<td>MCP Number</td>
<td>None</td>
<td>String</td>
<td>12</td>
<td>1991-2016</td>
<td>This variable is kept in Master File, but no longer appears in Longitudinal File.</td>
</tr>
<tr>
<td>mcp_validated</td>
<td>Validate MCP Number</td>
<td>MCP # checked and verified by NLCHI</td>
<td>Numeric</td>
<td>12</td>
<td>2001-2016</td>
<td>New in 2009, but all MCP numbers in Longitudinal File validated also.</td>
</tr>
<tr>
<td>sgc_res</td>
<td>SGC for Usual Residence</td>
<td>7-digit sgc code</td>
<td>String</td>
<td>7</td>
<td>1991-2016</td>
<td>New for 2009, but all MP #s in Longitudinal File validated also.</td>
</tr>
<tr>
<td>sgc</td>
<td>SGC – Derived</td>
<td>Truncated to 4-5 digits (e.g. 1001519 To 1519)</td>
<td>Numeric</td>
<td>8</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>pcode</td>
<td>Postal Code</td>
<td>None</td>
<td>String</td>
<td>6</td>
<td>2003-2016</td>
<td></td>
</tr>
<tr>
<td>hth_auth</td>
<td>Regional Health Authority</td>
<td>1=Eastern 2=Central 3=Western 4=Labrador-Grenfell 9=Out of Province 99=Unknown</td>
<td>Numeric</td>
<td>8</td>
<td>1991-2016</td>
<td>Derived from sgc</td>
</tr>
<tr>
<td>comm_brd</td>
<td>Health &amp; Community Services Board</td>
<td>1=St. John’s 2=Eastern 3=Central 4=Western 5=Labrador 6=Grenfell 9=Out of Province 99=Unknown</td>
<td>Numeric</td>
<td>8</td>
<td>1991-2016</td>
<td>Derived from sgc</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
<td>Value/Example</td>
<td>Type</td>
<td>Length</td>
<td>Applicable Year(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>---------------</td>
<td>---------</td>
<td>--------</td>
<td>--------------------</td>
<td>----------</td>
</tr>
<tr>
<td>inst_brd</td>
<td>Institutional Health Board</td>
<td>1=St. John’s  2=Avalon  3=Central East  4=Central West  5=Grenfell  6=Labrador  7=Peninsulas  8=Western  9=Out of Province  99=Unknown</td>
<td>Numeric</td>
<td>8</td>
<td>1991-2016</td>
<td>Derived from sgc</td>
</tr>
<tr>
<td>momname</td>
<td>Mother’s Maiden Surname &amp; Given Names</td>
<td>None</td>
<td>String</td>
<td>35</td>
<td>1991-2006</td>
<td>Data partially available</td>
</tr>
<tr>
<td>locality</td>
<td>Locality of Death</td>
<td>1=Hospital  2=Private Home  3=Other Health Care Facility  4=Other  9=System Missing</td>
<td>Numeric</td>
<td>4</td>
<td>2007-2016</td>
<td></td>
</tr>
<tr>
<td>location_other</td>
<td>Other location (specify)</td>
<td>None</td>
<td>String</td>
<td>50</td>
<td>2007-2016</td>
<td></td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
<td>Value/Example</td>
<td>Type</td>
<td>Length</td>
<td>Applicable Year(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>---------------</td>
<td>--------</td>
<td>--------</td>
<td>--------------------</td>
<td>----------</td>
</tr>
<tr>
<td>dur_preg</td>
<td>If deceased is a female, did the death occur:</td>
<td>□ During Pregnancy</td>
<td>Numeric</td>
<td>2</td>
<td>1991-2009</td>
<td></td>
</tr>
<tr>
<td>dur_preg_days</td>
<td>If deceased is a female, did the death occur:</td>
<td>□ Within 42 days thereafter Or □ between 43 days and 365 days thereafter.</td>
<td>Numeric</td>
<td>2</td>
<td>1991-2009</td>
<td></td>
</tr>
<tr>
<td>gest_weeks</td>
<td>Gestational Age (Weeks)</td>
<td>Used for NB death due to prematurity</td>
<td></td>
<td></td>
<td>2010-2016</td>
<td></td>
</tr>
<tr>
<td>gest_days</td>
<td>Gestational Age (Days)</td>
<td>Used for NB death due to prematurity</td>
<td></td>
<td></td>
<td>2010-2016</td>
<td></td>
</tr>
<tr>
<td>weight</td>
<td>Birth Weight (grams)</td>
<td>None</td>
<td>String</td>
<td>4</td>
<td>1991-2002</td>
<td></td>
</tr>
<tr>
<td>medterm</td>
<td>Was this Death Due to the Medical Termination of Pregnancy</td>
<td>1= Yes 2= No</td>
<td>Numeric</td>
<td>4</td>
<td>2008-2016</td>
<td></td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
<td>Value/Example</td>
<td>Type</td>
<td>Length</td>
<td>Applicable Year(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------</td>
<td>----------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>--------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>death_dueto</td>
<td>Is this death due to...</td>
<td>1=Natural Causes 2=Accident 3=Suicide 4=Homicide 5=Undetermined</td>
<td>Numeric</td>
<td>4</td>
<td>2007-2016</td>
<td></td>
</tr>
<tr>
<td>death_duetospecify</td>
<td>Was this death due to...(Other specified)</td>
<td>None</td>
<td>String</td>
<td>100</td>
<td>2007-2016</td>
<td></td>
</tr>
<tr>
<td>autopsy</td>
<td>Autopsy</td>
<td>1=Yes 2=No</td>
<td>String</td>
<td>8</td>
<td>1991-2016</td>
<td></td>
</tr>
<tr>
<td>dispos</td>
<td>Disposition</td>
<td>1=Burial 2=Cremation 3=Other 4=Unknown</td>
<td>Numeric</td>
<td>8</td>
<td>2003-2010</td>
<td>Not collected beyond 2010</td>
</tr>
<tr>
<td>disp_oth</td>
<td>Disposition (Other)</td>
<td>None</td>
<td>String</td>
<td>50</td>
<td>2003-2010</td>
<td></td>
</tr>
<tr>
<td>comments</td>
<td>Comments</td>
<td>None</td>
<td>String</td>
<td>70</td>
<td>1998-2002 2011-2016</td>
<td></td>
</tr>
<tr>
<td>medinjury</td>
<td>Maternal Injury</td>
<td>1 = Yes 2 = No</td>
<td>Numeric</td>
<td>8</td>
<td>2016</td>
<td></td>
</tr>
</tbody>
</table>
**Appendix 2: 2016 Form**

The image shows a page with a form titled "REGISTRATION OF DEATH 2016" from the Government of Newfoundland and Labrador. The form contains various sections for collecting information about the deceased, such as personal details, place of death, method of death, and details about the funeral home. The form is structured with fields for inputting relevant data.
The form below, entitled “Registration of A Stillborn or Death Within 28 Days of Birth” was used prior to the creation of the individual vital event forms for mortalities, and recorded live births with subsequent death within the noted time period, as well as stillbirths within the province. It is important to note that although this form is technically a form for mortality (either death or stillbirth), it has, on occasion been used as a registration of both birth and death. Copies of past Registration of Death forms are available upon request.

**FATHER (where information is available)**

- Name
- Address
- Occupation
- Date and place of birth
- Age at time of death

**MEDICAL CERTIFICATION**

- Cause of Stillbirth or Death
- Date and time of death
- Age at time of death
- Immediate cause (do not list as a medical diagnosis or the cause of death)
- Antecedent cause
- Antecedent cause (do not list the cause of stillbirth or death)
- Other significant conditions contributing to the stillbirth or death
- Place of birth
- Date of birth
- Age at time of birth

**MOTHER**

- Name
- Address
- Occupation
- Date and place of birth
- Age at time of death
- Immediate cause (do not list as a medical diagnosis or the cause of death)
- Antecedent cause
- Antecedent cause (do not list the cause of stillbirth or death)
- Other significant conditions contributing to the stillbirth or death
- Place of birth
- Date of birth
- Age at time of birth
- In your opinion, is the stillbirth due to some other cause? (check one)
- Congenital anomaly
- Neoplasia
- Infection
- Endocrine
- Drug effect
- Ectopic pregnancy
- Other and unclassified
- Specify and justify

**SIGNATURE OF INFORMANT**

- Relationship to child
- Date signed (month, day, year)

**DISPOSITION**

- Date and address of burial or disposition
- Name and address of attending physician or medical examiner
- Address and number of the place of disposition
- Date and address of entombment or disposal
- Name and address of attending physician or medical examiner

**FUNERAL DIRECTOR**

- Name and address of funeral director
- Signature of funeral director

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**PROVINCE OF NEWFOUNDLAND (Canada)**

**DEPARTMENT OF HEALTH**

**Office of the Registrar General**

**St. John’s**

**REGISTRATION OF A STILLBORN OR DEATH WITHIN 28 DAYS OF BIRTH**

**FATHER**

- Name
- Address
- Occupation
- Date and place of birth
- Age at time of death

**MEDICAL CERTIFICATION**

- Cause of Stillbirth or Death
- Date and time of death
- Age at time of death
- Immediate cause (do not list as a medical diagnosis or the cause of death)
- Antecedent cause
- Antecedent cause (do not list the cause of stillbirth or death)
- Other significant conditions contributing to the stillbirth or death
- Place of birth
- Date of birth
- Age at time of birth
- In your opinion, is the stillbirth due to some other cause? (check one)
- Congenital anomaly
- Neoplasia
- Infection
- Endocrine
- Drug effect
- Ectopic pregnancy
- Other and unclassified
- Specify and justify

**SIGNATURE OF INFORMANT**

- Relationship to child
- Date signed (month, day, year)

**DISPOSITION**

- Date and address of burial or disposition
- Name and address of attending physician or medical examiner
- Address and number of the place of disposition
- Date and address of entombment or disposal
- Name and address of attending physician or medical examiner

**FUNERAL DIRECTOR**

- Name and address of funeral director
- Signature of funeral director
Appendix 3: Glossary

Client Registry
The Client Registry is maintained at the Centre and contains data including resident demographic information such as name, address, date of birth and administrative information such as date of birth registration, MCP number, etc. It is the first foundational registry of the Newfoundland and Labrador Electronic health Record (EHR). The Client Registry enables the accurate identification of individuals in the provincial EHR by linking person-specific information from clinical information systems to the correct person. It is currently used by staff in hospitals; community services offices, long term care facilities and MCP to accurately identify clients.

Hospital Code
This code identifies a Newfoundland and Labrador health care facility. A hospital code in the Mortality System consists of a four characters, starting with an alpha followed by three numbers. This code identifies a Newfoundland and Labrador health care facility.

MCP Number
A 12 digit number issued to residents of the province by Newfoundland and Labrador Medical Care Plan.

Medical Coding
International Classification of Diseases and Related Health Problems, Tenth Revision, Canada (ICD-10-CA), this system consists of codes to classify diseases and health problems.

Canadian Classification of Health Interventions (CCI) is a national standard for classifying health care procedures. CCI is the companion classification system to ICD-10-CA.

Office of the Chief Information Officer (OCIO)
The OCIO provides Information Technology and Information Management capability aligned to support the business of government and the citizens of Newfoundland and Labrador.

Secondary Uses Committee
This Committee provides advice to the Chief Privacy Officer, who is accountable for the approval of new uses and disclosures of personal health information. Any committee member who has requested the new uses or is a party to the request for disclosure of data/information shall state the conflict of interest at the beginning of the discussion on the request. There shall be between three and seven members. Membership shall include expertise in research, data quality, and privacy.

Social Coding
This is a code that identifies a place of residence. The Standard Geographical Classification (SGC) is Statistics Canada's official classification of geographic areas in Canada. The SGC provides unique numeric codes for three types of geographic areas: provinces and territories, census divisions (counties, regional municipalities), and census subdivisions (municipalities).