NLCHI Mortality System
Data User Guide
August 2017 v.1.0

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Mortality Data User Document
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2011 v.1.0	Rosalie Haire and Michele Bishop	March 30, 2012	Annual Updates
2012 v.1.1	Michele Bishop	June 12, 2013	Annual Updates
2013 V.1.0	Rosalie Haire	March 22, 2014	Annual Updates
2016 V.1.0	Beatrice Pittman and Lisa McKenzie	August 14, 2017	Annual Updates

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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:

Section	Responsibility for Completion
Registration	Vital Statistics
Information on Deceased	Health Care Professional /Funeral Home
Parental Information	Health Care Professional/Funeral Home
Informant	Health Care Professional/Funeral Home
Place of Death	Health Care Professional
Medical Certification	Health Care Professional
Disposition	Funeral Home
Office Use	Vital Statistics

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:

- Copy of RD form(s), 1989-2017.
- 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

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

*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.

Process Schedule for Coding, Keying, Editing and Importing of Vital Statistics Data				
Registration of Death				
Process	**Position Responsible**	**Start Timeframe**	**Start Date**	**Completion Date**
Medical Coding	HIM Analyst	Within 10 days after receiving from Vital Statistics **Minimum Target 150 a week**		
Social Coding	Data Entry Operator	Within 5 days after receiving from HIM Analyst **Minimum Target 150 a week**		
Keying	Data Entry Operator	Within 10 days after social coding **Minimum Target 150 a week**	January to December	**End of Month** February to January
Edit Process	HIM Analyst	Within 10 days after keying completed for year	April	April
MCP Verification and Annual Database Import	Database Analyst	Within 15 days after Edit Process	May	May

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 house 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 polices 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.

Variable Name	Label	Value/Example	Type	Length	Applicable Year(s)	Comments
regisnum	Registration Number	Year-Province - Accession Number YYYY/NL/1234… 10 = Newfoundland and Labrador	Numeric	11	1991-2016	
year	Year of Death	Value: YYYY	Numeric	4	1991-2016	
sex	Sex	1=Male 2=Female 3=Unknown	String	1	1991-2016	
deadname	Name of Deceased (Surname, Given Names)	None	String	40	1991-2016	
dob	Date of Birth (mm/dd/yyyy)	None	Date	10	1991-2016	
dob_derivd	Date of Birth derived from validated MCP number	None	Date	10	1991-2016	
age_yrs	Age (Years)	None	Numeric	3	1991-2016	
age_yrs_derived	Age (Years) derived from derived dob	None	Numeric	3	1991-2016	
dod	Date of Death (mm/dd/yyyy)	None	Date	10	1991-2016	When a range of dates is documented, the last date listed in the range is entered as the estimated date of death.
age_mths	Age (Months)	For deaths under 1 year of age	Numeric	2	1991-2006 2010-2016	
age_days	Age (Days)	For deaths under 1 year of age	Numeric	2	1991-2006 2010-2016	
age_hrs	Age (Hours)	For deaths under 24 hours	Numeric	2	1991-2006 2010-2016	
age_mins	Age (Minutes)	For deaths under 24 hours	Numeric	2	1991-2006 2010-2016	
time_dth	Time of Death	For deaths ≤ 1 year of age (24 hr clock)	Numeric	4	2010-2016	To ***only*** be used for deaths ≤ I year of age

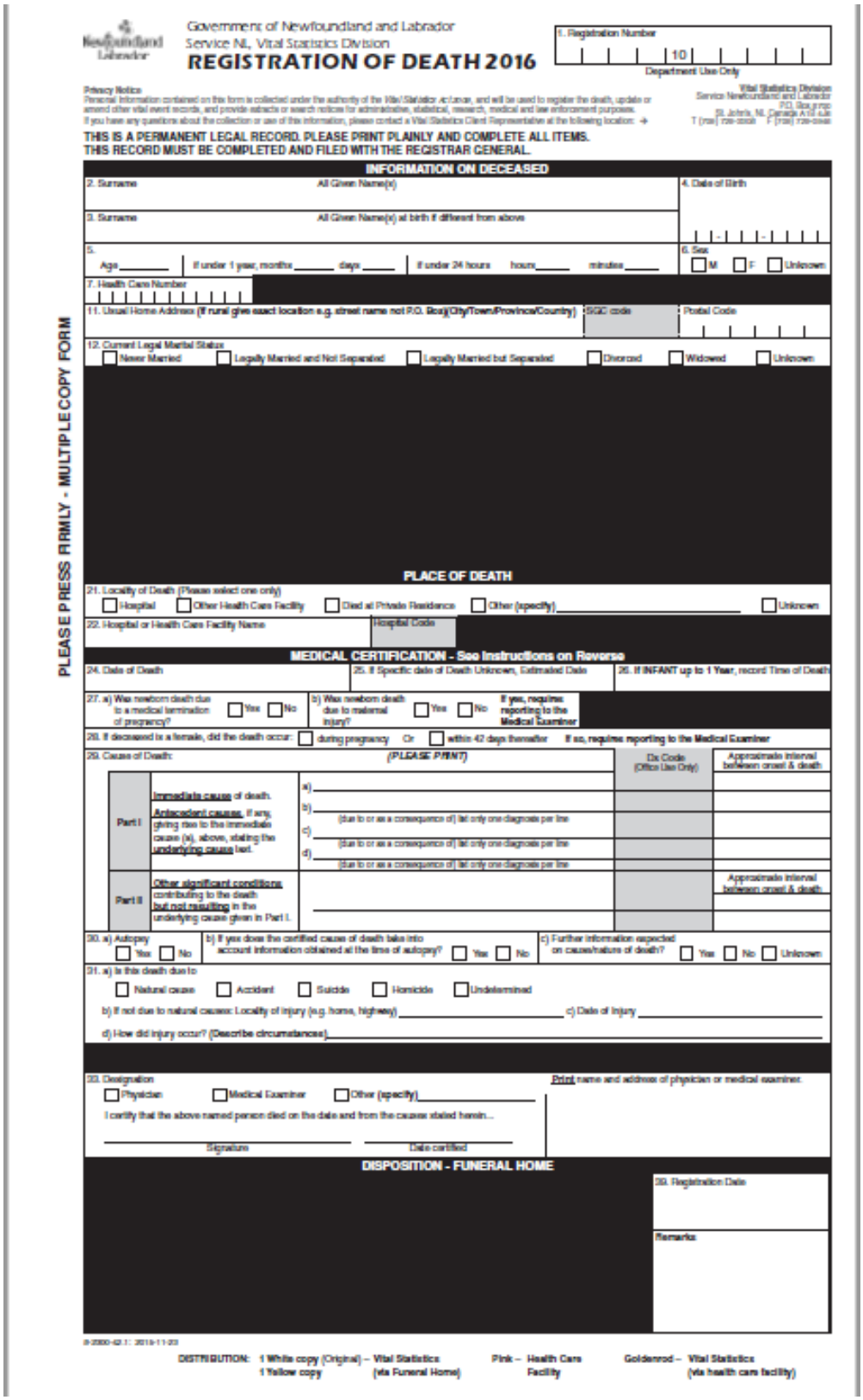
Variable Name	Label	Value/Example	Type	Length	Applicable Year(s)	Comments
marsta	Current Legal Marital Status	1=Never Married 2=Legally Married and not Separated 3=Legally Married but Separated 4=Divorced 5=Widowed 6=Unknown 9=System Missing	Numeric	4	2007-2016	
mcp	MCP Number	None	String	12	1991-2016	This variable is kept in Master File, but no longer appears in Longitudinal
mcp_validated	Validate MCP Number	MCP # checked and verified by NLCHI	Numeric	12	2001-2016	New in 2009, but all MCP numbers in Longitudinal File validated also.
sgc_res	SGC for Usual Residence	7-digit sgc code	String	7	1991-2016	New for 2009, but all MP #s in Longitudinal File validated also.
sgc	SGC – Derived	Truncated to 4-5 digits (e.g. 1001519 To 1519)	Numeric	8	1991-2016	
pcode	Postal Code	None	String	6	2003-2016	
hth_auth	Regional Health Authority	1=Eastern 2=Central 3=Western 4=Labrador-Grenfell 9=Out of Province 99=Unknown	Numeric	8	1991-2016	Derived from sgc
comm_brd	Health & Community Services Board	1=St. John's 2=Eastern 3=Central 4=Western 5=Labrador 6=Grenfell 9=Out of Province 99=Unknown	Numeric	8	1991-2016	Derived from sgc

Variable Name	Label	Value/Example	Type	Length	Applicable Year(s)	Comments
inst_brd	Institutional Health Board	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	Numeric	8	1991-2016	Derived from sgc
momname	Mother's Maiden Surname & Given Names	None	String	35	1991-2006	Data partially available
hospital	Hospital Code	None	Numeric	8	1991-2004 1998-2002 2005-2016	
facility	Hospital Name	None	String	35	1991-2004 1998-2002 2005-2016	Derived from Hospital Code
locality	Locality of Death	1=Hospital 2=Private Home 3=Other Health Care Facility 4=Other 9=System Missing	Numeric	4	2007-2016	
location_other	Other location (*specify*)	None	String	50	2007-2016	
icd_a	Immediate Cause of Death	None	String	6	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
icd_b	Antecedent Cause of Death – Other Significant Condition	None	String	6	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
icd_c	Antecedent Cause of Death – Other Significant Condition	None	String	6	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
icd_d	Antecedent Cause of Death – Other Significant Condition	None	String	6	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
icd_e	Antecedent Cause of Death – Other Significant Condition	None	String	6	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012

Variable Name	Label	Value/Example	Type	Length	Applicable Year(s)	Comments
icd_f	Antecedent Cause of Death – Other Significant Condition	None	String	6	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
icd_g	Antecedent Cause of Death – Other Significant Condition	None	String	6	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
oth_con1	Condition-1(ICD-10 code)	None	String	8	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
oth_con2	Condition-2 (ICD-10 code)	None	String	8	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
oth_con3	Condition-3 (ICD-10 code)	None	String	8	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
oth_con4	Condition-4 (ICD-10 code)	None	String	8	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
oth_con5	Condition-5 (ICD-10 code)	None	String	8	1991-2016	ICD-9 used in 1991-2002 ICD-10 used in 2003-2012
dur_preg	If deceased is a female, did the death occur:	□ During Pregnancy	Numeric	2	1991-2009	
dur_preg_days	If deceased is a female, did the death occur:	□ Within 42 days thereafter Or □ between 43 days and 365 days thereafter.	Numeric	2	1991-2009	
gest_weeks	Gestational Age (Weeks)	Used for NB death due to prematurity			2010-2016	
gest_days	Gestational Age (Days)	Used for NB death due to prematurity			2010-2016	
weight	Birth Weight (grams)	None	String	4	1991-2002	
medterm	Was this Death Due to the Medical Termination of Pregnancy	1= Yes 2= No	Numeric	4	2008-2016	

Variable Name	Label	Value/Example	Type	Length	Applicable Year(s)	Comments
death_dueto	Is this death due to…	1=Natural Causes 2=Accident 3=Suicide 4=Homicide 5=Undetermined	Numeric	4	2007-2016	
death_duetospecify	Was this death due to…(Other specified)	None	String	100	2007-2016	
autopsy	Autopsy	1=Yes 2=No	String	8	1991-2016	
disposit	Disposition	1=Burial 2=Cremation 3=Other 4=Unknown	Numeric	8	2003-2010	
disp_oth	Disposition (Other)	None	String	50	2003-2010	Not collected beyond 2010
comments	Comments	None	String	70	1998-2002 2011-2016	
medinjury	Maternal Injury	1 = Yes 2 = No	Numeric	8	2016	

Appendix 2: 2016 Form



Government of Newfoundland and Labrador
Service NL, Vital Statistics Division

REGISTRATION OF DEATH 2016

1. Registration Number — 10 — Department Use Only

Privacy Notice
Personal information contained on this form is collected under the authority of the Vital Statistics Act, 2009, and will be used to register the death, update or amend other vital event records, and provide extracts or search notices for administrative, statistical, research, medical and law enforcement purposes.
If you have any questions about the collection or use of this information, please contact a Vital Statistics Client Representative at the following location: →

Vital Statistics Division
Service Newfoundland and Labrador
P.O. Box [illegible]
St. John's, NL Canada A1B 4J6
T (709) 729-3308 F (709) 729-3440

THIS IS A PERMANENT LEGAL RECORD. PLEASE PRINT PLAINLY AND COMPLETE ALL ITEMS.
THIS RECORD MUST BE COMPLETED AND FILED WITH THE REGISTRAR GENERAL.

PLEASE PRESS FIRMLY - MULTIPLE COPY FORM

INFORMATION ON DECEASED

2. Surname — All Given Name(s) — 4. Date of Birth
3. Surname — All Given Name(s) at birth if different from above
5. Age _____ | If under 1 year, months _____ days _____ | If under 24 hours hours _____ minutes _____ — 6. Sex ☐ M ☐ F ☐ Unknown
7. Health Care Number
11. Usual Home Address (If rural give exact location e.g. street name not P.O. Box) (City/Town/Province/Country) — SGC code — Postal Code
12. Current Legal Marital Status ☐ Never Married ☐ Legally Married and Not Separated ☐ Legally Married but Separated ☐ Divorced ☐ Widowed ☐ Unknown

PLACE OF DEATH

21. Locality of Death (Please select one only) ☐ Hospital ☐ Other Health Care Facility ☐ Died at Private Residence ☐ Other (specify) _____ ☐ Unknown
22. Hospital or Health Care Facility Name — Hospital Code

MEDICAL CERTIFICATION - See Instructions on Reverse

24. Date of Death — 25. If Specific date of Death Unknown, Estimated Date — 26. If INFANT up to 1 Year, record Time of Death
27. a) Was newborn death due to a medical termination of pregnancy? ☐ Yes ☐ No — b) Was newborn death due to maternal injury? ☐ Yes ☐ No — If yes, requires reporting to the Medical Examiner
28. If deceased is a female, did the death occur: ☐ during pregnancy Or ☐ within 42 days thereafter — If so, requires reporting to the Medical Examiner
29. Cause of Death: (PLEASE PRINT) — Dx Code (Office Use Only) — Approximate interval between onset & death

Part I	Immediate cause of death. Antecedent causes. If any, giving rise to the immediate cause (a), above, stating the underlying cause last.	a)	
		b) (due to or as a consequence of) list only one diagnosis per line	
		c) (due to or as a consequence of) list only one diagnosis per line	
		d) (due to or as a consequence of) list only one diagnosis per line	
Part II	Other significant conditions contributing to the death but not resulting in the underlying cause given in Part I.		Approximate interval between onset & death

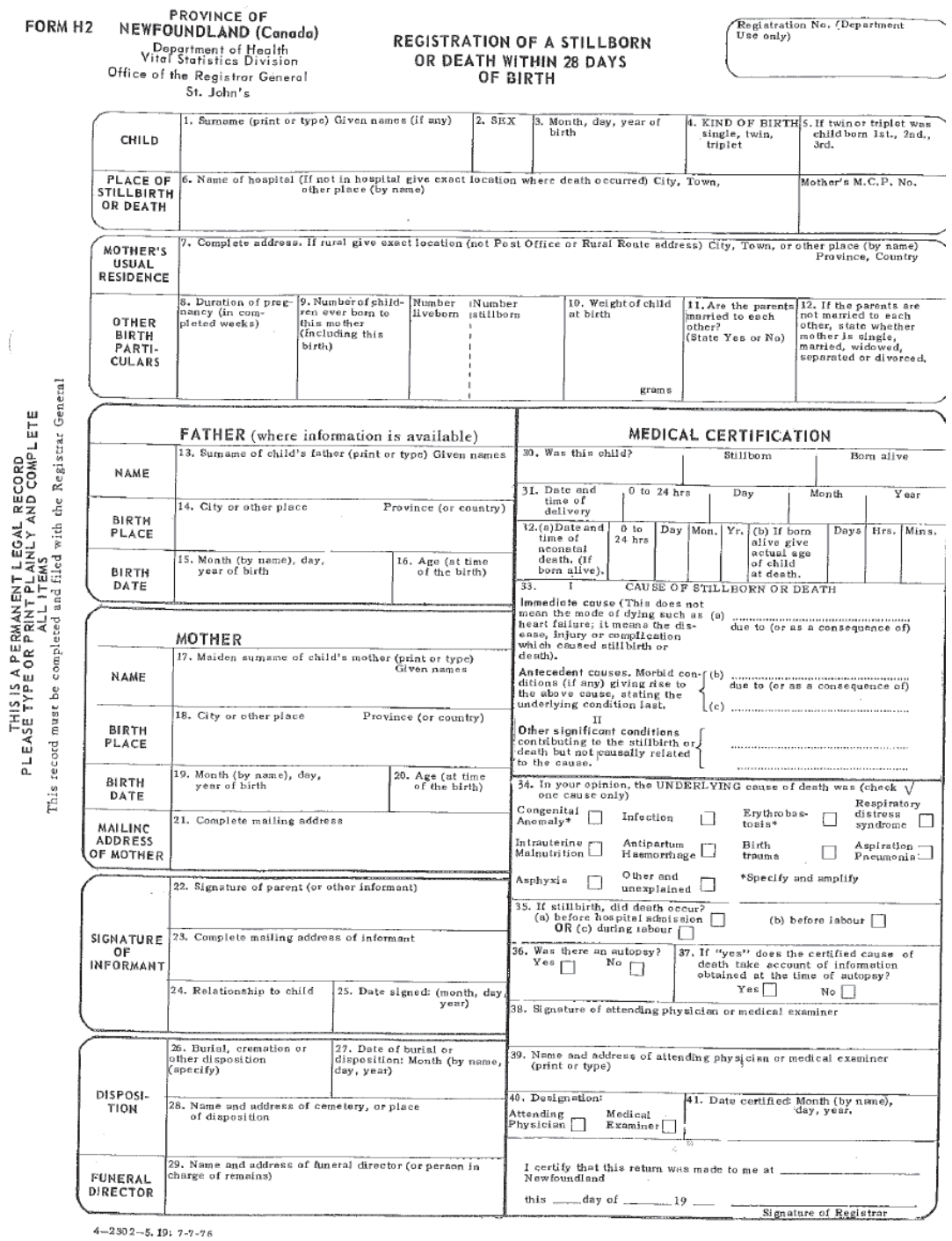
30. a) Autopsy ☐ Yes ☐ No — b) If yes does the certified cause of death take into account information obtained at the time of autopsy? ☐ Yes ☐ No — c) Further information expected on cause/nature of death? ☐ Yes ☐ No ☐ Unknown
31. a) Is this death due to ☐ Natural cause ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined
b) If not due to natural causes: Locality of injury (e.g. home, highway) _____ c) Date of Injury _____
d) How did injury occur? (Describe circumstances) _____
33. Designation ☐ Physician ☐ Medical Examiner ☐ Other (specify) _____ — Print name and address of physician or medical examiner.
I certify that the above named person died on the date and from the causes stated herein...
Signature _____ Date certified _____

DISPOSITION - FUNERAL HOME

39. Registration Date
Remarks

DISTRIBUTION: 1 White copy (Original) – Vital Statistics; 1 Yellow copy (via Funeral Home); Pink – Health Care Facility; Goldenrod – Vital Statistics (via health care facility)

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.



FORM H2

PROVINCE OF NEWFOUNDLAND (Canada)
Department of Health
Vital Statistics Division
Office of the Registrar General
St. John's

REGISTRATION OF A STILLBORN OR DEATH WITHIN 28 DAYS OF BIRTH

Registration No. (Department Use only)

THIS IS A PERMANENT LEGAL RECORD
PLEASE TYPE OR PRINT PLAINLY AND COMPLETE ALL ITEMS
This record must be completed and filed with the Registrar General

CHILD
1. Surname (print or type) Given names (if any)
2. SEX
3. Month, day, year of birth
4. KIND OF BIRTH single, twin, triplet
5. If twin or triplet was child born 1st., 2nd., 3rd.

PLACE OF STILLBIRTH OR DEATH
6. Name of hospital (If not in hospital give exact location where death occurred) City, Town, other place (by name)
Mother's M.C.P. No.

MOTHER'S USUAL RESIDENCE
7. Complete address. If rural give exact location (not Post Office or Rural Route address) City, Town, or other place (by name) Province, Country

OTHER BIRTH PARTICULARS
8. Duration of pregnancy (in completed weeks)
9. Number of children ever born to this mother (including this birth)
Number liveborn
Number stillborn
10. Weight of child at birth grams
11. Are the parents married to each other? (State Yes or No)
12. If the parents are not married to each other, state whether mother is single, married, widowed, separated or divorced.

FATHER (where information is available)

NAME
13. Surname of child's father (print or type) Given names

BIRTH PLACE
14. City or other place
Province (or country)

BIRTH DATE
15. Month (by name), day, year of birth
16. Age (at time of the birth)

MOTHER

NAME
17. Maiden surname of child's mother (print or type) Given names

BIRTH PLACE
18. City or other place
Province (or country)

BIRTH DATE
19. Month (by name), day, year of birth
20. Age (at time of the birth)

MAILING ADDRESS OF MOTHER
21. Complete mailing address

SIGNATURE OF INFORMANT
22. Signature of parent (or other informant)
23. Complete mailing address of informant
24. Relationship to child
25. Date signed: (month, day, year)

DISPOSITION
26. Burial, cremation or other disposition (specify)
27. Date of burial or disposition: Month (by name), day, year)
28. Name and address of cemetery, or place of disposition

FUNERAL DIRECTOR
29. Name and address of funeral director (or person in charge of remains)

MEDICAL CERTIFICATION

30. Was this child? Stillborn Born alive

31. Date and time of delivery: 0 to 24 hrs; Day; Month; Year

12.(a) Date and time of neonetal death. (If born alive). 0 to 24 hrs; Day; Mon.; Yr.
(b) If born alive give actual age of child at death. Days; Hrs.; Mins.

33. I CAUSE OF STILLBORN OR DEATH

Immediate cause (This does not mean the mode of dying such as heart failure; it means the disease, injury or complication which caused stillbirth or death). (a) ..... due to (or as a consequence of)

Antecedent causes. Morbid conditions (if any) giving rise to the above cause, stating the underlying condition last. (b) ..... due to (or as a consequence of) (c) .....

II
Other significant conditions contributing to the stillbirth or death but not causally related to the cause. .....

34. In your opinion, the UNDERLYING cause of death was (check √ one cause only)

Congenital Anomaly* ☐ Infection ☐ Erythroblastosis* ☐ Respiratory distress syndrome ☐
Intrauterine Malnutrition ☐ Antipartum Haemorrhage ☐ Birth trauma ☐ Aspiration Pneumonia ☐
Asphyxia ☐ Other and unexplained ☐ *Specify and amplify

35. If stillbirth, did death occur? (a) before hospital admission ☐ OR (c) during labour ☐ (b) before labour ☐

36. Was there an autopsy? Yes ☐ No ☐

37. If "yes" does the certified cause of death take account of information obtained at the time of autopsy? Yes ☐ No ☐

38. Signature of attending physician or medical examiner

39. Name and address of attending physician or medical examiner (print or type)

40. Designation: Attending Physician ☐ Medical Examiner ☐

41. Date certified: Month (by name), day, year.

I certify that this return was made to me at _____ Newfoundland

this _____ day of _____ 19 ___

_____ Signature of Registrar

4—2302—5. 19: 7-7-76

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 heath Record (EHR). The Client Registry enables the accurate identification of individuals in the provincial EHR by linking person-specific information form 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).