TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CERTIFICATE OF LIVE BIRTH

139-

BIRTH NUMBER

EBC SAMPLE

CHILD

1. CHILD'S NAME First Middle Last
2. DATE OF BIRTH (Month, Day, Year)
3. TIME OF BIRTH M
4. SEX
5. CITY, TOWN, OR LOCATION OF BIRTH
6. COUNTY OF BIRTH
7. PLACE OF BIRTH
8. FACILITY NAME (If not institution, give street and number)

CERTIFIER/ATTENDANT

9. I certify that this child was born alive at the place and time and on the date [illegible]
Signature ▶
10. DATE SIGNED (Month, Day, Year)
11. ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print)
12. CERTIFIER'S NAME AND TITLE
13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14. REGISTRAR'S SIGNATURE ▶
15. DATE FILED BY REGISTRAR (Month, Day, Year)

MOTHER

16a. MOTHER'S NAME First Middle Last
16b. MAIDEN SURNAME
17. DATE OF BIRTH (Month, Day, Year)
18. BIRTHPLACE (State or Foreign Country)
19a. RESIDENCE - STATE
19b. COUNTY
19c. CITY, TOWN, OR LOCATION
19d. STREET AND NUMBER
19e. ZIP CODE
19f. INSIDE CITY LIMITS
20. MOTHER'S MAILING ADDRESS (If different than residence)

FATHER

21. FATHER'S NAME First Middle Last
22. DATE OF BIRTH (Month, Day, Year)
23. BIRTHPLACE (State or Foreign Country)
24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.
Signature of Parent or Other Informant ▶

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

25. IS OF HISPANIC ORIGIN?
25a. [illegible]
25b. [illegible]
26. RACE (American Indian, Black, White) (Specify below)
26a. Mother
26b. Father
27. EDUCATION (Specify only highest [illegible] completed)
Elementary/Secondary (0-12) | COLLEGE (1-4 or 5+)
27a. Mother
27b. Father
28. SOCIAL SECURITY NUMBER (Specify below)
28a. Mother
28b. Father

29. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS (Do not include this child)		OTHER TERMINATIONS (Spontaneous and induced at any time after conception)
29a. Now Living Number ____	29b. Now Dead Number ____	29d. Number ____
29c. DATE OF LAST LIVE BIRTH (Month/Year)		29e. DATE OF LAST OTHER TERMINATION (Month/Year)

30. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or No)
31. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
32. MONTH OF PREGNANCY PRENATAL CARE BEGAN - First, Second, Third, etc. (Specify)
33. PRENATAL VISITS - Total Number (including physician, clinic, Health Department visits)
34. BIRTH WEIGHT (Specify unit)
35. CLINICAL ESTIMATE OF GESTATION (Weeks)
36a. PLURALITY - Single, Twin, Triplet, etc. (Specify)
36b. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)

37. APGAR SCORE
37a. 1 Minute
37b. 5 Minutes
38a. MOTHER TRANSFERRED PRIOR TO DELIVERY? If Yes, enter name of facility transferred from:
38b. INFANT TRANSFERRED? If Yes, enter name of facility transferred to:
39. WHAT PROPHYLACTIC USED IN EYES? (Specify)
TIME USED M.

Do Not Fold This Certificate

DHEC 0609E 10/17/91

40a. MEDICAL RISK FACTORS FOR THIS PREGNANCY
40b. OTHER RISK FACTORS FOR THIS PREGNANCY
Tobacco use during pregnancy
Average number cigarettes per day
Alcohol use during pregnancy
Average number drinks per week
Weight gained during pregnancy
41. OBSTETRIC PROCEDURES
42. COMPLICATIONS OF LABOR AND/OR DELIVERY
43. METHOD OF DELIVERY
44. ABNORMAL CONDITIONS OF THE NEWBORN
45. CONGENITAL ANOMALIES OF CHILD
46. Has a relative of the baby had a hearing loss that existed since childhood? (Permanent, Hereditary loss)

Parental Request for Issuance of SS #

State Office Use Only

DHEC 0609E 10/17/91

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

CERTIFICATE OF DEATH

STATE BIRTH NUMBER

STATE FILE NUMBER

DECEDENT

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

SEX — 2.

DATE OF DEATH (Month, Day, Year) — 3.

SOCIAL SECURITY NUMBER — 4.

AGE - Last Birthday (Years) — 5a.

UNDER 1 YEAR: Months / Days — 5b.

UNDER 1 DAY: Hours / Minutes — 5c.

DATE OF BIRTH (Mo., Day, Year) — 6.

BIRTHPLACE (City, and State or Foreign Country) — 7.

WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) — 8.

9a. PLACE OF DEATH (Check only one; see instructions on other side)

HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

FACILITY NAME (If not institution, give street and number) — 9b.

CITY, TOWN, OR LOCATION OF DEATH — 9c.

COUNTY OF DEATH — 9d.

MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) — 10.

SURVIVING SPOUSE (If wife, give maiden name) — 11.

DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) — 12a.

KIND OF BUSINESS/INDUSTRY — 12b.

RESIDENCE - STATE — 13a.

COUNTY — 13b.

CITY, TOWN, OR LOCATION — 13c.

STREET AND NUMBER — 13d.

INSIDE CITY LIMITS (Yes or No) — 13e.

ZIP CODE — 13f.

Was Decedent of Hispanic Origin (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) — 14. ☐ Yes ☐ No (Specify)

RACE - American Indian, Black, White, etc. (Specify) — 15.

DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+) — 16.

PARENTS

FATHER'S NAME (First, Middle, Last) — 17.

MOTHER'S NAME (First, Middle, Maiden Surname) — 18.

INFORMANT'S NAME (Type/Print) — 19a.

MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) — 19b.

DISPOSITION

METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) — 20a.

PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) — 20b.

LOCATION - (City or Town, State) — 20c.

FUNERAL DIRECTOR OR PERSON ACTING AS SUCH (Signature) — 21a.

FUNERAL DIR. LICENSE NO. — 21b.

NAME AND ADDRESS OF FACILITY — 22a.

LICENSE NUMBER (of facility) — 22b.

EMBALMER (Signature) — 21c.

EMBALMER LICENSE NO. — 21d.

Pronouncing Physician Only →

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

To the best of my knowledge, death occurred at the time, date, and place stated.

23a. Signature and Title

LICENSE NUMBER — 23b.

DATE SIGNED (Month, Day, Year) — 23c.

TIME OF DEATH — 24. M

DATE PRONOUNCED DEAD (Month, Day, Year) — 25.

WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) — 26.

CAUSE OF DEATH

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AUTOPSY (Yes or No) — 28a.

IF YES, WERE AUTOPSY FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH? (Yes or No) — 28b.

29. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

DATE OF INJURY (Month, Day, Year) — 30a.

TIME OF INJURY — 30b. M

INJURY AT WORK? (Yes or No) — 30c.

DESCRIBE HOW INJURY OCCURRED — 30d.

PLACE OF INJURY - (Home, Farm, Street, Factory, Office, etc.) (Specify) — 30e.

LOCATION (Street and Number or Rural Route Number, City or Town, State) — 30f.

CERTIFIER

CERTIFIER (Check only one): ☐ CERTIFYING PHYSICIAN (Physician certifying cause of death) ☐ MEDICAL EXAMINER ☐ CORONER ☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) — 31.

NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER — 32.

SIGNATURE AND TITLE OF CERTIFIER To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. — 33a.

LICENSE NUMBER — 33b.

DATE SIGNED (Month, Day, Year) — 33c.

NAME AND ADDRESS OF PERSON WHO SIGNED IN 33a. (Type/Print) — 34.

REGISTRAR

REGISTRAR'S SIGNATURE — 35.

DATE FILED (Month, Day, Year) — 36.

SAMPLE

See Instructions On Other Side.

See Definition On Other Side

For Use By Physician Or Institution

See Instructions On Other Side

See Definition On Other Side

HEC 670
ev. 1990

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CERTIFICATE OF LIVE BIRTH

139 -

BIRTH NUMBER

CHILD

1. CHILD'S NAME First Middle Last
2. DATE OF BIRTH (Month, Day, Year)
3. TIME OF BIRTH M
4. SEX
5. CITY, TOWN, OR LOCATION OF BIRTH
6. COUNTY OF BIRTH
7. PLACE OF BIRTH: ☐ Hospital ☐ Clinic/Doctor's Office ☐ Residence ☐ Freestanding Birthing Center ☐ Other (Specify)
8. FACILITY NAME (If not institution, give street and number)

CERTIFIER/ATTENDANT

9. I certify that this child was born alive at the place and time and on the date stated. Signature ➤
10. DATE SIGNED (Month, Day, Year)
11. ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print) Name ☐ M.D. ☐ C.N.M. ☐ Other (Specify)
12. CERTIFIER'S NAME AND TITLE (Type/Print) Name ☐ M.D. ☐ C.N.M. ☐ Other (Specify)
13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14. REGISTRAR'S SIGNATURE ➤
15. DATE FILED BY REGISTRAR (Month, Day, Year)

MOTHER

16a. MOTHER'S NAME First Middle Last
16b. MAIDEN SURNAME
17. DATE OF BIRTH (Month, Day, Year)
18. BIRTHPLACE (State or Foreign Country)
19a. RESIDENCE - STATE
19b. COUNTY
19c. CITY, TOWN, OR LOCATION
19d. STREET AND NUMBER
19e. ZIP CODE
19f. INSIDE CITY LIMITS? Yes ☐ No ☐
20. MOTHER'S MAILING ADDRESS (If different than residence)

FATHER

21. FATHER'S NAME First Middle Last
22. DATE OF BIRTH (Month, Day, Year)
23. BIRTHPLACE (State or Foreign Country)
24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. Signature of Parent or Other Informant ➤

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

25a. Mother: Yes ☐ No ☐ If yes indicate ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Other Spanish origin (not listed)
25b. Father: Yes ☐ No ☐ If yes indicate ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Other Spanish origin (not listed)
26. RACE American Indian, Black, White, etc. (Specify below) — 26a. MOTHER — 26b. FATHER
27. EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+) — 27a. MOTHER — 27b. FATHER
28. SOCIAL SECURITY NUMBER (Specify below) — 28a. MOTHER — 28b. FATHER

29. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS (Do not include this child)		OTHER TERMINATIONS (Spontaneous and induced at any time after conception)
29a. Now Living Number ☐ None	29b. Now Dead Number ☐ None	29c. Number ☐ None
29d. DATE OF LAST LIVE BIRTH (Month, Year)		29e. DATE OF LAST OTHER TERMINATION (Month, Year)

30. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or No)
31. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
32. MONTH OF PREGNANCY PRENATAL CARE BEGAN - First, Second, Third, etc. (Specify)
33. PRENATAL VISITS - Total Number (Including physician, clinic, Health Department visits) Number ☐ None
34. BIRTH WEIGHT (Specify unit)
35. CLINICAL ESTIMATE OF GESTATION (Weeks)
36a. PLURALITY - Single, Twin, Triplet, etc. (Specify)
36b. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)
37. APGAR SCORE — 37a. 1 Minute — 37b. 5 Minutes
38a. MOTHER TRANSFERRED PRIOR TO DELIVERY? Yes ☐ No ☐ If Yes, enter name of facility transferred from:
38b. INFANT TRANSFERRED? Yes ☐ No ☐ If Yes, enter name of facility transferred to:
39. WHAT PROPHYLACTIC USED IN EYES? (Specify) TIME USED M.

Do Not Fold This Certificate

DHEC 609 1/1/92

40a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

Anemia (HCL < 33/Hgb. < 10)	01 ☐	Genital herpes	05 ☐
Cardiac disease	02 ☐	Hydramnios/Oligohydramnios	06 ☐
Acute or chronic lung disease	03 ☐	Hemoglobinopathy	07 ☐
Diabetes	04 ☐	Hypertension, chronic	08 ☐
		Hypertension, pregnancy-associated	09 ☐
		Eclampsia	10 ☐
		Incompetent cervix	11 ☐
		Previous infant 4000 + grams	12 ☐
		Previous preterm or small-for-gestational-age infant	13 ☐
		Renal disease	14 ☐
		Rh sensitization	15 ☐
		Uterine bleeding	16 ☐
		None	00 ☐
		Other (Specify)	17 ☐

40b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items)

Tobacco use during pregnancy ..... Yes ☐ No ☐ Average number cigarettes per day ____
Alcohol use during pregnancy ..... Yes ☐ No ☐ Average number drinks per week ____
Weight gained during pregnancy ____ lbs.

PARENTAL REQUEST FOR ISSUANCE OF SS#? Yes ☐ No ☐

STATE OFFICE USE ONLY

41. OBSTETRIC PROCEDURES (Check all that apply)

Amniocentesis	01 ☐		
Electronic fetal monitoring	02 ☐		
Induction of labor	03 ☐		
Stimulation of labor	04 ☐		
Tocolysis	05 ☐		
Ultrasound	06 ☐		
None	00 ☐		
Other (Specify)	07 ☐		

42. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)

Febrile (>100 °F. or 38 °C.)	01 ☐		
Meconium, moderate/heavy	02 ☐		
Premature rupture of membrane (> 12 hours)	03 ☐		
Abruptio placenta	04 ☐		
Placenta previa	05 ☐		
Other excessive bleeding	06 ☐		
Seizures during labor	07 ☐		
Precipitous labor (< 3 hours)	08 ☐		
Prolonged labor (> 20 hours)	09 ☐		
Dysfunctional labor	10 ☐		
Breech/Malpresentation	11 ☐		
Cephalopelvic disproportion	12 ☐		
Cord prolapse	13 ☐		
Anesthetic complications	14 ☐		
Fetal distress	15 ☐		
None	00 ☐		
Other (Specify)	16 ☐		

43. METHOD OF DELIVERY (Check all that apply)

Vaginal	01 ☐		
Vaginal birth after previous C-section	02 ☐		
Primary C-section	03 ☐		
Repeat C-section	04 ☐		
Forceps	05 ☐		
Vacuum	06 ☐		

44. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

Anemia (HCL < 39/Hgb. < 13)	01 ☐		
Birth injury	02 ☐		
Fetal alcohol syndrome	03 ☐		
Hyaline membrane disease/RDS	04 ☐		
Meconium aspiration syndrome	05 ☐		
Assisted ventilation < 30 min	06 ☐		
Assisted ventilation ≥ 30 min	07 ☐		
Seizures	08 ☐		
None	00 ☐		
Other	09 ☐		

45. CONGENITAL ANOMALIES OF CHILD (Check all that apply)

Anencephalus	01 ☐		
Spina bifida/Meningocele	02 ☐		
Hydrocephalus	03 ☐		
Microcephalus	04 ☐		
Other central nervous system anomalies (Specify)	05 ☐		
Heart malformations (Specify)	06 ☐		
Other circulatory anomalies (Specify)	07 ☐		
Respiratory anomalies (Specify)	08 ☐		
Rectal atresia/stenosis	09 ☐		
Tracheo-esophageal fistula/Esophageal atresia	10 ☐		
Omphalocele/Gastroschisis	11 ☐		
Other gastrointestinal anomalies (Specify)	12 ☐		
Malformed genitalia	13 ☐		
Renal agenesis	14 ☐		
Other urogenital anomalies (Specify)	15 ☐		
Cleft lip/palate	16 ☐		
Polydactyly/Syndactyly/Adactyly	17 ☐		
Club foot	18 ☐		
Diaphragmatic hernia	19 ☐		
Other musculoskeletal/integumental anomalies (Specify)	20 ☐		
Down's syndrome	21 ☐		
Other chromosomal anomalies (Specify)	22 ☐		
None	00 ☐		
Other (Specify)	23 ☐		

46. Has a relative of the baby had a hearing loss that existed since childhood? (Permanent, Hereditary loss)

DHEC 609 1/1/92

SAMPLE

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

REPORT OF FETAL DEATH

STATE FILE NUMBER

SAMPLE

1. FACILITY NAME (If not institution, give street and number)

2. CITY, TOWN, OR LOCATION OF DELIVERY | 3. COUNTY OF DELIVERY | 4. DATE OF DELIVERY (Month, Day, Year) | 5. SEX OF FETUS

PARENTS

6a. MOTHER'S NAME First Middle Last | 6b. MAIDEN SURNAME | 7. DATE OF BIRTH (Month, Day, Year)

8a. RESIDENCE-STATE | 8b. COUNTY | 8c. CITY, TOWN, OR LOCATION | 8d. STREET AND NUMBER

8e. INSIDE CITY LIMITS? Yes ☐ No ☐ | 8f. ZIP CODE | 9. FATHER'S NAME First Middle Last | 10. DATE OF BIRTH (Month, Day, Year)

11. OF HISPANIC ORIGIN?

11a. MOTHER YES ☐ NO ☐	11b. FATHER YES ☐ NO ☐
If yes indicate	If yes indicate
☐ Mexican	☐ Mexican
☐ Cuban	☐ Cuban
☐ Puerto Rican	☐ Puerto Rican
☐ Of Spanish origin not listed.	☐ Of Spanish origin not listed.

12. RACE — American Indian, Black, White, etc. (Specify below)

13. EDUCATION (Specify only highest grade completed)

	Elementary/Secondary (0-12)	College (1 - 4 or 5 +)
12a. MOTHER	13a. MOTHER	
12b. FATHER	13b. FATHER	

14. OCCUPATION AND BUSINESS/INDUSTRY (Worked during last year)

	Occupation	Business/Industry
MOTHER	14a.	14b.
FATHER	14c.	14d.

15. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS		OTHER TERMINATIONS (Spontaneous and induced; any time after conception)
15a. Now Living Number ___ ☐ None	15b. Now Dead Number ___ ☐ None	15d. (Do not include this fetus) Number ___ ☐ None
15c. DATE OF LAST LIVE BIRTH (Month, Year)		15e. DATE OF LAST OTHER TERMINATION (Month, Year)

16. MOTHER MARRIED? (At delivery, conception, or any time between) (Yes or no)

17. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)

18. MONTH OF PRENATAL CARE BEGAN - First, Second, Third, etc. (Specify)

19. PRENATAL VISITS - Total Number (including physician, clinic, Health Department visits) Number ___ None

20. WEIGHT OF FETUS (Specify Unit)

21. CLINICAL ESTIMATE OF GESTATION (Weeks)

22a. PLURALITY - Single, Twin, Triplet, etc. (Specify)

22b. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)

MEDICAL AND HEALTH INFORMATION

23a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

Anemia (Hct. < 30/Hgb. < 10)	01 ☐
Cardiac disease	02 ☐
Acute or chronic lung disease	03 ☐
Diabetes	04 ☐
Genital herpes	05 ☐
Hydramnios/Oligohydramnios	06 ☐
Hemoglobinopathy	07 ☐
Hypertension, chronic	08 ☐
Hypertension, pregnancy-associated	09 ☐
Eclampsia	10 ☐
Incompetent cervix	11 ☐
Previous infant 4000 + grams	12 ☐
Previous preterm or small-for-gestational-age infant	13 ☐
Renal disease	14 ☐
Rh sensitization	15 ☐
Uterine bleeding	16 ☐
None	00 ☐
Other (Specify) ___	17 ☐

23b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items)

Tobacco use during pregnancy ..... Yes ☐ No ☐
Average number cigarettes per day ___
Alcohol use during pregnancy ..... Yes ☐ No ☐
Average number drinks per week ___
Weight gained during pregnancy ___ lbs.

24. OBSTETRIC PROCEDURES (Check all that apply)

Amniocentesis	01 ☐
Electronic fetal monitoring	02 ☐
Induction of labor	03 ☐
Stimulation of labor	04 ☐
Tocolysis	05 ☐
Ultrasound	06 ☐
None	00 ☐
Other (Specify) ___	07 ☐

25. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)

Febrile (>100 °F. or 38 °C.)	01 ☐
Meconium, moderate/heavy	02 ☐
Premature rupture of membrane (> 12 hours)	03 ☐
Abruptio placenta	04 ☐
Placenta previa	05 ☐
Other excessive bleeding	06 ☐
Seizures during labor	07 ☐
Precipitous labor (< 3 hours)	08 ☐
Prolonged labor (> 20 hours)	09 ☐
Dysfunctional labor	10 ☐
Breech/Malpresentation	11 ☐
Cephalopelvic disproportion	12 ☐
Cord prolapse	13 ☐
Anesthetic complications	14 ☐
Fetal distress	15 ☐
None	00 ☐
Other (Specify) ___	16 ☐

26. METHOD OF DELIVERY (Check all that apply)

Vaginal	01 ☐
Vaginal birth after previous C-section	02 ☐
Primary C-section	03 ☐
Repeat C-section	04 ☐
Forceps	05 ☐
Vacuum	06 ☐
Hysterotomy/Hysterectomy	07 ☐

27. CONGENITAL ANOMALIES OF FETUS (Check all that apply)

Anencephalus	01 ☐
Spina bifida/Meningocele	02 ☐
Hydrocephalus	03 ☐
Microcephalus	04 ☐
Other central nervous system anomalies (Specify) ___	05 ☐
Heart malformations (Specify) ___	06 ☐
Other circulatory anomalies (Specify) ___	07 ☐
Respiratory anomalies (Specify) ___	08 ☐
Rectal atresia/stenosis	09 ☐
Tracheo esophageal fistula/Esophageal atresia	10 ☐
Omphalocele/Gastroschisis	11 ☐
Other gastrointestinal anomalies (Specify) ___	12 ☐
Malformed genitalia	13 ☐
Renal agenesis	14 ☐
Other urogenital anomalies (Specify) ___	15 ☐
Cleft lip/palate	16 ☐
Polydactyly/Syndactyly/Adactyly	17 ☐
Club foot	18 ☐
Diaphragmatic hernia	19 ☐
Other musculoskeletal/integumental anomalies (Specify) ___	20 ☐
Down's syndrome	21 ☐
Other chromosomal anomalies (Specify) ___	22 ☐
None	00 ☐
Other (Specify) ___	23 ☐

CAUSE OF FETAL DEATH

28. Enter only one cause per line for a, b, and c.

PART I. Fetal or maternal condition directly causing fetal death.
a. IMMEDIATE CAUSE — Specify Fetal or Maternal
DUE TO (OR AS A CONSEQUENCE OF):
Fetal and/or maternal conditions, if any, giving rise to the immediate cause(s), stating the underlying cause last.
b. — Specify Fetal or Maternal
DUE TO (OR AS A CONSEQUENCE OF):
c. — Specify Fetal or Maternal

PART II. Other significant conditions of fetus or mother contributing to fetal death but not resulting in the underlying cause given in Part I.

29. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY UNKNOWN (Specify)

30. AUTOPSY (Specify Yes or No)

31. ATTENDANT'S NAME AND TITLE (Type/Print)
Name
☐ M.D. ☐ C.N.M.
☐ Other (Specify)

32. NAME AND TITLE OF PERSON COMPLETING REPORT (Type/Print)
Name
Title

33. DATE REPORT COMPLETED

34. DATE RECEIVED BY HEALTH DEPARTMENT

DHEC 665
Rev. 1989

LICENSE AND CERTIFICATE FOR MARRIAGE
STATE OF SOUTH CAROLINA

LICENSE NUMBER _____ COUNTY _____

GROOM—NAME (FIRST) (MIDDLE) (LAST)
(1)

BIRTHDATE (MONTH, DAY, YEAR) (2a) | AGE (2b)

BIRTHPLACE (State or foreign country) (3) | RACE (4) | RESIDENCE (Street and Number) (5a)

CITY, TOWN OR LOCATION (5b) | COUNTY (5c) | STATE (5d) | NO. OF THIS MARRIAGE (1st, 2nd, etc.) (6)

BRIDE—NAME (FIRST) (MIDDLE) (LAST)
(7)

BIRTHDATE (MONTH, DAY, YEAR) (8a) | AGE (8b)

BIRTHPLACE (State or foreign country) (9) | RACE (10) | RESIDENCE (Street and Number) (11a)

CITY, TOWN OR LOCATION (11b) | COUNTY (11c) | STATE (11d) | NO. OF THIS MARRIAGE (1st, 2nd, etc.) (12)

MAIDEN NAME OF BRIDE (If Different From Above)
(13)

Application for a license was filed with this court at _____ M., on the _____ day of _____, 19__. These are, therefore, to authorize any person qualified to perform marriage ceremonies to perform the marriage ceremony for the persons above named, and for the so doing this shall be sufficient warrant. Given under my hand and seal at _____ M., this the _____ day of _____, A.D. 19__.

_____ Signature of Issuing Officer

_____ Title of Issuing Officer

GROOM—Signature
(14)

BRIDE—Signature
(15)

I certify that the above named persons were married on
(16) (MONTH) (DAY) (YEAR)

Place of Marriage
(17) (CITY) (COUNTY) SOUTH CAROLINA

OFFICIANT—Signature
(18a)

OFFICIANT—Title
(18b)

OFFICIANT—Mailing Address
(18c)

SAMPLE

DHEC 681 REV. 12-87

BRIDE/GROOM COPY

SCDHEC—682—Rev. 4-1979 15M

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

OFFICE OF VITAL RECORDS AND PUBLIC HEALTH STATISTICS

Columbia, South Carolina

REPORT OF DIVORCE OR ANNULMENT OF MARRIAGE

State File No.

ATTORNEY FOR PLAINTIFF

ADDRESS

1 HUSBAND—NAME (first) (middle) (last)	2 DATE OF BIRTH	3 STATE OF BIRTH
4 RESIDENCE (state) (county) (city)	5 NUMBER OF THIS MARRIAGE	6 RACE OR COLOR (specify)
7 WIFE—MAIDEN NAME (first) (middle) (last)	8 DATE OF BIRTH	9 STATE OF BIRTH
10 RESIDENCE (state) (county) (city)	11 NUMBER OF THIS MARRIAGE	12 RACE OR COLOR (specify)
13 PLACE OF THIS MARRIAGE (state) (county)	14 DATE OF MARRIAGE (month) (day) (year)	15 NUMBER OF CHILDREN UNDER 18
16 PLAINTIFF (specify) / 17 DECREE GRANTED TO (specify)	18 WAS DIVORCE CONTESTED (specify yes or no)	19 LEGAL GROUNDS
20 DATE DECREE SIGNED (month) (day) (year)	21 TYPE OF DECREE absolute divorce or annulment (specify)	
22a MAIDEN NAME RESUMED BY DECREE Yes ☐ No ☐	22b SUPPLEMENTAL ORDER (if any) (month-day-year)	
23 COUNTY	24 DOCKET NUMBER	
25 I CERTIFY THAT THE ABOVE IS CORRECT ACCORDING TO THE RECORDS OF THIS COURT FILED ON: signature of clerk of court — month day year		

AUTHORITY FOR THIS REPORT IS FOUND IN SECTION 20-3-230 CODE OF LAWS OF SOUTH CAROLINA

INSTRUCTIONS: To the Clerk of Court: When a petition for divorce or annulment is filed, please hand a copy of this form to the attorney for completion of items No. 1 through No. 19. When the decree is signed, check completeness of these items, execute the bottom section and mail to South Carolina Department of Health and Environmental Control, Office of Vital Records and Public Health Statistics, Columbia, South Carolina, on or before the 10th of the month next succeeding the divorce or annulment.

To the Attorney: Please complete items No. 1 through No. 19 of the Report of Divorce of Annulment of Marriage and ask your client to verify the information. WHEN THE DECREE IS SIGNED, RETURN THE FORM TO THE CLERK OF COURT FOR CERTIFICATION.

South Carolina DHEC
Department of Health and Environmental Control

REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

1. FACILITY NAME *(If not clinic or hospital, give address)*

2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION

3. COUNTY OF PREGNANCY TERMINATION

4. PATIENT IDENTIFICATION NUMBER (Do Not Enter Patient's Name)

5. AGE LAST BIRTHDAY

6. MARRIED? ☐ YES ☐ NO

7. DATE OF PREGNANCY TERMINATION *(Month, Day, Year)*

8a. RESIDENCE-STATE

8b. COUNTY

8c. CITY, TOWN, OR LOCATION

8d. INSIDE CITY LIMITS? ☐ YES ☐ NO

8e. ZIP CODE

9. OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☐ No
Specify:

10. RACE
☐ American Indian
☐ Black
☐ White
☐ Other *(Specify)*

11. EDUCATION *(Specify only highest grade completed)*

Elementary/Secondary (0 - 12)	College (1 - 4 or 5+)

SAMPLE

12. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

13. DATE OF CONCEPTION *(Month, Day, Year)*

14. CLINICAL ESTIMATE OF GESTATION *(Weeks)*

15. PREVIOUS PREGNANCIES *(Complete each section)*

LIVE BIRTHS		OTHER TERMINATIONS	
15a. Now Living	15b. Now Dead	15c. Spontaneous	15d. Induced *(Do not include this termination)*
Number ____ ☐ None	Number ____ ☐ None	Number ____ ☐ None	Number ____ ☐ None

16. TERMINATION PROCEDURES

16a. PROCEDURE THAT TERMINATED PREGNANCY *(Check only one)*

TYPE OF TERMINATION PROCEDURES

16b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY *(Check all that apply)*

1 ☐	Suction Curettage	☐ 1
2 ☐	Sharp Curettage	☐ 2
3 ☐	Dilation and Evacuation (D & E)	☐ 3
4 ☐	Intra-Uterine Saline Instillation	☐ 4
5 ☐	Intra-Uterine Prostaglandin Instillation	☐ 5
6 ☐	Hysterotomy	☐ 6
7 ☐	Hysterectomy	☐ 7
8 ☐	Other (Specify) _____	☐ 8
	None	☐ 0

17 - 18 CONSENT REQUIREMENTS
(Pursuant to Chapter 41, Title 44, of the Code of Laws of South Carolina, 1976, as amended)

17a. WAS INFORMED WRITTEN CONSENT OBTAINED FROM THE PATIENT? ☐ Yes ☐ No

17b. IF NO, INFORMED WRITTEN CONSENT WAS NOT OBTAINED DUE TO: *(check one)*
1 ☐ MEDICAL EMERGENCY
2 ☐ INCEST
3 ☐ NOT CAPABLE/MENTALLY INCOMPETENT
4 ☐ NONE OF THE ABOVE

17c. IF PATIENT HAS BEEN COURT ADJUDGED MENTALLY INCOMPETENT, INFORMED WRITTEN CONSENT OBTAINED FROM: *(check one)*
1 ☐ SPOUSE
2 ☐ PARENT
3 ☐ LEGAL GUARDIAN
4 ☐ NONE OF THE ABOVE

18a. IF PATIENT IS UNDER 17 YEARS OF AGE, ADDITIONAL INFORMED WRITTEN CONSENT OBTAINED FROM: *(check one)*
1 ☐ PARENT
2 ☐ LEGAL GUARDIAN
3 ☐ GRANDPARENT
4 ☐ PERSON IN LOCO PARENTIS
5 ☐ NONE OF THE ABOVE

18b. IF PATIENT IS UNDER 17 YEARS OF AGE AND ADDITIONAL INFORMED WRITTEN CONSENT WAS NOT OBTAINED, CHECK REASON BELOW: *(check one)*
1 ☐ EMANCIPATED MINOR
2 ☐ COURT ORDER
3 ☐ MEDICAL EMERGENCY
4 ☐ INCEST
5 ☐ NONE OF THE ABOVE

19. NAME OF PERSON COMPLETING FORM *(Type/Print)* TITLE

20. DATE REPORT COMPLETED (Month, Day, Year)

FOR STATE OFFICE USE ONLY
21. DATE REPORT RECEIVED

17 MUST COMPLETED EACH ENT, ARDLESS OF

18 MUST OMPLETED EACH ENT UNDER 17 S OF AGE.

EC 672 (3/95)

COMPARABLE CATEGORY NUMBERS AND *ESTIMATED* COMPARABILITY RATIOS FOR 72 SELECTED CAUSES OF DEATH ACCORDING TO THE NINTH AND EIGHTH REVISIONS

Cause of death according to the Ninth Revision of the International Classification of Disease, 1975	Category Numbers According to:		Estimated comparability ratio[1]	Standard Error of the Estimate in Column (3)	95 Percent confidence limits[2]	
	ICD-9 Revision (1)	ICDA-8 Revision (2)	(3)	(4)	Upper (5)	Lower (6)
Shigellosis and amebiasis	004,006	004,006	0.9818	0.0378	1.0559	0.9077
Certain other intestinal infections	007-009	008,009	0.1821	0.0207	0.2227	0.1415
Tuberculosis	010-018	010-019	0.7668	0.0119	0.7901	0.7435
Tuberculosis of respiratory system	010-012	010-012	0.8429	0.0146	0.8715	0.8143
Other tuberculosis	013-018	013-019	0.5077	0.0167	0.5404	0.4750
Whooping cough	033	033	0.8571	0.0000	0.8571	0.8571
Streptococcal sore throat, scarlatina, and erysipelas	034-035	034	1.4286	0.0000	1.4286	1.4286
Meningococcal infection	036	036	0.9788	0.0124	1.0030	0.9546
Septicemia	038	038	0.8500	0.0180	0.8853	0.8147
Acute poliomyelitis	045	040-043	0.5000	0.0000	0.5000	0.5000
Measles	055	055	0.9167	0.0000	0.9167	0.9167
Viral hepatitis	070	070	1.3986	0.0820	1.5593	1.2379
Syphilis	090-097	090-097	1.0089	0.0259	1.0596	0.9582
All other infectious and parasitic diseases	001-003,005,020-032, 037,039-041,046-054, 056-066,071-088,098-139	Remainder of 000-136	1.0321	0.0634	1.1563	0.9079
Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	140-208	140-209	1.0026	0.0017	1.0059	0.9993
Malignant neoplasms of lip, oral cavity, and pharynx	140-149	140-149	1.0117	0.0087	1.0286	0.9948
Malignant neoplasms of digestive organs and peritoneum	150-159	150-159	1.0330	0.0035	1.0398	1.0262
Malignant neoplasms of respiratory and intrathoracic organs	160-165	160-163	1.0007	0.0033	1.0071	0.9943
Malignant neoplasm of breast	174-175	174	1.0089	0.0022	1.0131	1.0047
Malignant neoplasms of genital organs	179-187	180-187	1.0111	0.0031	1.0171	1.0051
Malignant neoplasms of urinary organs	188-189	188,189	0.9924	0.0045	1.0011	0.9837
Malignant neoplasms of all other and unspecified sites	170-173,190-199	170-173,190-199	0.9557	0.0082	0.9718	0.9396
Leukemia	204-208	204-207	1.0070	0.0056	1.0180	0.9960
Other malignant neoplasms of lymphatic and hematopoietic tissues	200-203	200-203,208,209	0.9385	0.0069	0.9519	0.9251
Benign neoplasms, carcinoma in situ, and neoplasms of uncertain behavior and of unspecified nature	210-239	210-239	1.2085	0.0261	1.2595	1.1575
Diabetes mellitus	250	250	0.9991	0.0087	1.0162	0.9820
Nutritional deficiencies	260-269	260-269	0.7167	0.0262	0.7680	0.6654
Anemias	280-285	280-285	0.9296	0.0124	0.9538	0.9054
Meningitis	320-322	320	0.9459	0.0163	0.9777	0.9141
Major cardiovascular diseases	390-448	390-448	1.0069	0.0004	1.0076	1.0062
Diseases of heart	390-398,402,404-429	390-398,402,404, 410-429	1.0126	0.0039	1.0202	1.0050
Rheumatic fever and rheumatic heart disease	390-398	390-398	0.6648	0.0080	0.6804	0.6492
Hypertensive heart disease	402	402	3.3022	0.0557	3.4114	3.1930
Hypertensive heart and renal disease	404	404	1.2119	0.0438	1.2978	1.1260
Ischemic heart disease	410-414	410-413	0.8784	0.0038	0.8859	0.8709
Acute myocardial infarction	410	410	1.0003	0.0054	1.0108	0.9898
Other acute and subacute forms of ischemic heart disease	411	411	1.2224	0.0661	1.3519	1.0929
Angina pectoris	413	413	1.0484	0.0666	1.1789	0.9179
Old myocardial infarction and other forms of chronic ischemic heart disease	412,414	412	0.7533	0.0055	0.7640	0.7426
Other diseases of endocardium	424	424,428	1.2286	0.0227	1.2731	1.1841
All other forms of heart disease	415-423,425-429	420-423,425-427,429	2.5035	0.0257	2.5539	2.4531
Hypertension with or without renal disease	401,403	400,401,403	1.2703	0.0294	1.3280	1.2126
Cerebrovascular diseases	430-438	430-438	1.0049	0.0066	1.0178	0.9920
Intracerebral and other intracranial hemorrhage	431-432	431	0.9969	0.0068	1.0102	0.9836
Cerebral thrombosis and unspecified occlusion of cerebral arteries	434.0,434.9	433	1.0340	0.0222	1.0774	0.9906
Cerebral embolism	434.1	434	1.1211	0.0924	1.3022	0.9400
All other and late effects of cerebrovascular diseases	430,433,435-438	430,432,435-438	0.9948	0.0061	1.0067	0.9829
Atherosclerosis	440	440	1.0649	0.0246	1.1130	1.0168
Other diseases of arteries, arterioles, and capillaries	441-448	441-448	0.7409	0.0098	0.7600	0.7218

COMPARABLE CATEGORY NUMBERS AND *ESTIMATED* COMPARABILITY RATIOS FOR 72 SELECTED CAUSES OF DEATH ACCORDING TO THE NINTH AND EIGHTH REVISIONS

Cause of death according to the Ninth Revision of the International Classification of Disease, 1975	Category Numbers According to:		Estimated comparability ratio[1]	Standard Error of the Estimate in Column (3)	95 Percent confidence limits[2]	
	ICD-9 Revision (1)	ICDA-8 Revision (2)	(3)	(4)	Upper (5)	Lower (6)
Acute bronchitis and bronchiolitis	466	466	0.8888	0.0274	0.9425	0.8351
Pneumonia and influenza	480-487	470-474,480-486	0.9264	0.0067	0.9394	0.9134
Pneumonia	480-486	480-486	0.9199	0.0076	0.9347	0.9051
Influenza	487	470-474	0.9714	0.0078	0.9866	0.9562
Chronic obstructive pulmonary diseases and allied conditions	490-496	490-493	1.8846	0.0150	1.9141	1.8551
Bronchitis, chronic and unspecified	490-491	490-491	0.9383	0.0134	0.9646	0.9120
Emphysema	492	492	0.9770	0.0127	1.0018	0.9522
Asthma	493	493	1.3544	0.0636	1.4790	1.2298
Other chronic obstructive pulmonary diseases and allied conditions	494-496	[2] ...	[3] ...	[3] ...	[3] ...	[3] ...
Ulcer of stomach and duodenum	531-533	531-533	1.1192	0.0247	1.1675	1.0709
Appendicitis	540-543	540-543	1.0080	0.0264	1.0597	0.9563
Hernia of abdominal cavity and intestinal obstruction without mention of hernia	550-553,560	550-553,560	0.9432	0.0169	0.9762	0.9102
Chronic liver disease and cirrhosis	571	571	1.0110	0.0069	1.0245	0.9975
Cholelithiasis and other disorders of gallbladder	574-575	574,575	1.0494	0.0445	1.1366	0.9622
Nephritis, nephrotic syndrome, and nephrosis	580-589	580-584	1.7397	0.0777	1.8920	1.5874
Acute glomerulonephritis and nephrotic syndrome	580-581	580,581	0.2422	0.0185	0.2783	0.2061
Chronic glomerulonephritis, nephritis and nephropathy, not specified as acute or chronic, and renal sclerosis, unspecified	582-583,587	582-584	0.4954	0.0195	0.5335	0.4573
Renal failure, disorders resulting from impaired renal function, and small kidney of unknown cause	584-586,588-589	582-584	1.6327	0.0958	1.8205	1.4449
Infections of kidney	590	590	0.9878	0.0091	1.0056	0.9700
Hyperplasia of prostate	600	600	1.0232	0.0226	1.0674	0.9790
Complications of pregnancy, childbirth, and the puerperium	630-676	630-678	1.1000	0.0435	1.1853	1.0147
Pregnancy with abortive outcome	630-638	640-645	3.8125	0.0000	3.8125	3.8125
Other complications of pregnancy, childbirth and the puerperium	640-676	630-639,650-678	0.9840	0.0454	1.0729	0.8951
Congenital anomalies	740-759	740-759	0.9984	0.0100	1.0179	0.9789
Certain conditions originating in the perinatal period	760-779	760-769.2,769.4-772, 774-778	1.0765	0.0238	1.1230	1.0300
Birth trauma, intrauterine hypoxia, birth asphyxia, and respiratory distress syndrome	767-769	764-768,772,776	0.7483	0.0306	0.8083	0.6883
Other conditions originating in the perinatal period	760-766,770-779	Remainder of 760-778	1.4639	0.0371	1.5367	1.3911
Symptoms, signs, and ill-defined conditions	780-799	780-796	0.9102	0.0121	0.9338	0.8866
All other diseases	Residual	Residual	0.7786	0.0082	0.7947	0.7625
Accidents and adverse effects	E800-E949	E800-E949	0.9970	0.0030	1.0029	0.9911
Motor vehicle accidents	E810-E825	E810-E823	1.0117	0.0027	1.0169	1.0065
All other accidents and adverse effects	E800-E807,E826-E949	E800-E807,E825-E949	0.9841	0.0051	0.9941	0.9741
Suicide	E950-E959	E950-E959	1.0032	0.0042	1.0114	0.9950
Homicide and legal intervention	E960-E978	E960-E978	1.0057	0.0030	1.0115	0.9999
All other external causes	E980-E999	E980-E999	0.9675	0.0144	0.9957	0.9393

COMPARABLE CATEGORY NUMBERS AND *ESTIMATED* COMPARABILITY RATIOS FOR 10 SELECTED CAUSES OF INFANT DEATHS ACCORDING TO THE NINTH AND EIGHTH REVISIONS

Cause of death according to the Ninth Revision of the International Classification of Disease, 1975	Category Numbers According to:		Estimated comparability ratio[1]	Standard Error of the Estimate in Column (3)	95 Percent confidence limits[2]	
	ICD-9 Revision (1)	ICDA-8 Revision (2)	(3)	(4)	Upper (5)	Lower (6)
All causes	....	....	1.0000	....	....	....
Certain gastrointestinal diseases	008-009,535,555-558	004,006-009,535, 561,563	0.4678	0.0228	0.5125	0.4231
Pneumonia and influenza	480-487	470-474,480-486	0.7471	0.0200	0.7862	0.7078
Congenital anomalies	740-759	740-759	1.0071	0.0062	1.0191	0.9949
Disorders relating to short gestation and unspecified low birthweight	765	777	0.9630	0.0107	0.9839	0.9421
Birth trauma	767	764-768(.0-.3),772	0.7154	0.0337	0.7813	0.6493
Intrauterine hypoxia and birth asphyxia	768	776.9	0.3270	0.0212	0.3684	0.2856
Respiratory distress syndrome	769	...	...	...	...	...
Other conditions originating in the perinatal period	760-764,766,770-779	Remainder of 760-778	0.8492	0.0098	0.8683	0.8301
Sudden infant death syndrome	798.0	...	...	...	...	...
All other causes	Residual	Residual	0.5455	0.0061	0.5573	0.5335

[1]Ratio of deaths assigned according to the Ninth Revision to deaths assigned according to the Eighth Revision.

[2]The probability is 95 percent that the true comparability ratio will have a value between the upper and lower limits shown. These limits were computed before the standard error was rounded to the fourth decimal.

[3]Chronic obstructive lung disease without mention of asthma, bronchitis, or emphysema (No. *519.3), introduced by NCHS to be used with the Eighth Revision, is comparable to Other chronic obstructive pulmonary diseases and allied conditions (ICD Nos. 494-496) of the Ninth Revision. The comparability ratio for this set of titles is 1.0054, with a standard error of 0.0118, a relative error of 1.2 percent, and 95 percent confidence limits of 1.0285 and 0.9823. These data are not shown in this table because there are no sample data for *519.3.

Source: *MONTHLY VITAL STATISTICS REPORT*, National Center for Health Statistics, DHEW Publication No. (PHS) 80-1120, Vol. 28, No. 11 Supplement, February 29, 1980, pp. 3-4, 12-13.