

SOURCES OF DATA

Death and fetal-death statistics

Mortality statistics for 1989 are, as for all previous years except 1972, based on information from records of all deaths occurring in the United States. Fetal-death statistics for every year are based on all reports of fetal death received by the National Center for Health Statistics (NCHS).

The death-registration system and the fetal-death reporting system of the United States encompass the 50 States, the District of Columbia, New York City (which is independent of New York State for the purpose of death registration), Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands. In the statistical tabulations of this publication, United States refers only to the aggregate of the 50 States (including New York City) and the District of Columbia. Tabulations for Guam, Puerto Rico, and the Virgin Islands are shown separately in this volume. No data have ever been included for American Samoa or the Trust Territory of the Pacific Islands.

The Virgin Islands was admitted to the registration area for deaths in 1924; Puerto Rico, in 1932; and Guam, in 1970. Tabulations of death statistics for Puerto Rico and the Virgin Islands were shown regularly in the annual volumes of Vital Statistics of the United States from the year of their admission through 1971 except for the years 1967 through 1969, and tabulations for Guam were included for 1970 and 1971. Death statistics for Puerto Rico, the Virgin Islands, and Guam were not included in the 1972 volume but have been included in section 8 of the volumes for each of the years 1973-78 and in section 9 beginning with 1979. Information for 1972 for these three areas was published in the respective annual vital statistics reports of the Department of Health of the Commonwealth of Puerto Rico, the Department of Health of the Virgin Islands, and the Department of Public Health and Social Services of the Government of Guam.

Procedures used by NCHS to collect death statistics have changed over the years. Before 1971, tabulations of deaths and fetal deaths were based solely on information obtained by NCHS from copies of the original certificates. The information from these copies was edited, coded, and tabulated. For 1960-70, all mortality information taken from these records was transferred by NCHS to magnetic tape for computer processing.

Beginning with 1971, an increasing number of States provided NCHS, with computer tapes of data coded according to NCHS specifications and provided to NCHS through the Vital Statistics Cooperative Program. The year State-coded demographic data were first transmitted on computer tape to NCHS is shown below for each of the States, New York City, Puerto Rico, and the District of Columbia, all of which now furnish demographic or nonmedical data on tape.

1971	Florida	1977	Alaska Idaho Massachusetts New York City Ohio Puerto Rico
1972	Maine Missouri New Hampshire Rhode Island Vermont	1978	Indiana Utah Washington
1973	Colorado Michigan New York (except) New York City)	1979	Connecticut Hawaii Mississippi New Jersey Pennsylvania Wyoming
1974	Illinois Iowa Kansas Montana Nebraska Oregon South Carolina	1980	Arkansas New Mexico South Dakota
1975	Louisiana Maryland North Carolina Oklahoma Tennessee Virginia Wisconsin	1982	North Dakota
1976	Alabama Kentucky Minnesota Nevada Texas West Virginia	1985	Arizona California Delaware Georgia District of Columbia

For the Virgin Islands and Guam, mortality statistics for 1989 are based on information obtained directly by NCHS from copies of the original certificates received from the registration offices.

In 1974 States began coding medical (cause-of-death) data on computer tapes according to NCHS specifications. The year State-coded medical data were first transmitted to NCHS is shown below for the 30 States now furnishing such data. For 1989 Georgia, Indiana, Maine, and Wisconsin submitted precoded medical data on computer tape for part of the year. NCHS contracted with Colorado, Kansas, and Mississippi to precode medical data for all deaths on computer tape for the five States added in 1988. Vermont subcontracted with Pennsylvania to code its medical data.

1974	Iowa Michigan	1984	Maryland New York State (except New York City) Vermont
1975	Louisiana Nebraska North Carolina Virginia Wisconsin	1986	California Florida Texas
1980	Colorado Kansas Massachusetts Mississippi New Hampshire Pennsylvania South Carolina	1988	Alaska Delaware Idaho North Dakota Wyoming
1981	Maine	1989	Georgia Indiana Washington
1983	Minnesota		

For 1989 and previous years except 1972, NCHS coded the medical information from copies of the original certificates received from the registration offices for all deaths occurring in those States that were not furnishing NCHS medical data coded according to NCHS specifications. In addition, Georgia, Indiana, Maine, and Wisconsin submitted copies of the original certificates from which NCHS coded the medical data for part of the year. For 1981 and 1982, these procedures were modified because of a coding and processing backlog resulting from personnel and budgetary restrictions. To produce the mortality files on a timely basis with reduced resources, NCHS used State-coded underlying cause-of-death information supplied by 19 States for 50 percent of the records; for the other 50 percent of the records for these States as well as for 100 percent of the records for the remaining 21 registration areas, NCHS coded the medical information. Mortality statistics for 1972 were based on information obtained from a 50-percent sample of death records instead of from all records as in other years. Sampling variation associated with the 50-percent sample is described below in the section "Estimates of errors arising from 50-percent sample for 1972."

Fetal-death data are obtained directly from copies of original reports of fetal deaths received by NCHS from State registration offices, except registration offices in New York State (excluding New York City), which submitted State-coded data in 1989. Fetal-death data are not published by NCHS for the Virgin Islands and Guam.

Standard certificates and reports

For many years, the U.S. Standard Certificate of Death and the U.S. Standard Report of Fetal Death, issued by the Public Health Service, have been used as the principle means to attain uniformity in the contents of documents used to collect information on these events. They have been modified in each State to the extent required by the particular needs of the State or by special provisions of the State vital statistics law. However, the certificates or reports of most States conform closely in content and arrangement to the standards.

The first issue of the U.S. Standard Certificate of Death appeared in 1900. Since then, it has been revised periodically by the national vital statistics agency through consultation with State health officers and registrars; Federal agencies concerned with vital statistics; national, State, and county medical societies; and others working in such fields as public health, social welfare, demography, and insurance. This revision procedure has ensured careful evaluation of each item in terms of its current and future usefulness for legal, medical and health, demographic, and research purposes. New items have been added when necessary, and old items have been modified to ensure better reporting; or in some cases, items have been dropped when their usefulness appeared to be limited.

New revisions of the U.S. Standard Certificate of Death and the U.S. Standard Report of Fetal Death were recommended for State use beginning January 1, 1989. The U.S. Standard Certificate of Death and the U.S. Standard Report of Fetal Death are shown in figures 7-A and 7-B (1).

Among the major changes made were the addition of a new item on educational attainment and changes to improve the medical certification of cause of death. Additional lines to report causes of death were added as well as more complete instructions with examples for properly completing the cause of death. Also, for the first time, the U.S. Standard Certificate of Death includes a question about the Hispanic origin of the decedent. A number of States had included an Hispanic-origin identifier on their certificates, resulting in data shown in this volume for years before 1989. To obtain information on type of place of death, the format of the item was changed from an open-ended question to a checkbox.

HISTORY

The first death statistics published by the Federal Government concerned events in 1850 and were based on statistics collected during the decennial census of that year. In 1880 a national "registration area" was created for recording deaths. Originally consisting of two States (Massachusetts and New Jersey), the District of Columbia, and several large cities having efficient systems for death registrations, the death-registration area continued to expand until 1933, when, for the first time, it included the entire United States. Tables showing data for death-registration States include the District of Columbia for all years; registration cities in nonregistration States are not included. For more details on the history of the death-registration area, see the Technical Appendix in Vital Statistics of the United States, 1979, Volume II, Mortality, Part A, section 7, pages 3 and 4, and the section "History and Organization of the Vital Statistics System," chapter 1, Vital Statistics of the United States, 1950, Volume I, pages 2-19. Statistics on fetal deaths were first published for the birth-registration area in 1918 and then annually beginning in 1922.

CLASSIFICATION OF DATA

The principal value of vital statistics data is realized through the presentation of rates, which are computed by relating the vital events of a class to the population of a similarly defined class. Vital statistics and population statistics must therefore be classified according to similarly defined systems and tabulated in comparable groups. Even when the variables common to both, such as geographic area, age, sex, and race, have been similarly classified and tabulated, differences between the enumeration method of obtaining population data and the registration method of obtaining vital statistics data may result in significant discrepancies.

The general rules used in the classification of geographic and personal items for deaths and fetal deaths for 1989 appear in two NCHS instruction manuals (2,3). A discussion of the classification of certain important items is presented below.

Classification by occurrence and residence

Tabulations for the United States and specified geographic areas in this volume are classified by place of residence unless stated as by place of occurrence. Before 1970, resident mortality statistics for the United States included all deaths occurring in the United States with deaths of "nonresidents of the United States" assigned to place of death. "Deaths of nonresidents of the United States" refers to deaths that occur in the United States to nonresident aliens; nationals residing abroad; and residents of Puerto Rico, the Virgin Islands, Guam, and other territories of the United States. Beginning with 1970, "deaths of nonresidents of the United States" are not included in tables by place of residence.

Tables by place of occurrence, on the other hand, include deaths of residents and nonresidents of the United States. Consequently, for each year beginning with 1970, the total number of deaths in the United States by place of occurrence was somewhat greater than the total by place of residence. For 1989 this difference amounted to 3,393 deaths. Mortality statistics by place of occurrence are shown in tables 1-11, 1-19, 1-20, 1-30, 1-31, 1-32, 3-1, 3-6, 8-1, and 8-7.

Before 1970, except in 1964 and 1965, deaths of nonresidents of the United States occurring in the United States were treated as deaths of residents of the exact places of occurrence, which in most instances were urban areas. In 1964 and 1965 deaths of nonresidents of the United States occurring in the United States were allocated as deaths of residents of the balance of the county in which they occurred.

Residence error—Results of a 1960 study showed the classification of residence information on the death certificates corresponded closely to the residence classification of the census records for the decedents whose records were matched (4).

A comparison of the results of this study of deaths with those for a previous matched record study of births (5) showed the quality of residence data had improved considerably between 1950 and 1960. Both studies found that events in urban areas were overstated by the NCHS classification in comparison with the U.S. Bureau of the Census classification. The magnitude of the difference was substantially less for deaths in 1960 than it was for births in 1950.

The improvement is attributed to an item added in 1956 to the U.S. Standard Certificates of Birth and of Death, asking whether residence was inside or outside city limits. This new item aided in properly allocating the residence of persons living near cities but outside the corporate limits.

Geographic classification

The rules followed in the classification of geographic areas for deaths and fetal deaths are contained in the two instruction manuals referred to previously (2,3). The geographic codes assigned by the NCHS during data reduction of source information on birth, death, and fetal-death records are given in another instruction manual (6). Beginning with 1982 data, the geographic codes were modified to reflect results of the 1980 census. For 1970-81, codes are based on results of the 1970 census.

Standard metropolitan statistical areas—The standard metropolitan statistical areas (SMSA's) used in this volume are those established by the U.S. Office of Management and Budget (7) from final 1980 census population counts and used by the U.S. Bureau of the Census, except in the New England States.

An SMSA is a county or a group of contiguous counties containing a city of 50,000 inhabitants or more or an urbanized area of 50,000 with a total metropolitan population of at least 100,000, except in the New England States. In addition to the county or counties containing such a city or urbanized area, contiguous counties are included in an SMSA if, according to specified criteria, they are essentially metropolitan in character and are socially and economically integrated with the central city or urbanized area (8).

In the New England States, the U.S. Office of Management and Budget uses towns and cities rather than counties as geographic components of SMSA's. However, NCHS cannot use the SMSA classification for these States because its data are not coded to identify all towns. Instead, NCHS uses New England County Metropolitan Areas (NECMA's). Made up of county units, these areas are established by the U.S. Office of Management and Budget (8,9).

Metropolitan and nonmetropolitan counties—Independent cities and counties included in SMSA's or in NECMA's are included in data for metropolitan counties; all other counties are classified as nonmetropolitan.

Population-size groups—In 1989 vital statistics data for cities and certain other urban places were classified according to the population enumerated in the 1980 Census of Population. Specific data are available for each city or urban place with 10,000 or more population. Data for the remaining areas not separately identified are shown in the tables under the heading "balance of area" or "balance of county." For the years 1970-81, classification of areas was determined by the population enumerated in the 1970 Census of Population. Beginning with 1982 data, some urban places identified in previous reports were deleted and others were added because of changes occurring in the enumerated population between 1970 and 1980.

Urban places other than incorporated cities for which vital statistics data are shown in this volume include the following:

- Each town in the New England States, New York, and Wisconsin and each township in Michigan, New Jersey, and Pennsylvania that had no incorporated municipality as a subdivision and had either 25,000 inhabitants or more, or a population of 10,000 to 25,000 and a density of 1,000 persons or more per square mile.
- Each county in States other than those indicated above that had no incorporated municipality within its boundary and had a density of 1,000 persons or more per square mile. (Arlington County, Virginia, is the only county classified as urban under this rule.)
- Each place in Hawaii with a population of 10,000 or more, as there are no incorporated cities in the State.

Before 1964, places were classified as "urban" or "rural." The Technical Appendixes for earlier years discuss the previous classification system.

State or country of birth

Mortality statistics by State or country of birth (table 1-36) became available beginning with 1979. State or country of birth of a decedent is assigned to 1 of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam—if specified on the death certificate. The place of birth also is tabulated for Canada, Cuba, Mexico, and for the Remainder of the World. Deaths for which information on State or country of birth was unknown, not stated, or not classifiable accounted for a small proportion, about 1.2 percent, of all deaths in 1989.

Early mortality reports published by the U.S. Bureau of the Census contained tables showing nativity of parents as well as nativity of decedent. Publication of these tables was discontinued in 1933. Mortality data showing nativity of decedent were published again in annual reports for 1939-41 and for 1950.

Age

The age recorded on the death record is the age at last birthday. With respect to the computation of death rates, the age classification used by the U.S. Bureau of the Census is based also on the age of the person in completed years.

For computation of age-specific and age-adjusted death rates, deaths with age not stated are excluded. For life table computation, deaths with age not stated are distributed proportionately.

Race

For vital statistics in the United States for 1989, deaths are classified by race—white, black, American Indian, Chinese, Hawaiian, Japanese, Filipino, Other Asian or Pacific Islander, and Other. Mortality data for Filipino and Other Asian or Pacific Islander were shown for the first time in 1979.

The white category includes, in addition to persons reported as white, those reported as Mexican, Puerto Rican, Cuban, and all other Caucasians. The American Indian category includes American, Alaskan, Canadian, Mexican, Eskimo, and Aleut. If the racial entry on the death certificate indicates a mixture of Hawaiian and any other race, the entry is coded to Hawaiian. If the race is given as a mixture of white and any other race, the entry is coded to the appropriate nonwhite race. If a mixture of races other than white is given (except Hawaiian), the entry is coded to the first race listed. This procedure for coding the first race listed has been used since 1969. Before 1969, if the entry for race was a mixture of black and any other race except Hawaiian, the entry was coded to black.

Most of the tables in this volume, however, do not show data for this detailed classification by race. In all the tables, the divisions are white, all other (including black), and black separately.

Race not stated—For 1989 the number of death records for which race was unknown, not stated, or not classifiable was 4,499, or 0.2 percent of the total deaths. Death records with race entry not stated are assigned to a racial designation as follows: If the preceding record is coded white, the code assignment is made to white; if the code is other than white, the assignment is made to black. Before 1964 all records with race not stated were assigned to white except records of residents of New Jersey for 1962-64.

New Jersey, 1962-64—New Jersey omitted the race item from its certificates of live birth, death, and fetal death used in the beginning of 1962. The item was restored during the latter part of 1962. However, the certificate revision without the race item was used for most of 1962 as well as 1963. Therefore, figures by race for 1962 and 1963 exclude New Jersey. For 1964, 6.8 percent of the death records used for residents of New Jersey did not contain the race item.

Adjustments made in vital statistics to account for the omission of the race item in New Jersey for part of the certificates filed during 1962 through 1964 are described in the Technical Appendix of Vital Statistics of the United States for each of those data years.

Hispanic origin

Mortality statistics for the Hispanic-origin population are based on information for those States and the District of Columbia that included items on the death certificate to identify Hispanic or ethnic origin of decedents. Data for 1989 were obtained from the District of Columbia and all States except Louisiana, New Hampshire, and Oklahoma.

Hispanic mortality data were published for the first time in 1984. Generally, the reporting States used items similar to one of two basic formats recommended by NCHS. The first format is directed specifically toward the Hispanic population and appears on the U.S. Standard Certificate of Death as follows:

Was decedent of Hispanic origin?
(Specify No or Yes- If Yes, specify Cuban, Mexican,
Puerto Rican, etc.) ___ No ___ Yes
Specify:

The second format is a more general ancestry item and appears as follows:

Ancestry- Mexican, Puerto Rican, Cuban, African,
English, Irish, German, Homong, etc., (specify)

For 1989, mortality data in tables 1-37 and 2-19 are based on deaths to residents of all 47 reporting States and the District of Columbia. In tables 1-38, 1-43, and 1-44, mortality data for the Hispanic-origin population are based on deaths to residents of 44 reporting States and the District of Columbia whose data were at least 90 percent complete on a place-of-occurrence basis and considered to be sufficiently comparable to be used for analysis. The 44 states are Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York (including New York City), North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. Data for three States--Connecticut, Maryland, and Virginia--are excluded from tables 1-38, 1-43, and 1-44 because of the large proportion of deaths (in excess of 10 percent) occurring in these States for which Hispanic origin was not stated or was unknown.

In tables 2-20, 2-21, 2-22, and 2-23, the reporting areas are based on deaths to residents of 43 reporting States and the District of Columbia whose mortality data for all ages and whose live birth data were at least 90 percent complete on a place-of-occurrence basis and considered to be sufficiently comparable to be used for analysis. The 43 States are Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York (including New York City), North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. Data for Connecticut, Maryland, and Virginia were excluded for the reasons stated above. Rhode Island also was excluded because of the large proportion of unknown.

The 44 and 43 reporting States and the District of Columbia for which general mortality data are shown in this report accounted for about 97 percent of the Hispanic population in the United States in 1980. This included about 99 percent of the Mexican population, 94 percent of the Puerto Rican population, 97 percent of the Cuban population, and 94 percent of the "Other Hispanic" population (10).

Accordingly, some caution should be exercised in generalizing mortality patterns of reporting areas to the Hispanic-origin population of the entire United States. For qualifications regarding infant mortality of the Hispanic-origin population, see "Infant deaths."

Marital status

Mortality statistics by marital status (tables 1-34 and 1-35) were published in 1979 for the first time since 1961. (They were previously published in the annual volumes for 1949-51 and 1959-61.) Several reports analyzing mortality by marital status have been published, including the special study based on 1959-61 data (11). Reference to earlier reports is given in the appendix of part B of the 1959-61 special study.

Mortality statistics by marital status are tabulated separately for never married, married, widowed, and divorced. Certificates in which the marriage is specified as being annulled are classified as never married. Where marital status is specified as separated or common-law marriage, it is classified as married. Of the 2,094,043 resident deaths 15 years of age and over in 1989, 20,709 certificates (1.0 percent) had marital status not stated.

Educational attainment

Beginning with the 1989 data year, mortality data on educational attainment are being tabulated from information reported on the death certificate. As a result of the revision of the U.S. Standard Certificate of Death (1), this item was added to the certificates of a large number of States:

- Decedent's Education (specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)

Mortality data on educational attainment for 1989 are based on deaths to residents of 21 reporting States whose data were at least 90 percent complete on a place-of-occurrence basis. The 21 reporting States are Arizona, California, Colorado, Delaware, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Montana, New Hampshire, Oregon, South Carolina, Utah, Vermont, Wisconsin, and Wyoming.

Place of death and status of decedent

Mortality statistics classified by place of death were published in 1979 for the first time since 1958 (tables 1-30, 1-31, and 1-32). In addition, mortality data were also available for the first time in 1979 for the status of decedent when death occurred in a hospital or medical center. The 1989 data were obtained from the following two items appearing on the revised U.S. Standard Certificate of Death: (1)

- Item 9a. Place of Death (check only one)
Hospital: Inpatient, ER/Outpatient, DOA
Other: Nursing Home, Residence, Other (specify)

- Item 9b. Facility Name (If not institution, give street and number)

Before to the 1989 revision of the Standard Certificate of Death, information on place of death and status of decedent should be determined if the hospital or institution indicated Inpatient, Outpatient, ER, and DOA, and if the name of the hospital or institution, which was used to determine the type of facility, on the certificate. The change to a checkbox format in many states for this item may affect the comparability of data between 1989 and previous years.

Except for Oklahoma, all of the States (including New York City) and the District of Columbia have item 9 (or its equivalent) on their certificates. Louisiana's certificate was revised in 1989, but the computer system was not changed. Therefore, the same detail categories used in 1988 were used in 1989. As a result, not all categories, were available. For all reporting States and the District of Columbia in the Vital Statistics Cooperative Program, NCHS accepts the State definition, classification, or code for hospitals, medical centers, nursing homes, or other institutions.

Effective with data year 1980, the coding for place of death and status of decedent was modified. A new coding category was added: "Death on arrival--hospital, clinic, medical center name not given." Deaths coded to this category are tabulated in tables 1-30, 1-31, and 1-32. Had the 1979 coding categories been used, these deaths would have been tabulated as "Place unknown."

California—For the first five months of data year 1989, California coded "residence" to "other" for "Place of Death."

Mortality by month and date of death

Deaths by month have been tabulated regularly and published in the annual volume for each year beginning with data year 1900. For 1989 deaths by month are shown in tables 1-20, 1-21, 1-24, 1-33, 2-12, 2-13, 2-14, and 3-7.

Date of death was published for the first time for data year 1972. In addition, unpublished data for selected causes by date of death for 1962 are available from NCHS.

Numbers of deaths by date of death in this volume are shown in table 1-33 for the total number of deaths and for the numbers of deaths for the following three causes, for which the greatest interest in date of occurrence of death has been expressed: Motor vehicle accidents, Suicide, and Homicide and legal intervention.

These data show the frequency distribution of deaths for the selected causes by day of the week. They also make it possible to identify holidays with peak numbers of deaths from specified causes.

Report of autopsy

Before 1972, the last year for which autopsy data were tabulated was 1958. Beginning in 1972, all registration areas requested information on the death certificates as to whether autopsies were performed. For 1989 autopsies were reported on 247,251 death certificates, 11.5 percent of the total (table 1-29).

Information indicating whether autopsy findings were used in determining the cause of death was tabulated for 1972-73 for all but nine registration areas and for 1974-77 for all but eight registration areas. The item "autopsy findings used" was deleted from the 1978 U.S. Standard Certificate of Death.

For eight of the cause-of-death categories shown in table 1-29, autopsies were reported as performed for 50 percent or more of all deaths (Meningococcal infection; Pregnancy with abortive outcome; Other complications of pregnancy, childbirth, and the puerperium; Symptoms, signs, and ill-defined conditions; Motor vehicle accidents; Suicide; Homicide and legal intervention; and All other external causes). There was one other category for which 40 percent or more of the death certificates reported autopsies. Autopsies were reported for only 7.3 percent of the Major cardiovascular diseases.

Cause of death

Cause-of-death classification—Since 1949, cause-of-death statistics have been based on the underlying cause of death, which is defined as "(a) the disease or injury which initiated the train of events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury" (12).

For each death the underlying cause is selected from an array of conditions reported in the medical certification section on the death certificate. This section provides a format for entering the cause of death sequentially. The conditions are translated into medical codes through use of the classification structure and the selection and modification rules contained in the applicable revision of the International Classification of Diseases (ICD), published by the World Health Organization (WHO). Selection rules provide guidance for systematically identifying the underlying cause of death. Modification rules are intended to improve the usefulness of mortality statistics by giving preference to certain classification categories over others and/or to consolidate two or more conditions on the certificate into one classification category.

As a statistical datum, underlying cause of death is a simple, one-dimensional statistic; it is conceptually easy to understand and a well-accepted measure of mortality. It identifies the initiating cause of death and is therefore most useful to public health officials in developing measures to prevent the onset of the chain of events leading to death. The rules for selecting the underlying cause of death are included in ICD as a means of standardizing classification, which contributes toward comparability and uniformity in mortality medical statistics among countries.

Tabulation lists—Beginning with data year 1979, the cause-of-death statistics published by NCHS have been classified according to the Ninth Revision of the International Classification of Diseases (12). In addition to specifying that ICD-9 be used, WHO also recommends how the data should be tabulated to promote international comparability. The recommended system for tabulating data ICD-9 allows countries to construct their mortality and morbidity tabulation lists from the rubrics of the WHO Basic Tabulation List (BTL) if the rubrics from the WHO mortality and morbidity lists, respectively, are included. This tabulation system for the Ninth Revision is more flexible than that for the Eighth Revision, in which specific lists were recommended for tabulating mortality and morbidity data.

The BTL recommended under the Ninth Revision consists of 57 two-digit rubrics that when added equal the "all causes" total. Identified within each two-digit rubric are up to nine three-digit rubrics that are numbered from zero to eight and whose total does not equal the two-digit rubric.

The two-digit BTL rubrics 01 through 46 are used for the tabulation of nonviolent deaths according to ICD categories 001-799. Rubrics relating to chapter 17 (nature-of-injury causes 47 through 56) are not used by NCHS for selecting underlying causes of death; rather, preference is given to rubrics E47 through E56. The 57th two-digit rubric VO is the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services and is not appropriate for the tabulation of mortality data. The WHO Mortality List, a subset of the titles contained in the BTL, consists of 50 rubrics that are the minimum necessary for the national display of mortality data.

Five lists of causes have been developed for tabulation and publication of mortality data in this volume—the Each-Cause List, List of 282 Selected Causes of Death, List of 72 Selected Causes of Death, List of 61 Selected Causes of Infant Death, and List of 34 Selected Causes of Death. These lists were designed to be as comparable as possible with the NCHS lists more recently used under the Eighth Revision. However, complete comparability could not always be achieved.

The Each-Cause List is made up of each three-digit category of the WHO Detailed List to which deaths may be validly assigned and most four-digit subcategories. The list is used for tabulation for the entire United States. The published Each-Cause table does not show the four-digit subcategories provided for Motor vehicle accidents (E810-E825); however, these subcategories that identify persons injured are shown in the accident tables of this report (section 5). Special fifth-digit subcategories also are used in the accident tables to identify place of accident when deaths from nontransport accidents are shown. These are not shown in the Each-Cause table.

The List of 282 Selected Causes of Death is constructed from BTL rubrics 01-46 and E47-E56. Each of the 56 BTL two-digit titles can be obtained either directly or by combining titles in the List. The three-digit level of the BTL is modified more extensively. Where more detail was desired, categories not shown in the three-digit rubrics were added to the List of 282 Selected Causes of Death. Where less detail was needed, the three-digit rubrics were combined. Moreover, each of the 50 rubrics of the WHO Mortality List can be obtained from the List of 282 Selected Causes of Death.

The List of 72 Selected Causes of Death was constructed by combining titles in the List of 282 Selected Causes of Death. It is used in tables published for the United States and each State, and for standard metropolitan statistical areas.

The List of 61 Selected Causes of Infant Death shows more detailed titles for Congenital anomalies and Certain conditions originating in the perinatal period than any other list except the Each-Cause List.

The List of 34 Selected Causes of Death was created by combining titles in the List of 72 Selected Causes. A table using this list is published for detailed geographic areas.

Beginning with data for 1987, changes were made in these lists to accommodate the introduction in the United States of new category numbers *042-*044 for Human immunodeficiency virus infection. The changes are described in the Technical Appendix from Vital Statistics for the United States, 1987.

Effect of list revisions—The International Lists or adaptations of them, used in the United States since 1900, have been revised approximately every 10 years so the disease classifications may be consistent with advances in medical science and with changes in diagnostic practice. Each revision of the International Lists has produced some break in comparability of cause-of-death statistics. Cause-of-death statistics beginning with 1979 are classified by NCHS according to the ICD-9 (12). For a discussion of each of the classifications used with death statistics since 1900, see the Technical Appendix from Vital Statistics of the United States, 1979, Volume II, Mortality, Part A, section 7, pages 9-14.

A dual coding study was undertaken comparing the Ninth and the Eighth Revisions to measure the extent of discontinuity in cause-of-death statistics resulting from introducing the new Revision. A study for the List of 72

Selected Causes of Death and the List of 10 Selected Causes of Infant Death has been published (13). The List of 10 Selected Causes of Infant Death is a basic NCHS tabulation list not used in this volume but used for provisional data in the Monthly Vital Statistics Report, another NCHS publication. Comparability studies also were undertaken between the Eighth and Seventh, Seventh and Sixth, and Sixth and Fifth Revisions. For additional information about these studies, see the 1979 Technical Appendix previously mentioned.

Significant coding changes under the Ninth Revision—Since the implementation of ICD-9 in the United States, effective with mortality data for 1979, several coding changes have been introduced. The more important changes are discussed below. In early 1983, a change was made in the coding of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection, which affected data from 1981 to 1986. Also effective with data year 1981 was a coding change for poliomyelitis. For data year 1982, the definition of child was changed (which affects the classification of deaths to a number of categories, including Child battering and other maltreatment), and guidelines for coding deaths to the category Child battering and other maltreatment (ICD No. E967) were changed also. During the calendar year 1985, detailed instructions for coding motor vehicle accidents involving all-terrain vehicles (ATV's) were implemented to ensure consistency in coding these accidents. Effective with data year 1986, "primary" and "invasive" tumors, unspecified were classified as "malignant;" these neoplasms had previously been classified to Neoplasms of unspecified nature (ICD-9 No. 239).

Beginning with data for 1987, NCHS introduced new category numbers *042-*044 for classifying and coding HIV infection, formerly referred to as human T-cell lymphotropic virus-III/lymphadenopathy associated virus (HTLV-III/LAV) infection. The asterisk appearing before the category numbers indicates these codes are not part of ICD-9. Also changed effective with data year 1987 were coding rules for the conditions "dehydration" and "disseminated intravascular coagulopathy." Effective with data year 1988 minor content changes were made to the classification for HIV infection. Detailed discussion of these changes may be found in the Technical Appendix for previous volumes.

Coding in 1989—The rules and instructions used in coding the 1989 mortality medical data remained essentially the same as those used for the 1988 data.

Medical certification—The use of a standard classification list, although essential for State, regional, and international comparison, does not ensure strict comparability of the tabulated figures. A high degree of comparability among areas could be attained only if all records of cause of death were reported with equal accuracy and completeness. The medical certification of cause of death can be made only by a qualified person, usually a physician, a medical examiner, or a coroner. Therefore, the reliability and accuracy of cause-of-death statistics are, to a large extent, governed by the ability of the certifier to make the proper diagnosis and by the care with which he or she records this information on the death certificate.

A number of studies have been undertaken on the quality of medical certification on the death certificate. In general, these have been of relatively small samples and for limited geographic areas. A bibliography prepared by NCHS (14), covering 128 references over 23 years, indicates no definitive conclusions have been reached about the quality of medical certification on the death certificate. No country has a well-defined program for systematically assessing the quality of medical certifications reported on death certificates or for measuring the error effects on the levels and trends of cause-of-death statistics.

One index of the quality of reporting causes of death is the proportion of death certificates coded to the Ninth Revision Chapter XVI, Symptoms, signs, and ill-defined conditions (ICD-9 Nos. 780-799). Although deaths for which it is impossible to determine the underlying cause, this proportion indicates the care and consideration given to the certification by the medical certifier. This proportion also may be used as a rough measure of the specificity of the medical diagnoses made by the certifier in various areas. In 1989 a record low of 1.3 percent of all reported deaths in the United States was assigned to this category compared with 1.4 for 1988. However, trends in the percent of deaths assigned to this category vary by age. Although the percent of deaths in this category for all ages combined has generally remained stable between 1980 and 1988, a slight increase in the percent occurred for the age group 5-14 years and a decrease occurred for all the age groups 55 years and over. However, between 1988 and 1989, the percent decreased for almost all age groups.

Automated selection of underlying cause of death—Beginning with data year 1968, NCHS began using a computer system for assigning the underlying cause of death. It has been used every year since. The system is called "Automated Classification of Medical Entities" (ACME).

The ACME system applies the same rules for selecting the underlying cause as would be applied manually by a nosologist; however, under this system, the computer consistently applies the same criteria, thus eliminating intercoder variation in this step of the process.

The ACME computer program requires the coding of all conditions shown on the medical certification. These codes are matched automatically against decision tables that consistently select the underlying cause of death for each record according to the international rules. The decision tables provide the comprehensive relationships among the conditions classified by ICD when applying the rules of selection and modification.

The decision tables were developed by NCHS staff on the basis of their experience in coding underlying causes of death under the earlier manual coding system and as a result of periodic independent validations. These tables are periodically updated to reflect additional new information on the relationship among medical conditions. For data year 1988 these tables were amended to incorporate minor changes to the previously mentioned classification for Human immunodeficiency virus infection (*042-*044) that had originally been implemented with data year 1987. Coding procedures for selecting the underlying cause of death by using the ACME computer program, as well as by using the ACME decision tables, are documented in NCHS instruction manuals (15-17).

Cause-of-death ranking—Cause-of-death ranking (except for infants) is based on numbers of deaths assigned to categories in the List of 72 Selected Causes of Death and the category Human immunodeficiency virus infection (HIV infection) (*042-*044); cause-of-death ranking for infants is based on the List of 61 Selected Causes of Infant Death and HIV infection. HIV infection was added to the list of rankable causes effective with data year 1987.

The group titles Major cardiovascular diseases and Symptoms, signs, and ill-defined conditions from the List of 72 Selected Causes of Death are not ranked; Certain conditions originating in the perinatal period and Symptoms, signs, and ill-defined conditions from the List of 61 Selected Causes of Infant Death are not ranked. In addition, category titles that begin with the words "Other" or "All other" are not ranked to determine the leading causes of death. When one of the titles that represents a subtotal is ranked (such as Tuberculosis), its component parts (in this case, Tuberculosis of respiratory system and Other tuberculosis) are not ranked.

Maternal deaths

Maternal deaths are those for which the certifying physician has designated a maternal condition as the underlying cause of death. Maternal conditions are those assigned to Complications of pregnancy, childbirth, and the puerperium (ICD-9 Nos. 630-676). In the Ninth Revision, WHO for the first time defined a maternal death as follows:

A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Under the Eighth Revision, maternal deaths were assigned to the category "Complications of pregnancy, childbirth, and the puerperium" (ICDA-8 Nos. 630-678). Although WHO did not define maternal mortality, there was an NCHS classification rule that limited a maternal death to a death within a year after termination of pregnancy from any "maternal cause," that is, any cause within the range of ICDA-8 Nos. 630-678. This rule applied only if a duration of time for the condition was given. If no duration was specified and the underlying cause of death was a maternal condition, then the duration was assumed to be within a year and the death was coded by NCHS as a maternal death. The change from an under-1-year limitation on duration used in the Eighth Revision to an under-42-days limitation used in the Ninth Revision did not have much effect on the comparability of maternal mortality statistics. However, comparability was affected by the following classification change. Under the Ninth Revision, maternal causes have been expanded to include Indirect obstetric causes (ICD-9 Nos. 647-648). These causes include Infective and parasitic conditions as well as other conditions present in the mother classifiable elsewhere but that complicate pregnancy, childbirth, and the puerperium, such as Syphilis, Tuberculosis, Diabetes mellitus, Drug dependence, and Congenital cardiovascular disorders.

Maternal mortality rates are computed on the basis of the number of live births. The maternal mortality rate indicates the likelihood that a pregnant woman will die of maternal causes. The number of live births used in the denominator is an approximation of the population of pregnant women who are at risk of a maternal death.

Race—Beginning with the 1989 data year, NCHS has changed the method of tabulating live birth and fetal death data by race from race of child to race of mother. This has resulted in a discontinuity in maternal mortality rates by race between 1989 and previous years; see section on "Change in race classification for live births and fetal deaths", under Infant deaths.

Infant deaths

Age—Infant death is defined as a death under 1 year of age. The term excludes fetal deaths. Infant deaths are usually divided into two categories according to age, neonatal and postneonatal. Neonatal deaths are those that occur during the first 27 days of life; postneonatal deaths are those that occur between 28 days and 1 year of age. It has generally been believed that different factors influencing the child's survival predominate in these two periods: Factors associated with prenatal development,

heredity, and the birth process were considered dominant in the neonatal period; environmental factors, such as nutrition, hygiene, and accidents, were considered more important in the postneonatal period. Recently, however, the distinction between these two periods has blurred due in part to advances in neonatology, which have enabled more very small premature infants to survive the neonatal period.

Rates—Infant mortality rates shown in sections 2 and 8 are the most commonly used indices for measuring the risk of dying during the first year of life; they are calculated by dividing the number of infant deaths in a calendar year by the number of live births registered for the same period and are presented as rates per 1,000 or per 100,000 live births. Infant mortality rates use the number of live births in the denominator to approximate the population at risk of dying before the first birthday. This measure is an approximation because some live births will not have been exposed to a full year's risk of dying and some of the infants who die during a year will have been born in the previous year. The error introduced in the infant mortality rate by this inexactness is usually small, especially when the birth rate is relatively constant from year to year (18,19). Other sources of error in the infant mortality rate have been attributed to differences in applying the definitions for infant death and fetal death when registering the event (20,21).

In contrast to infant mortality rates based on live births, infant death rates shown in Section 1 are based on the estimated population under 1 year of age. Infant death rates, which appear in tabulations of age-specific death rates, are calculated by dividing the number of infant deaths in a calendar year by the estimated midyear population of persons under 1 year of age and are presented as rates per 100,000 population in this age group. Patterns and trends in the infant death rate may differ somewhat from those of the more commonly used "infant mortality rate," mainly because of differences in the nature of the denominator and in the time reference period. Whereas the population denominator for the infant death rate is estimated using data on births, infant deaths, and migration for the 12-month period of July through June, the denominator for the infant mortality rate is a count of births occurring during the 12 months of January through December. The difference in the time reference period can result in different trends between the two indices during periods when birth rates are moving up or down markedly.

The infant death rate is also subject to greater imprecision than is the infant mortality rate because of problems of enumerating and estimating the population under 1 year of age (21).

Race

Change in tabulation of race data for live births and fetal deaths—Beginning with the 1989 data year, NCHS has changed the method of tabulating live birth and fetal death data by race from race of child to race of mother. This results in infant, fetal, perinatal, and maternal mortality rates for 1989 that are not comparable with those published

for previous years, because live births comprise the denominator of these rates. To facilitate continuity and ease of interpretation, key published tables for 1989 and 1990, including all trend tables, will show data computed on the basis of live births and fetal deaths tabulated by both race of mother and race of child. This will make it possible to distinguish the effects of this change from real changes in the data.

As in previous years, race for infant and maternal deaths (the numerator of the rate) is tabulated by the race of the decedent. For fetal and perinatal mortality rates, both the numerator and the denominator of the rates are affected, since the change to race of mother affects both fetal deaths and live births.

As noted in detail in the Technical Appendix to Vital Statistics of the United States, 1989, Vol. I, Natality, data on live births and fetal deaths are being tabulated by the race of the mother. When the race of the mother is unknown, the race of the mother is assigned to the father's race; when information for both parents is missing, the race of the mother is assigned to the specific race of the mother of the preceding record with known race. In previous years, birth and fetal death tabulations were by race of child, as determined statistically by an algorithm based on information reported for the mother and father. Briefly, in cases of mixed parentage where only one parent was white, the child was assigned to the other parent's race. When neither parent was white, the child was assigned the race of the father, except if either parent was Hawaiian, the child was assigned to Hawaiian. If race was not reported for one parent, the child was assigned the race of the parent for whom race was given.

The change in the tabulation of live births and fetal deaths by race reflects three factors over the past two decades: the topical content of the birth certificate has been expanded to include considerable health and demographic information related to the mother, the increasing incidence of interracial parentage, and the growing proportion of births for which the race of the father is not reported.

Quantitatively, the change in the basis for tabulating live births and fetal deaths by race results in more white births and fetal deaths and fewer to the black population and to other races. As a consequence, infant, fetal, perinatal, and maternal mortality rates under the new classification tend to be lower for white infants and higher for infants of other races (Table A). In general, discontinuities are larger for infant and maternal mortality rates, where only the denominator of the rate is affected by the change, than for fetal and perinatal mortality rates, where both the numerator and the denominator are affected. For some minority race groups, the effect of the change is quite large.

The change in the race classification of live births and fetal deaths presents challenges to those analyzing infant, fetal, perinatal, and maternal mortality data, particularly trend data. To facilitate analysis of infant mortality by race, reports will be prepared showing historic data tabulated by race of mother.

Comparison of race data from birth and death certificates

—Regardless of whether vital events are tabulated by race of mother or by race of child, there are inconsistencies in reporting race for the same infant between birth and death certificates, based on results of studies in which race on the birth and death certificates for the same infant were compared (22).

These reporting inconsistencies can result in systematic biases in infant mortality rates by specified race, in particular, under-estimates for specified races other than white or black. In the computation of race-specific infant mortality rates published in Vital Statistics of the United States, the race item for the numerator comes from the death certificate, and for the denominator, from the birth certificate. Biases in the rates may arise because of possible inconsistencies in reporting race on these two vital records. Race of the mother and father is reported on the birth certificate by the mother at the time of delivery; whereas race of the deceased infant is reported on the death certificate by the funeral director based on observation or on information supplied by an informant, such as a parent. Previous studies have noted that the race of an infant who died and was of a smaller minority race group to sometimes be reported as white on the death certificate, but as of the minority race on the birth certificate, resulting, in the aggregate, in understatement of infant mortality for smaller race groups (22).

Estimates can be made of the degree of bias in race-specific infant mortality rates by comparing rates for birth cohorts based on the newly-available linked birth and infant death data set (23,24) with period rates based on mortality data published in Vital Statistics of the United States (VSUS) for the same year(s). In this comparison, cohorts rates are based entirely on the linked data set while period rates are constructed using a numerator (infant deaths) based on mortality data published in VSUS and a denominator (live births) based on the linked data set.

The comparison of cohort and period rates is somewhat affected by small differences in the events included in the numerators of the two rates. The numerator of the cohort rate is comprised of infant deaths to the cohort of infants born in a calendar year whereas the numerator of the period rate is comprised of infant deaths that occur in the calendar year.

Based on comparing infant mortality rates from the linked data set for the birth cohorts of 1984-85 with period rates constructed for 1984-85, bias in the rates for the two major race groups—white and black—is small (Table B). In contrast, period rates for the smaller race groups are estimated to be lower than cohort rates by 10 to 50 percent. Cohort rates have not been adjusted to reflect the approximately 2 percent of infant death records that were not linked to their corresponding birth records. Because of systematic understatement of infant mortality rates based on period data, one should use data from the national linked files to measure infant mortality for these groups. For the major race groups, period data are a close approximation of the rates based on linked files.

Hispanic origin—Infant mortality rates for the Hispanic-origin population are based on numbers of resident infant deaths reported to be of Hispanic origin (see section "Hispanic origin") and numbers of resident live births by Hispanic origin of mother for the 43 reporting States and the District of Columbia. In computing infant mortality rates, deaths and live births of unknown origin are not distributed among the specified Hispanic and non-Hispanic groups. Because the percent of infant deaths of unknown origin for 1989 was 2.6 percent and the percent of live births of unknown origin was 1.1 percent, infant mortality rates by specified Hispanic origin and race for non-Hispanic origin are underestimated.

In addition, as discussed above for specified races, period infant mortality rates for specific Hispanic-origin groups tend to be underestimated when compared with rates based on the national linked birth and infant death data set as shown in Table C. Comparisons are also affected by the approximate 2 percent of infant death records that are not linked to their corresponding birth record.

Caution should be exercised when generalizing from the ratios of cohort-to-period rates for 1986 with data for 1989, because the reporting area for Hispanic data has expanded from 18 reporting States and the District of Columbia in 1986 to 43 reporting States and the District of Columbia in 1989. The Hispanic reporting area for 1986 included: Arizona, Arkansas, California, Colorado, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Kansas, Mississippi, Nebraska, New Jersey, New York, North Dakota, Ohio, Texas, Utah and Wyoming.

Small numbers of infant deaths for specific Hispanic-origin groups can result in infant mortality rates subject to relatively large random variation (see section "Random variation in numbers of deaths, death rates, and mortality rates and ratios").

Tabulation list—Causes of death for infants are tabulated according to a list of causes that is different from the list of causes for the population of all ages, except for the Each Cause List. (See section "Cause-of-death classification.")

California—From 1985 to 1988, data on age at death for California, were biased in the categories 1-23 hours and 1 day because of processing errors that affected selected infants who died within 24 hours after birth. Specifically, some infants who died within 1-23 hours of birth were erroneously coded as dying at 1 day after birth.

Beginning with 1985 data, California provided NCHS with computer tapes of precoded mortality data through the Vital Statistics Cooperative Program (VSCP); whereas prior to 1985, data from the State of California were based on information coded by NCHS from copies of original death certificates. The effect of these errors on national data, for the years 1985-88 shown in table 2-3 is negligible. The problem has been identified and corrected for 1989 and subsequent years.

Fetal deaths

In May 1950 the World Health Organization (WHO) recommended that the following definition of fetal death be adopted for international use:

Death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles (25).

The term "fetal death" was defined on an all-inclusive basis to end confusion arising from the use of such terms as stillbirth, spontaneous abortion, and miscarriage.

Shortly thereafter, this definition of fetal death was adopted by the National Center for Health Statistics (NCHS) as the nationally recommended standard. Currently all registration areas except Puerto Rico have definitions similar to the standard definition (26). Puerto Rico has no formal definition.

As another step toward increasing the comparability of data on fetal deaths for different countries, WHO recommended that for statistical purposes fetal deaths be classified as early, intermediate, and late. These groups are defined as follows:

- Less than 20 completed weeks of gestation (early fetal deaths)..... Group I
- 20 completed weeks of gestation but less than 28 (intermediate fetal deaths)..... Group II
- 28 completed weeks of gestation and over (late fetal deaths)..... Group III
- Gestation period not classifiable in groups I, II, and III.....Group IV

Note that in table 3-11, group IV consists of fetal deaths with gestation not stated but presumed to be 20 weeks or more.

Until 1939 the nationally recommended procedure for registration of a fetal death required the filing of both a live-birth and a death certificate. In 1939 a separate Standard Certificate of Stillbirth (fetal death) was created to replace the former procedure. This was revised in 1949, 1955, 1956, 1968, 1978, and 1989. The 1989 U.S. Standard Report of Fetal Death is shown in figure 7-B.

The 1977 revision of the Model State Vital Statistics Act and Model State Vital Statistics Regulations (27) recommended spontaneous fetal deaths at a gestation of 20 weeks or more or a weight of 350 grams or more and all induced terminations of pregnancy regardless of gestational age be reported and further be reported on separate forms. These forms are to be considered legally required statistical reports rather than legal documents.

Beginning with 1970 fetal deaths, procedures were implemented that attempted to separate reports of spontaneous fetal deaths from those of induced terminations of pregnancy. These procedures were implemented because the health implications of spontaneous fetal deaths are different from those of induced terminations of pregnancy. These procedures are still used.

Comparability and completeness of data—Registration area requirements for reporting fetal deaths vary. Most of these areas require reporting of fetal death at gestations of 20 weeks or more. Table D shows the minimum period of gestation required by each State to report fetal death. Substantial evidence exists that indicates some fetal deaths for which reporting is required are not reported (28).

Underreporting of fetal deaths is most likely to occur in the earlier part of the required reporting period for each State. Thus, for States requiring reporting of all periods of gestation, fetal deaths occurring at younger gestational ages are less completely reported. The reporting of fetal deaths at 20-23 weeks of gestation may be more complete for those States that report fetal deaths at all periods of gestation than for others.

To maximize the comparability of data by year and by State, most of the tables in section 3 are based on fetal deaths occurring at gestations of 20 weeks or more. These tables also include fetal deaths for which gestation is not stated for those States requiring reporting at 20 weeks or more gestation only. Beginning with 1969, fetal deaths of not stated gestation were excluded for States requiring reporting of all products of conception except for those with a stated birth weight of 500 grams or more. In 1989 this rule was applied to the following States: Georgia, Hawaii, New York (including New York City), Rhode Island, and Virginia. Each year there are some exceptions to this procedure.

Arkansas—Since 1971, Arkansas has been using two reporting forms for fetal deaths: A confidential Spontaneous Abortion form that is not sent to the National Center for Health Statistics (NCHS) and a Fetal Death Certificate that is. During the period 1971 through 1980, it is believed that most spontaneous fetal deaths of less than 20 weeks' gestation were reported on the confidential form and, therefore, were not reported to NCHS. During the period 1981 through 1983, Arkansas specified that fetal deaths of less than 28 weeks' gestation or weighing less than 1,000 grams could be reported on the confidential form; beginning with 1984 data, the State specified that fetal deaths of 20 weeks' gestation or weighing 500 grams be reported on the Fetal Death Certificate. Because of these changes, the comparability of counts of early fetal deaths may be affected. In particular, counts of fetal deaths at 20 to 27 weeks for 1981-83 were not comparable between Arkansas and other reporting areas or with Arkansas data for 1984-89. It is believed that reporting has improved but is still not comparable with data for 1980 and earlier years.

Colorado—While Colorado State law requires reporting fetal deaths of all periods of gestation, beginning in 1989, the State only provides to NCHS data for fetal deaths of 20 weeks gestation or more.

Maine—Maine uses two reporting forms for fetal deaths: A Report of Abortion (Spontaneous and Induced) and a Report of Fetal Death. Most spontaneous fetal deaths at less than 20 weeks' gestation are reported on the Report of Abortion, and, therefore, are excluded from fetal death counts in this volume.

Maryland—From the counts of frequencies by month, it appears that not all fetal deaths occurring in the first quarter of 1989 were reported. This may account in part for the decrease in the reported number of fetal deaths and in fetal mortality rates for Maryland between 1988 and 1989.

Wisconsin—Beginning in 1986, Wisconsin changed its reporting requirements for spontaneous fetal deaths from "20 weeks" to "20 weeks or 350 grams."

Revised Report of Fetal Death for 1989—Beginning with data for 1989, new items were added to the U.S. Standard Report of Fetal Death, including Hispanic origin of the mother and father, medical and other risk factors of pregnancy, obstetric procedures, and method of delivery. In addition, questions on complications of labor and delivery and congenital anomalies of fetus were changed from an open-ended to a checkbox format, to ensure more complete reporting of information. However, because of differences in implementation dates of the new fetal death report between States, and because of inexperience in reporting and processing the new items, reporting of the new items in individual States may not be complete for 1989. The data quality and completeness of many of these items are being evaluated.

Period of gestation—The period of gestation is the number of completed weeks elapsed between the first day of the last normal menstrual period (LMP) and the date of delivery. The first day of the LMP is used as the initial date because it can be more accurately determined than the date of conception, which usually occurs 2 weeks after LMP. Data on period of gestation are computed from information on "date of delivery" and "date last normal menses began." If "date last normal menses began" is not on the record or if the calculated gestation falls beyond a duration considered biologically plausible, the "Physician's estimate of gestation" is used.

To improve data quality, beginning with data for 1989, NCHS instituted a new computer edit to check for consistency between gestation and birth weight (29). Briefly, if LMP gestation is inconsistent with birth weight, and the physician's estimate is consistent, the physician's estimate is used; if both are inconsistent, LMP gestation is used, and birth weight is assigned to unknown. When the period of gestation is reported in months on the report, it is allocated to gestational intervals in weeks as follows:

- 1 - 3 months to under 16 weeks
- 4 months to 16 - 19 weeks
- 5 months to 20 - 23 weeks
- 6 months to 24 - 27 weeks
- 7 months to 28 - 31 weeks
- 8 months to 32 - 35 weeks
- 9 months to 40 weeks
- 10 months and over to 43 weeks and over

All areas reported LMP in 1989 except Puerto Rico, and all areas reported physician's estimate of gestation except California, the District of Columbia, Louisiana, Maryland, and Oklahoma. Nebraska was also excluded because of the large proportion of unknown.

Birth weight—Most of the 55 registration areas do not specify how weight should be given, that is, in pounds and ounces or in grams. In the tabulation and presentation of birth weight data, the metric system (grams) has been used to facilitate comparison with other data published in the United States and internationally. Birth weight specified in pounds and ounces is assigned the equivalent of the gram intervals, as follows:

Less than 350 grams	=	0 lb	12 oz	or less
350 - 499 grams	=	0 lb	13 oz	- 1 lb 1 oz
500 - 999 grams	=	1 lb	2 oz	- 2 lb 3 oz
1,000 - 1,499 grams	=	2 lb	4 oz	- 3 lb 4 oz
1,500 - 1,999 grams	=	3 lb	5 oz	- 4 lb 6 oz
2,000 - 2,499 grams	=	4 lb	7 oz	- 5 lb 8 oz
2,500 - 2,999 grams	=	5 lb	9 oz	- 6 lb 9 oz
3,000 - 3,499 grams	=	6 lb	10 oz	- 7 lb 11 oz
3,500 - 3,999 grams	=	7 lb	12 oz	- 8 lb 13 oz
4,000 - 4,499 grams	=	8 lb	14 oz	- 9 lb 14 oz
4,500 - 4,999 grams	=	9 lb	15 oz	- 11 lb 0 oz
5,000 grams or more	=	11 lb	1 oz	or more

With the introduction of ICD-9, the birth-weight classification intervals for perinatal mortality statistics were shifted downward by 1 gram, as shown above. Previously, the intervals were, for example, 1,001-1,500; 1,501-2,000; and so forth. Beginning in 1989, NCHS instituted a consistency check between birth weight and gestation; see previous section on gestation.

Race—Beginning with data for 1989, NCHS changed the method of tabulating fetal death, perinatal, and live birth data by race from race of child to race of mother. This has resulted in a discontinuity in fetal mortality rates by race between 1989 and previous years; see section on "Change in race classification for live births and fetal deaths", under Infant deaths.

Hispanic origin of mother—Fetal mortality data for the Hispanic-origin population are based on fetal deaths to mothers of Hispanic origin who were residents of those States and the District of Columbia that included items on the report of fetal death to identify Hispanic or ethnic origin of mother. Data for 1989 were obtained from 44 States; areas not supplying data were the District of Columbia, Louisiana, Maryland, Massachusetts, New Hampshire, Oklahoma, and Rhode Island.

For 1989, fetal and perinatal mortality data in table 3-19 are for a reporting area of 44 States and tables 3-20, 4-6 and 4-7 are for a reporting area of 31 States that had an item on Hispanic or ethnic origin on the death certificate, birth certificate, and report of fetal death, and whose data for all three files were at least 90 percent complete on a place-of-occurrence basis and considered to be sufficiently comparable to be used for analysis. The States included are Alabama, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, and Wyoming.

The 31 reporting States for which fetal and perinatal data by Hispanic origin are shown accounted for about 75 percent of the Hispanic population in 1980, including 92 percent of the Mexican population, 27 percent of the Puerto Rican population, 75 percent of the Cuban population, and 57 percent of the "Other Hispanic" population (10). Accordingly, caution should be exercised in generalizing mortality patterns from the reporting area to the Hispanic-origin population (especially Puerto Ricans) of the entire United States. (See also section on Hispanic origin under Classification of Data).

Total-birth order—Total-birth order refers to the sum of the live births and other terminations (including both spontaneous fetal deaths and induced terminations of pregnancy) that a woman has had, including the fetal death being recorded. For example, if a woman has previously

given birth to two live babies and to one born dead, the next fetal death to occur is counted as number four in total-birth order.

Beginning with implementation of the 1989 revision of the U. S. Standard Report of Fetal Death, total-birth order is calculated from three items on pregnancy history: Number of previous live births, now living; number of previous live births, now dead; and number of other terminations (spontaneous and induced at anytime after conception). For prior years, total-birth order was calculated from four items, see the Technical Appendix From Vital Statistics of the United States 1988, Volume II, Mortality, Part A.

Although all registration areas use the two standard items pertaining to number of previous live births, registration areas phrase the item on pertaining to other terminations of pregnancy differently. Total-birth order for all areas is calculated from the sum of available information. Thus, information on total-birth order may not be completely comparable among the registration areas. In addition, there may be substantial underreporting of other terminations of pregnancy on the fetal death report.

Marital status—Table 3-3 shows fetal deaths and fetal-death rates by mother's marital status. The following states were excluded from this table because their report of fetal death did not include an item on marital status: California, Connecticut, Maryland, Michigan, Nevada, New York (including New York City), Ohio, and Texas. Because live births comprise the denominator of the rate, marital status must also be reported for mothers of live births. Marital status of the mother of the live birth is inferred for States that did not report it on the birth certificate.

Beginning with data for 1989, fetal deaths with marital status not stated are shown as not stated in frequencies, but are proportionally distributed for rate computations into either the married or unmarried categories according to the percent of fetal deaths with stated marital status that fall into each category. Prior to 1989, fetal deaths with not-stated marital status were assigned to the married category. Because of this change, fetal death frequencies and rates by marital status for 1989 are not strictly comparable with those for previous years.

No quantitative data exist on the characteristics of unmarried women who do not report, misreport their marital status or fail to register fetal deaths. Underreporting may be greater for the unmarried group than for the married group.

Age of mother—Beginning with data for 1989, the U.S. Standard Report of Fetal Death asks for the mother's date of birth. Age of mother is computed from the mother's date of birth and the date of the termination of the pregnancy. For

those States whose certificates do not contain an item on the mother's date of birth, reported age of the mother (in years) is used. The age of the mother is edited in NCHS for upper and lower limits. When mothers are reported to be under 10 years of age or 50 years of age and over, the age of the mother is considered not stated and is assigned as follows: Age on all fetal-death records with age of mother not stated is assigned according to the age appearing on the record previously processed for a mother of identical race and having the same total-birth order (total of live births and other terminations).

Sex of fetus—Beginning with data for 1989, for all fetal deaths of 20 or more weeks gestation, not-stated sex of fetus is assigned the sex of the fetus from the previous record. Prior to 1989, no such assignment was made.

Plurality—All registration areas except Louisiana report the plurality of the fetus. Although Louisiana has not reported this item for many years, prior to 1989, data for Louisiana was erroneously converted to a plurality of 1 (single birth), and included in United States totals. Beginning 1989, Louisiana is excluded from tables reporting plurality of the fetus. For reporting areas, not-stated plurality of the fetus is assigned to single births.

Perinatal mortality

Perinatal definitions—Beginning with data year 1979, perinatal mortality data for the United States and each State have been published in section 4. WHO recommends, in ICD-9 "national perinatal statistics should include all fetuses and infants delivered weighing at least 500 grams (or when birth weight is unavailable, the corresponding gestational age (22 weeks) or body length (25 cm crown-heel)), whether alive or dead..." It further recommends that "countries should present, solely for international comparisons, 'standard perinatal statistics' in which both the numerator and denominator of all rates are restricted to fetuses and infants weighing 1,000 grams or more (or, where birth weight is unavailable, the corresponding gestational age (28 weeks) or body length (35 cm crown-heel))." Because birth weight and gestational age are not reported on the death certificate in the United States, NCHS was unable to adopt these definitions. Three definitions of perinatal mortality are currently used by NCHS: Perinatal Definition I, generally used for international comparisons, which includes fetal deaths of 28 weeks' gestation or more and infant deaths of less than 7 days; Perinatal Definition II, which includes fetal deaths of 20 weeks' gestation or more and infant deaths of less than 28 days; and Perinatal Definition III, which includes fetal deaths of 20 weeks' gestation or more and infant deaths of less than 7 days.

Variations in fetal death reporting requirements and practices have implications for comparing perinatal rates among States. Because reporting is generally sporadic near the lower limit of the reporting requirement, States that

require reporting of all products of pregnancy regardless of gestation are likely to have more complete reporting of fetal deaths at 20 weeks or more than are other States. The larger number of fetal deaths reported for these "all periods" States may result in higher perinatal mortality rates than those rates reported for States whose reporting is less complete. Accordingly, reporting completeness may account, in part, for differences among the State perinatal rates, particularly differences for Definitions II and III, which use data for fetal deaths at 20-27 weeks.

Not stated—Fetal deaths with gestational age not stated are presumed to be of 20 weeks' gestation or more if the State requires reporting of all fetal deaths at a gestational age of 20 weeks or more or the fetus weighed 500 grams or more in those States requiring reporting of all fetal deaths regardless of gestational age. For Definition I, fetal deaths at a gestation not stated but presumed to have been of 20 weeks or more are allocated to the category 28 weeks or more, according to the proportion of fetal deaths with stated gestational age that falls into that category. For Definitions II and III, fetal deaths at a presumed gestation of 20 weeks or more are included with those at a stated gestation of 20 weeks or more.

The allocation of not-stated gestational age for fetal deaths is made individually for each State, for metropolitan and nonmetropolitan areas, and separately for the United States as a whole. Accordingly, the sum of perinatal deaths for the areas according to Definition I may not equal the total number of perinatal deaths for the United States.

Race—Beginning with the 1989 data year, NCHS has changed the method of tabulating fetal death and live birth data by race from race of child to race of mother. This has resulted in a discontinuity in perinatal mortality rates by race between 1989 and previous years; see section on "Change in race classification for live births and fetal deaths" under Infant deaths.

Hispanic origin—See section on "Hispanic origin of mother" under Fetal deaths.

QUALITY OF DATA

Completeness of registration

All States have adopted laws that require the registration of births and deaths, and the reporting of fetal deaths. It is believed that more than 99 percent of the births and deaths occurring in this country are registered.

Reporting requirements for fetal deaths vary somewhat from State to State (see "Comparability and completeness of data"). Overall reporting is not as complete for fetal deaths as for births and deaths, but it is believed to be relatively complete for fetal deaths at a gestation of 28 weeks or more. National statistical data on fetal deaths include only fetal deaths occurring at a stated or presumed gestation of 20 weeks or more.

Massachusetts data

The 1964 statistics for deaths exclude approximately 6,000 events registered in Massachusetts, primarily to residents of that State. Microfilm copies of these records were not received by NCHS. Figures for the United States and the New England Division are also somewhat affected.

Alabama data

The 1988 statistics for deaths show no deaths assigned to the City of Prattville in Autauga County. The death records that should have been assigned to this area were instead assigned to the Balance of County due to a processing error.

Quality control procedures

Demographic items on the death certificate—As previously indicated, for 1989 the mortality data for these items were obtained from two sources: Photocopies of the original certificates furnished by the Virgin Islands and Guam and records on data tape furnished by the 50 States, the District of Columbia, New York City, and Puerto Rico. For the Virgin Islands and Guam, which sent only copies of the original certificates, the demographic items were coded for 100 percent of the death certificates. The demographic coding for 100 percent of the certificates was independently verified.

As part of the quality control procedures for mortality data, each registration area goes through a calibration period, during which it must achieve the specified error tolerance level of 2 percent per item for 3 consecutive months, based on independent verification by NCHS of a 50-percent sample of that area's records. Once the area has achieved the required error tolerance level, a sample of 70-80 records per month is used to monitor quality of coding. All areas providing data on computer tapes prior to 1989 have achieved the specified error tolerance; accordingly, the

demographic items on about 70-80 records per area per month were independently verified by NCHS. The estimated average error rate for all demographic items in 1989 was 0.25 percent.

These verification procedures involve controlling for two types of error (coding and entering into the data record tape) at the same time, and the error rates are a combined measure of both types. It may be assumed that the entering errors are randomly distributed across all items on the record, but this assumption cannot be made as readily for coding errors. Although systematic errors in coding infrequent events may escape detection during sample verification, it is probable that some of these errors were detected during the initial period when 50 percent of the file was being verified, thus providing an opportunity to retrain the coders.

Medical items on the death certificate—As is true for demographic data, mortality medical data are also subject to quality control procedures to control for errors of both coding and data entry. Each of the 30 registration areas that in 1989 furnished NCHS with coded medical information according to NCHS specifications first had to qualify for sample verification. During an initial calibration period, the area had to demonstrate that its staff could achieve a specified error tolerance level of less than 5 percent for coding all medical items. After the area had achieved the required error tolerance level, a sample of 70-80 records per month was used to monitor quality of medical coding. For the 30 reporting States, the average coding error rate in 1989 was estimated at just over 4 percent.

For the remaining 20 States, the District of Columbia, New York City, Puerto Rico, the Virgin Islands, and Guam, NCHS coded the medical items for 100 percent of the death records. A 1-percent sample of the records was independently coded for quality control purposes. The estimated average error rate for these areas was about 3 percent.

The ACME system for selecting the underlying cause of death through computer application contributes to the quality control of medical items on the death certificate. (See section "Automated selection of underlying cause of death.")

Demographic items on the report of fetal death—For 1989, all data on fetal deaths, except for New York State (excluding New York City), were coded under contract by the U.S. Bureau of the Census. Coding and entering of information on data tapes were verified on a 100-percent basis because of the relatively small number of records involved.

Other control procedures—After coding and entering on data tape are completed, record counts are balanced against control totals for each shipment of records from a registration area. Editing procedures ensure that records with inconsistent or impossible codes are modified.

Inconsistent codes are those, for example, indicating a contradiction between cause of death and age or sex of the decedent. Records so identified during the computer editing process are either corrected by reference to the source record or adjusted by arbitrary code assignment (30). Further, conditions specified on a list of infrequent or rare causes of death are confirmed by the certifier or a State Health Officer. All subsequent operations in tabulating and in preparing tables are verified during the computer processing or by statistical clerks.

Estimates of errors arising from 50-percent sample for 1972

Death statistics for 1972 in this report (excluding fetal-death statistics) are based on a 50-percent sample of all deaths occurring in the 50 States and the District of Columbia. A description of the sample design and a table of the percent errors of the estimated numbers of deaths by size of estimate and total deaths in the area are shown in the Technical Appendix From Vital Statistics of the United States, 1972, Volume II, Mortality, Part A.

COMPUTATION OF RATES AND OTHER MEASURES

Population bases

The population bases from which death rates shown in this report are computed are prepared by the U.S. Bureau of the Census. Rates for 1940, 1950, 1960, 1970, and 1980 are based on the population enumerated as of April 1 in the censuses for those years. Rates for all other years use the estimated midyear (July 1) population. Death rates for the United States, individual States, and SMSA's are based on the total resident populations of the respective areas. Except as noted, these populations exclude the Armed Forces abroad but include the Armed Forces stationed in each area.

The resident populations of the birth- and death-registration States for 1900-32 and of the United States for 1900-89 are shown in table 7-1. In addition, the population including Armed Forces abroad is shown for the United States. Table E lists the sources for these populations.

Population estimates for 1989—The population of the United States estimated by age, race, and sex for 1989 is shown in table 7-2, and the population for each State by broad age groups follows in table 7-3. Population estimates for 1984-89 incorporate new estimation procedures for net migration and net undocumented immigration. The 1989 estimates are comparable with those for 1984-88 but are not strictly comparable with the postcensal estimates for 1981-83 shown in tables 7-2 and 7-3 of Vital Statistics of the United States, Volume II, for those years. Although the death rates and estimates of life expectancy for 1984-89 are not strictly comparable with those for previous years, the trends for the total population and most age-race-sex groups are not substantially affected. For additional details, see the

Technical Appendix From Vital Statistics of the United States, 1984, Volume II, and the report of the U.S. Bureau of the Census (31). Population data by race are consistent with the modified (see below) 1980 population by race.

Population for 1980—The population of the United States by age, race, and sex; and the population for each State by age are shown in tables 7-2 and 7-3, respectively, of Vital Statistics of the United States, 1980, Volume II. The figures by race have been modified as described below.

Changes in reporting practices affected the racial counts of the 1980 census, particularly those of the Hispanic population. Changes in coding and classifying practices also impacted the racial counts in the 1980 census. One particular change created a major inconsistency between the 1980 census data and historical data series, including censuses and vital statistics. About 40 percent of the Hispanic population counted in 1980, more than 5.8 million persons, did not mark one of the specified races listed on the census questionnaire but instead marked the "Other" category.

In the 1980 census, coding procedures were modified for persons who marked "Other" race and wrote in a national origin designation of a Latin American country or a specific Hispanic-origin group in response to the racial question. These persons remained in the "Other" racial category in 1980 census data; in previous censuses and in vital statistics, such responses had almost always been coded into the "White" category.

To maintain comparability, the "Other" racial category in the 1980 census was reallocated to be consistent with previous procedures. Persons who marked the "Other" racial category and reported any Spanish origin on the Spanish origin question (5,840,648 persons) were distributed to white and black races in proportion to the distribution of persons of Hispanic origin who actually reported their race as "White" or "Black." This was done for each age-sex group.

As a result of this procedure, 5,705,155 persons (98 percent) were added to the white population and 135,493 persons (2 percent) to the black population. Persons who marked the "Other" racial category and reported that they were not of Spanish origin (916,338 persons) were distributed as follows: 20 percent in each age-sex group were added to the "Asian and Pacific Islander" category (183,268 persons), and 80 percent were added to the "White" category (733,070 persons). The count of American Indians, Eskimos, and Aleuts was not affected by these procedures. Unpublished tabulations of these modified census counts were obtained from the U.S. Bureau of the Census and used to compute the rates for this volume.

Population estimates for 1971-79—Death rates in this volume for 1971-79 used revised population estimates that are consistent with the 1980 census levels. The 1980 census enumerated approximately 5.5 million more persons than had previously been estimated for April 1, 1980 (32). These revised estimates for the United States by age, race, and sex are published by the U.S. Bureau of the Census in Current Population Reports, Series P-25, Number 917. Unpublished revised estimates for States were obtained from the U.S. Bureau of the Census. For Puerto Rico, the Virgin Islands, and Guam, revised estimates are published in Current Population Reports, Series P-25, Number 919.

Population estimates for 1961-69—Death rates in this volume for 1961-69 are based on revised estimates of the population and thus may differ slightly from rates published before 1976. The rates shown in tables 1-1 and 1-2, the life table values in table 6-5, and the population estimates in table 7-1 for each year in the period 1961-69 have been revised to reflect modified population bases, as published in the U.S. Bureau of the Census, Current Population Reports, Series P-25, Number 519. The data shown in table 1-10 for 1961-69 have not been revised.

Rates and ratios based on live births—Infant and maternal mortality rates, and fetal death and perinatal mortality ratios, are computed on the basis of the number of live births. Fetal death and perinatal mortality rates are computed on the basis of the number of live births and fetal deaths. Counts of live births are published annually in Vital Statistics of the United States, Volume I, Natality.

New Jersey—As previously indicated, data by race are not available for New Jersey for 1962 and 1963. Therefore, for 1962 and 1963 the, NCHS estimated a population by age, race, and sex that excluded New Jersey for rates shown by race. The methodology used to estimate the revised population excluding New Jersey is discussed in the Technical Appendixes of the 1962 and 1963 volumes.

Net census undercount

Just as the underenumeration of deaths and the misreporting of demographic characteristics on the death certificate can introduce error into the annual rates, so can enumeration errors in the latest decennial census. This is because annual population estimates for the postcensal interval, which are used in the denominator for calculating death rates, are computed using the decennial census count as a base (33). Net census undercount is the result of miscounting and misreporting of demographic characteristics such as age. Age-specific death rates are affected by both the net census undercount and the misreporting of age on the death certificate (34). To the extent that the net undercount is substantial and that it varies among subgroups and geographic areas, it may have important consequences for vital statistics measures.

Although death rates based on a population adjusted for net census undercount may be more accurate than rates based on an unadjusted population, rates in this volume are not adjusted; rather, they are computed using population estimates that preserve the age pattern of the net census undercount across the postcensal interval. Thus, it is important to consider the possible impact of net census undercount on death rates.

The U.S. Bureau of the Census has conducted extensive research on the completeness of coverage of the U.S. population (including underenumeration and misstatement of age, race, and sex) in the last four decennial censuses-- 1950, 1960, 1970, and 1980. From this work have come estimates of the national population that was not counted by age, race, and sex (35,36). The reports for 1980 include estimates of net census undercount using alternative methodological assumptions for age, race, and sex subgroups of the national population (37). These studies indicate that, although coverage was improved over previous censuses, there was differential coverage in the 1980 census among the population subgroups; that is, some age, race, and sex groups were more completely counted than others.

Net census undercounts can affect levels of the observed vital rates, differences among groups, and levels and group differences shown by summary measures such as age-adjusted death rates and life expectancy.

Levels and differentials—If adjustments were made for net census undercount, the size of denominators of the death rates generally would increase and the rates, therefore, would decrease. The adjusted rates for 1980 can be computed by multiplying the reported rates by ratios of the census-level resident population to the resident population adjusted for the estimated net census undercount (table 7-4). A ratio of less than 1.0 indicates a net census undercount and, when applied, results in a corresponding decrease in the death rate. A ratio greater than 1.0—indicating a net census overcount—multiplied by the reported rate results in an increase in the death rate.

Coverage ratios for all ages show that, in general, females were more completely enumerated than males and the white population more completely than the population of all other races in the 1980 Census of Population. The black population was undercounted relative to the total population of all other races.

For the total population, underenumeration varied by age group, with the greatest differences found for persons aged 80-84 and 85 years and over. All other age groups were overcounted or undercounted by less than 3 percent.

Among the age-sex-race groups, coverage was lowest for black males aged 40-44 and 45-49 years. Underenumeration for these groups was 19 percent. In contrast, white females in these age groups were essentially completely enumerated. For

black females and white males in these same age groups, the undercount ranged from 3 to 6 percent. For the under-1-year age group, the white population was overenumerated by 2 percent, whereas infants of other races were underenumerated by 9 percent.

If vital statistics measures were calculated with adjustments for net census undercounts for each population subgroup, the resulting rates would be differentially reduced from their original levels; that is, rates for those groups with the greatest estimated undercounts would show the greatest relative reductions due to these adjustments. Similar effects would be evident in the opposite direction for groups with overcounts. As a consequence, the ratio of mortality between the rates for males and females, and between the rates for the white population and the population of other races, or the black population, usually would be reduced.

Similarly, the differences between the death rates among subgroups of the population by cause of death would be affected by adjustments for net census undercounts. For example, for the age group 35-39 years in 1980, the ratio of the death rate for Homicide and legal intervention for black males to that for white males is 7.3, whereas the ratio of the death rates adjusted for net census undercount is 6.2. For Ischemic heart disease for males aged 40-44 years, the ratio of the death rate for the population of all other races to that for the white population is 1.2 using the unadjusted rates, but it is 1.1 when adjusted for estimated underenumeration.

Summary measures—The effect of net census undercount on age-adjusted death rates depends on the underenumeration of each age group and on the distribution of deaths by age. Thus, the age-adjusted death rate in 1980 for All causes would decrease from 585.8 to 579.3 per 100,000 population if the age-specific death rates were corrected for net census undercount.

For Diseases of the heart, the age-adjusted death rate for white males would decrease from 277.5 to 273.0 per 100,000 population, a decline of 1.3 percent. For black males the change, from an unadjusted rate of 327.3 to an adjusted rate of 308.3, would amount to 5.8 percent.

If death rates by age were adjusted, then the corresponding life expectancy at birth computed from these rates would change. The importance of adjustments varies by age; that is, when calculating life expectancy, the impact of an undercount or overcount is greatest at the younger ages. In general, the effect of correcting the death rates is to increase the estimate of life expectancy at birth. Differential underenumeration among race-sex groups would lead to greater changes in life expectancy for some groups than for others. For white females who were completely enumerated in 1980, revised estimates of life expectancy would remain roughly constant; those for black males would show the greatest increase.

Age-adjusted death rates

Age-adjusted death rates shown in this volume are computed using the distribution in 10-year age intervals of the enumerated population of the United States in 1940 as the standard population. Each figure represents the rate that would have existed had the age-specific rates of the particular year prevailed in a population whose age distribution was the same as that of the United States in 1940. The rates for the total population and for each race-sex group were adjusted using the same standard population. It is important not to compare age-adjusted death rates with crude rates. The standard 1940 population, on the basis of one million total population, is as follows:

<u>Age</u>	<u>Number</u>
All ages.....	1,000,000
Under 1 year.....	15,343
1-4 years.....	64,718
5-14 years.....	170,355
15-24 years.....	181,677
25-34 years.....	162,066
35-44 years.....	139,237
45-54 years.....	117,811
55-64 years.....	80,294
65-74 years.....	48,426
75-84 years.....	17,303
85 years and over.....	2,770

Life Tables

U.S. abridged life table are constructed by reference to a standard table (38). Life tables for the decennial period 1979-81 are used as the standard life tables in constructing the 1980-89 abridged life tables. With the availability of the 1979-81 standard life tables, revised life table values were computed for 1980-82; these appeared for the first time in Vital Statistics of the United States, 1983.

Life tables for the decennial period 1969-71 are used as the standard life tables in constructing the 1970-79 abridged life tables. Life table values for 1970-73 were first revised in Vital Statistics of the United States, 1977; before 1977, life table values for 1970-73 were constructed using the 1959-61 decennial life tables. In addition, life table values for 1951-59, 1961-69, and 1971-79 appearing in this volume are based on revised intercensal estimates of the populations for those years. As such, these life table values may differ from life table values for those years published in previous volumes.

The change in the population estimation methodology (see above section "Population bases") results in life expectancies at certain 5-year age intervals for 1984-89 that are lower than those that would have resulted had they been based on the same methodology used to compute 1983 life expectancies. For additional details, see Technical Appendix for Vital Statistics of the United States, 1984, Volume II.

There has been an increasing interest in data on the average length of life (e_0) for single calendar years before the initiation of the annual abridged life table series for selected race-sex groups in 1945. The figures in table 6-5 for the race and sex groups for the following years were estimated to meet these needs (39).

<u>Years</u>	<u>Race and sex groups</u>
1900-45.....	Total
1900-47.....	Male
1900-47.....	Female
1900-50.....	White
1900-44.....	White, male
1900-44.....	White, female
1900-50.....	All other
1900-44.....	All other, male
1900-44.....	All other, female

The geographic areas covered in life tables before 1929-31 were limited to the death-registration areas. Life tables for 1900- 1902 and 1909-11 were constructed using mortality data from the 1900 death-registration States—10 States and the District of Columbia—and for 1919-21 from the 1920 death-registration States- 34 States and the District of Columbia. The tables for 1929-31 through 1958 cover the conterminous United States. Decennial life table values for the 3-year period 1959-61 were derived from data that include both Alaska and Hawaii for each year (table 6-4). Data for each year shown in table 6-5 include Alaska beginning in 1959 and Hawaii beginning in 1960. It is believed that the inclusion of these two States does not materially affect life table values.

Random variation in numbers of deaths, death rates, and mortality rates and ratios

Deaths and population-based rates—Except for 1972, the numbers of deaths reported for a community represent complete counts of such events. As such, they are not subject to sampling error, although they are subject to errors in the registration process. However, when the figures are used for analytical purposes, such as the comparison of rates over a time period or for different areas, the number of events that actually occurred may be considered as one of a large series of possible results that could have arisen under the same circumstances (40). The probable range of values may be estimated from the actual figures according to certain statistical assumptions.

In general, distributions of vital events may be assumed to follow the binomial distribution. Estimates of standard error and tests of significance under this assumption are described in most standard statistics texts. When the number of events is large, the standard error, expressed as a percent of the number or rate, is usually small.

When the number of events is small (perhaps less than 100) and the probability of such an event is small, considerable caution must be observed in interpreting the conditions described by the figures. This is particularly true for infant mortality rates, cause-specific death rates, and death rates for counties. Events of a rare nature may be assumed to follow a Poisson probability distribution. For this distribution, a simple approximation may be used to estimate a confidence interval, as follows.

If N is the number of registered deaths in the population and R is the corresponding rate, the chance is 19 in 20 that

1. $N - 2\sqrt{N}$ and $N + 2\sqrt{N}$
covers the "true" rate.

2. $R - 2\frac{R}{\sqrt{N}}$ and $R + 2\frac{R}{\sqrt{N}}$
covers the "true" rate.

If the rate R_1 corresponding to N_1 events is compared with the rate R_2 corresponding to N_2 events, the difference between the two rates may be regarded as statistically significant at the 0.05 level of significance, if it exceeds

For example, if the observed death rate for a community were 10.0 per 1,000 population and if this rate were based on 20 recorded deaths, then the chance is 19 in 20 that the "true" death rate for that community lies between 5.5 and 14.5 per 1,000 population. If the death rate for this community of 10.0 per 1,000 population were being compared with a rate of 15.0 per 1,000 population for a second community, which is based on 25 recorded deaths, then the difference between the rates for the two communities is 5.0.

This difference is less than twice the standard error of the difference of the two rates, which is computed to be 7.5. From this, it is concluded that the difference between the rates for the two communities is not statistically significant at the 0.05 level of significance.

Rates, proportions, and ratios—Beginning in 1989 an asterisk is shown in place of a rate based on fewer than 20 deaths. These rates have a relative standard error of 23 percent or more and are, therefore, considered highly variable. For age-adjusted death rates, this criterion is applied to the sum of the age-specific deaths.

SYMBOLS USED IN TABLES

Data not available----- ---
Category not applicable----- ...
Quantity zero----- -
Quantity more than zero but less than 0.05----- 0.0
Figure does not meet standard of reliability or
precision (estimate is based on fewer than 20 events in
numerator or denominator)----- *

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Table A. Ratio of infant, neonatal, postneonatal, maternal, and perinatal rates, with race for live births tabulated according to race of mother to those with race for live births tabulated according to race of child: United States, 1989

Race	Infant deaths	Neonatal deaths	Postneonatal deaths	Maternal deaths	Fetal deaths	Perinatal definition		
						I	II	III
All races	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.
White	0.98	0.98	0.98	0.98	0.98	1.00	0.99	9.
Black	1.05	1.05	1.05	1.05	1.05	1.02	1.04	4.
American Indian	1.25	1.25	1.25	*	*	1.07	1.17	4.
Chinese	1.07	1.07	1.07	*	*	0.99	1.03	2.
Japanese	1.22	1.22	*	*	*	0.94	1.06	5.
Hawaiian	1.45	1.45	1.45	*	*	1.15	1.31	6.
Filipino	1.06	1.06	1.06	*	*	1.03	1.04	4.
Other Asian	1.09	1.09	1.09	*	*	1.01	1.04	4.
Other nonwhite	*	*	*	*	*	1.03	1.21	12.

Table B. Infant mortality rates by race of mother for the period 1984-85 and for birth cohorts, 1984-85; and ratio of birth cohort to period rates: United States
[Rates per 1,000 live births in specified groups]

Race	Period rate 1984-85	Birth cohort rate 1984-85	Ratio cohort/ period rates
All races	10.7	10.4	0.97
White	9.3	8.9	0.96
Black	19.1	18.4	0.96
American Indian	11.7	13.2	1.13
Chinese	5.9	6.5	1.10
Japanese	5.3	6.2	1.17
Filipino	5.4	8.1	1.50
Other Asian	7.8	9.1	1.17
Other nonwhite	7.7	9.8	1.27

NOTE: Births for race not stated are not distributed.

Table C. Infant mortality rates by specified Hispanic origin of mother for the period 1986 and birth cohort 1986; and ratio of birth cohort to period rates: Total of 18 reporting States and the District of Columbia, 1986

[Rates per 1,000 live births in specified group. Figures for origin not stated included in "All origins" but not distributed among origin groups]

Origin	Period rate 1986	Birth cohort rate 1986	Ratio cohort/ period rates
All Origins	10.2	9.9	0.97
Hispanic total	8.0	8.4	1.05
Mexican	7.7	7.9	1.03
Puerto Rican	8.6	11.8	1.37
Cuban	*	8.2	*
Other Hispanic ¹	9.1	8.4	0.9
Non-Hispanic total ²	10.0	10.1	1.01
White	8.6	8.3	0.97
Black	16.9	17.8	1.05

¹Includes Central and South American, and other and unknown Hispanic.

²Includes races other than white and black.

Table D. Period of gestation at which fetal-death reporting is required: Each reporting area, 1989

Area	All period of gestation	16 weeks	20 weeks	20 weeks or 350 grams	20 weeks or 400 grams	20 weeks or 500 grams	5 months	350 grams	500 grams
Alabama			X						
Alaska			X						
Arizona			X ¹						
Arkansas	X ²								
California			X						
Colorado	X ²								
Connecticut			X						
Delaware			X						
District of Columbia						X			
Florida			X						
Georgia	X								
Hawaii	X								
Idaho				X					
Illinois			X						
Indiana			X						
Iowa			X						
Kansas								X	
Kentucky				X					
Louisiana				X					
Maine	X ²								
Maryland			X ³						
Massachusetts				X					
Michigan					X				
Minnesota			X						
Mississippi				X					
Missouri				X					
Montana			X						
Nebraska			X						
Nevada			X						
New Hampshire				X					
New Jersey			X						
New Mexico									X
New York									
New York excluding NYC	X								
New York City	X								
North Carolina			X						
North Dakota			X						
Ohio			X						
Oklahoma			X						
Oregon			X ⁴						
Pennsylvania		X							
Rhode Island	X								
South Carolina				X					
South Dakota									X
Tennessee									X ⁵
Texas			X						
Utah			X						
Vermont			X ⁶						
Virginia	X								
Washington			X						
West Virginia			X						
Wisconsin				X					
Wyoming			X						
Puerto Rico							X		
Virgin Islands	X								
Guam			X						

1.If gestational age is unknown, weight of 350 grams or more.
 2.Although state law requires the reporting of fetal deaths of all periods of gestation, only data for fetal deaths of 20 weeks or more gestation are provided to NCHS.
 3.If gestational age is unknown, weight of 500 grams or more.
 4.If gestational age is unknown, weight of 400 grams or more, or crown-heel of 28 centimeters or more.
 5.If weight is unknown, 22 completed weeks' gestation or more.
 6.If gestational age is unknown, weight of 400 or more grams, 15 or more ounces.

Table E. Source for resident population and population including Armed Forces abroad:
 Birth- and death-registration States, 1900-1932, and United States, 1900-1989

Year	Source
1989.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 1057, 1990.
1988.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 1045, 1990.
1986-87.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 1022, Mar. 1988.
1985.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 1000, Feb. 1987.
1984.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 985, Apr. 1986.
1983.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No.965, Mar. 1985.
1982.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 949, May. 1984.
1981.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 929, May. 1983.
1980.....	U.S. Bureau of the Census, <u>U.S. Census of Population:1980, Number of Inhabitants,PC80-1A1, United States Summary, 1983.</u>
1971-79.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 917, July 1982.
1970.....	U.S. Bureau of Census, <u>U.S. Census of Population:1970, Number of Inhabitants,Final Report PC(1)-A1, United States Summary, 1971.</u>
1961-69.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 519, April 1974.
1960.....	U.S. Bureau of the Census, <u>U.S. Census of Population: 1960, Number of Inhabitants, PC (1)-A1, United States Summary, 1964.</u>
1951-59.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No.310, June 30, 1965.
1940-50.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 499, May 1973.
1930-39.....	U.S. Bureau of the Census, <u>Current Population Reports</u> , Series P-25, No. 499, May 1973, and National Office of Vital Statistics, <u>Vital Statistics Rates in the United States,1900-1940, 1947.</u>
1920-29.....	National Office of Vital Statistics, <u>Vital Statistics Rates in the United States,1900-1940, 1947.</u>
1917-19.....	Same as for 1930-39
1900-1916...	Same as for 1920-29

U.S. STANDARD
CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

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

1. DECEDENT'S NAME (First, Middle, Last)		2. SEX	3. DATE OF DEATH (Month, Day, Year)		
4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Month, Day, Year)	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or no)		9a. PLACE OF DEATH (Check only one; see instructions on other side) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number)		9c. CITY, TOWN, OR LOCATION OF DEATH		9d. COUNTY OF DEATH	
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use: retired.)		12b. KIND OF BUSINESS/INDUSTRY	
13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER		
13e. INSIDE CITY LIMITS? (Yes or no)	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:	15. RACE—American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION—City or Town, State		
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH		21b. LICENSE NUMBER (of Licensee)	22. NAME AND ADDRESS OF FACILITY		
Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.		23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title	23b. LICENSE NUMBER	23c. DATE SIGNED (Month, Day, Year)	
24. TIME OF DEATH M	25. DATE PRONOUNCED DEAD (Month, Day, Year)		26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)		
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. 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. _____				Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
29. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		30a. DATE OF INJURY (Month, Day, Year)	30b. TIME OF INJURY M	30c. INJURY AT WORK? (Yes or no)	30d. DESCRIBE HOW INJURY OCCURRED
		30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
31a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER/CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.		31b. SIGNATURE AND TITLE OF CERTIFIER		31c. LICENSE NUMBER	
				31d. DATE SIGNED (Month, Day, Year)	
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)					
33. REGISTRAR'S SIGNATURE				34. DATE FILED (Month, Day, Year)	

NAME OF DECEDENT:
For use by physician or institution

SEE INSTRUCTIONS ON OTHER SIDE

SEE INSTRUCTIONS ON OTHER SIDE

SEE DEFINITION ON OTHER SIDE

SEE DEFINITION ON OTHER SIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES — PUBLIC HEALTH SERVICE — NATIONAL CENTER FOR HEALTH STATISTICS — 1989 REVISION

INSTRUCTIONS FOR SELECTED ITEMS

Item 9.— Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work

Items 13-a-f. — Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home State," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence.

If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13f.

If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant

Items 23 and 31 — Medical Certification

The PRONOUNCING PHYSICIAN is the person who determines that the decedent is legally dead but who was not in charge of the patient's care for the illness or condition which resulted in death. Items 23a through 23c are to be completed only when the physician responsible for completing the medical certification of cause of death (Item 27) is not available at time of death to certify cause of death. The pronouncing physician is responsible for completing only items 23 through 26.

The CERTIFYING PHYSICIAN is the person who determines the cause of death (Item 27). This box should be checked only in those cases when the person who is completing the medical certification of cause of death is not the person who pronounced death (Item 23). The certifying physician is responsible for completing items 27 through 32

The PRONOUNCING AND CERTIFYING PHYSICIAN box should be checked when the same person is responsible for completing Items 24 through 32, that is, when the same physician has both pronounced death and certified the cause of death. If this box is checked, items 23a through 23c should be left blank

The MEDICAL EXAMINER/CORONER box should be checked when investigation is required by the Post Mortem Examination Act and the cause of death is completed by a medical examiner or coroner. The Medical Examiner/Coroner is responsible for completing items 24 through 32

Item 27. — Cause of Death

The cause of death means the disease, abnormality, injury, or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

In Part I, the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause, should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. **ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE.** Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify.

In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

See examples below.

SEE INSTRUCTIONS ON OTHER SIDE	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	Rupture of myocardium			Mins.
	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) Acute myocardial infarction			6 days
		c	DUE TO (OR AS A CONSEQUENCE OF) Chronic ischemic heart disease			5 years
	d	DUE TO (OR AS A CONSEQUENCE OF)				
CAUSE OF DEATH	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I				28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	Diabetes, Chronic obstructive pulmonary disease, smoking				Yes	Yes
29. MANNER OF DEATH		30a. DATE OF INJURY (Month, Day, Year)	30b. TIME OF INJURY	30c. INJURY AT WORK? (Yes or no)	30d. DESCRIBE HOW INJURY OCCURRED	
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide			M			
		30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc (Specify)		30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
		Street		Route 4, Raleigh, North Carolina		

SEE INSTRUCTIONS ON OTHER SIDE	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	Cerebral laceration			10 mins.
	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) Open skull fracture			10 mins.
		c	DUE TO (OR AS A CONSEQUENCE OF) Automobile accident			10 mins.
	d	DUE TO (OR AS A CONSEQUENCE OF)				
CAUSE OF DEATH	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I				28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
					No	No
29. MANNER OF DEATH		30a. DATE OF INJURY (Month, Day, Year)	30b. TIME OF INJURY	30c. INJURY AT WORK? (Yes or no)	30d. DESCRIBE HOW INJURY OCCURRED	
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		11/15/85	1 p. M	No	2-car collision—driver	
		30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc (Specify)		30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
		Street		Route 4, Raleigh, North Carolina		

U.S. STANDARD REPORT OF FETAL DEATH

STATE FILE NUMBER

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

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. MOTHER'S 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 or no)
8f. ZIP CODE
9. FATHER'S NAME (First, Middle, Last)
10. DATE OF BIRTH (Month, Day, Year)

MOTHER

FATHER

11. OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)
12. RACE - American Indian, Black, White, etc (Specify below)
13. EDUCATION (Specify only highest grade completed)
14. OCCUPATION AND BUSINESS/INDUSTRY (Worked during last year)
11a. No Yes
11b. No Yes
12a.
12b.
13a.
13b.
14a.
14b.
14c.
14d.

MULTIPLE BIRTHS Enter State File Number for Mate(s) LIVE BIRTH(S)

FETAL DEATH(S)

16. PREGNANCY HISTORY (Complete each section)
LIVE BIRTHS: 15a. Now Living, 15b. Now Dead, 15c. DATE OF LAST LIVE BIRTH
OTHER TERMINATIONS: 15d. (Do not include this fetus), 15e. DATE OF LAST OTHER TERMINATION
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 PREGNANCY PRENATAL CARE BEGAN - First, Second, Third, etc. (Specify)
19. PRENATAL VISITS - Total Number (If none, so state)
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)

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MEDICAL AND HEALTH INFORMATION

23a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)
24. OBSTETRIC PROCEDURES (Check all that apply)
25. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)
26. METHOD OF DELIVERY (Check all that apply)
27. CONGENITAL ANOMALIES OF FETUS (Check all that apply)
23b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items)
29. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN (Specify)

CAUSE OF FETAL DEATH

29. PART I. Fetal or maternal condition directly causing fetal death. IMMEDIATE CAUSE. Specify Fetal or Maternal.
a. DUE TO (OR AS A CONSEQUENCE OF)
b. DUE TO (OR AS A CONSEQUENCE OF)
c.
PART II. Other significant conditions of fetus or mother contributing to fetal death but not resulting in the underlying cause given in Part I.

30. ATTENDANT'S NAME AND TITLE (Type/Print)
31. NAME AND TITLE OF PERSON COMPLETING REPORT (Type/Print)