Reset Form

MATERNAL NOTICE OF DEATH

State Form 57687 (2-25)
INDIANA DEPARTMENT OF HEALTH

Indiana Department of Health

INSTRUCTIONS: 1. *PER **IC-16-50-1-6(A)** PLEASE SEND THIS REPORT IMMEDIATELY AFTER THE DEATH OF A WOMAN WHO WAS CURRENTLY PREGNANT OR WAS PREGNANT WITHIN 365 DAYS OF DEATH. REPORT THE EVENT REGARDLESS OF WHERE THE PATIENT DIED WITH AS MUCH DETAILS AS POSSIBLE.*

Name of Woman: _____
Last First Middle Maiden

Address: _____
Street City State ZIP-code

Date of Birth (MM/DD/YYYY): _____

Date of Death (MM/DD/YYYY): _____

Name of birth hospital (if known): _____

Name of Obstetric Provider (if known): _____

Place of Death
☐ Hospital (name of facility and city): _____

☐ Residence ☐ Other (Please specify): _____

Medical Record number: _____
☐ No Autopsy

☐ Autopsy Performed
Facility or address where autopsy was performed: _____

Autopsy performed by: _____
☐ Autopsy Pending

Cause of Death
Primary: _____

Contributing factors: _____

_____

_____

Manner of Death: _____

Report Prepared by: _____ Date: _____

Email: _____ Telephone Number: _____

Please send any questions and complete forms to MMR@health.in.gov