ANNEX- I

REPUBLIC OF THE GAMBIA

HEALTH FACILITY -MATERNITY WARD DEATH REPORT FORM

This is to certify that the stillbirth /neonate, of Mrs

/Ms……..and Mr……of

……, occurred at ……..on the

day……month……..year……..

Cause of death (neonate)……

……..

Name of DR/Midwife/ Nurse

……. Signature……

Health facility…….... Region……date……

……..

Variables

'Foetus/ neonatal death/ still birth/ abortion, Sex, Date of death, Place of death, Name of mother, Name of father, Cause of death (event)'