

Appendix VII Live birth registration draft entry form

Reg. Dist.	District & SD. Nos.	Entry No.	LIVE BIRTH		District & SD. Nos.	Entry No.
Sub. Dist.	Date of registration				Date of registration	
DRAFT OF PARTICULARS OF LIVE BIRTH TO BE REGISTERED			Z		CONFIDENTIAL PARTICULARS	
1. Date and place of birth CHILD (date)			L <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> grams		The particulars below, required under the Population (Statistics) Acts, will not be entered in the register. This information will be confidential and used only for the preparation of statistics by the Registrar General.	
2. Name and surname		3. Sex	(i) <input type="text"/> (ii) <input type="text"/>		1. Where the father's name is entered in register: Father's date of birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
4. Name and surname FATHER			(iii) <input type="text"/> (iv) <input type="text"/>		2. In all cases: Mother's date of birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
5. Place of birth			G(a) Father		3. Where the child is of legitimate birth: (i) Date of marriage <input type="text"/> <input type="text"/> <input type="text"/>	
6. Occupation			(va) <input type="text"/>		(ii) Has the mother been married more than once? *YES NO	
7. Name and surname MOTHER			H(a)* 1 2 3 4 5 <small>See cover for Employment Status codes</small>		(iii) Mother's previous children (excluding birth or births now being registered) by her present husband and any former husband	
8. Place of birth			G(b) Mother		(a) Number born alive (including any who have died) <input type="checkbox"/>	
9. (a) Maiden surname		(b) Surname at marriage if different from maiden surname	H(b)* 1 2 3 4 5 <small>See cover for Employment Status codes</small>		(b) Number still-born <input type="checkbox"/>	
10. Usual address (if different from place of child's birth)			POSTCODE <input type="text"/>		X Is this birth one of twins, triplets, etc *YES NO If YES, complete (a) and (b)	
11. Name and surname (if not the mother or father)		12. Qualification	Edit Control		*(a) Total number of births at this maternity 2 3 4 5 6	
13. Usual address (if different from that in 10 above)					(vi) Live births _____ (vii) Still-births _____	
Signature of registration officer by whom the above particulars were obtained			Signature of registrar registering birth on declaration			

SP(1)160 8/85

* Ring as appropriate

FORM 309

Appendix VIII Stillbirth registration draft entry form

Reg. Dist.	District & SD. Nos.	Entry No.	STILL-BIRTH		District & SD. Nos.	Entry No.
Sub. Dist.	Date of registration				Date of registration	
DRAFT OF PARTICULARS OF STILL-BIRTH TO BE REGISTERED			L		Z	
1. Date and place of birth CHILD (date)			L <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> grams		K <input type="text"/> <input type="text"/> weeks	
2. Cause of Stillbirth		3. Sex	N * Post Mortem YES NO		Y * Before Labour During Labour Not Known	
a			B SD * Eng YES NO (iv) 1 ME 2 3 4 5 6		a b c	
b			U		(vi)	
c			(v) a			
d			b			
e			c			
Certified by			d			
4. Name and surname FATHER			e			
5. Place of birth			M		CONFIDENTIAL PARTICULARS	
6. Occupation			(vii) <input type="text"/> (viii) <input type="text"/>		The particulars below, required under the Population (Statistics) Acts, will not be entered in the register. This information will be confidential and used only for the preparation of statistics by the Registrar General.	
7. Name and surname MOTHER			G(a) Father (ixa) <input type="text"/>		1. Where the father's name is entered in register: Father's date of birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
8. Place of birth			H(a)* 1 2 3 4 5 <small>See cover for Employment Status codes</small>		2. In all cases: Mother's date of birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
9. (a) Maiden surname			G(b) Mother (ixb) <input type="text"/>		3. Where the child is of legitimate birth: (i) Date of marriage <input type="text"/> <input type="text"/>	
(b) Surname at marriage if different from maiden surname			H(b)* 1 2 3 4 5 <small>See cover for Employment Status codes</small>		(ii) Has the mother been married more than once? *YES NO	
10. Usual address (if different from place of child's birth)			POSTCODE <input type="text"/>		(iii) Mother's previous children (excluding birth or births now being registered) by her present husband and any former husband	
11. Name and surname (if not the mother or father)		12. Qualification	X Is this birth one of twins, triplets, etc *YES NO If YES, complete (a) and (b)		(a) Number born alive (including any who have died) <input type="checkbox"/>	
13. Usual address (if different from that in 10 above)			*(a) Total number of births at this maternity 2 3 4 5 6		(b) Number still-born <input type="checkbox"/>	
Edit Control			Signature of registrar		(x) Live births _____ (xi) Still-births _____	
					(b) Entry No. of births _____ (b) Entry No. of births _____	

SP(1)158 7/85

* Ring as appropriate

FORM 308

Appendix IX Death registration draft entry form

Reg. Dist.	District & SD Nos.	Entry No.	(i)	DEATH		District & SD Nos.	Entry No.						
Sub-Dist.	Date of registration					Date of registration							
DRAFT OF PARTICULARS OF DEATH TO BE REGISTERED				C		CONFIDENTIAL PARTICULARS							
1. Date and place of death (date)				(iia)		The particulars below, required under the Population (Statistics) Acts, will not be entered in the register. This information will be confidential and used only for the preparation of statistics by the Registrar General. At date of death the deceased was (ring appropriate number) Single 1 Married 2 → (if married insert date of birth of spouse) <table border="1" style="display: inline-table; margin-left: 20px;"> <tr><td>Day</td><td>Month</td><td>Year</td></tr> <tr><td> </td><td> </td><td> </td></tr> </table> Widowed 3 Divorced 4 Not known 5		Day	Month	Year			
Day	Month	Year											
2. Name and surname		3. Sex	D & SD No. (v)		E *6 mths or over *Under 6 mths								
		4. Maiden surname of woman who has married	F										
5. Date and place of birth (date)				(vii) P									
6. Occupation and usual address				G(a) Deceased		G(b) Husband or †Parent							
				(via)		(vib)							
8. Cause of death				H*(a) 1 2 3 4 5		H*(b) 1 2 3 4 5							
Ia				J		(viii) (ix)							
Ib				J									
Ic				J		N Post Mortem B SD Enq							
Id				J		* YES NO * YES NO							
Certified by				M									
7. (a) Name and surname of informant		(b) Qualification		(x)									
(c) Usual address						(xiii) Z							
						Edit control							
O National Health Service medical card collected? * YES NO		Signature of registrar		(xi)		(xii)							
If NO, NHS No.													

* Ring as appropriate † If deceased is under 15 years of age Form 310

Appendix X Neonatal death certificate

MED B 000000
1

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by the Registration of Births, Deaths and Marriages (Amendment) (No. 2) Regulations 1985)

MEDICAL CERTIFICATE OF CAUSE OF DEATH OF A LIVE-BORN CHILD DYING WITHIN THE FIRST TWENTY-EIGHT DAYS OF LIFE

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths.

Registrar to enter No. of Death Entry

Name of child

Date of death day of 19 Sex

Age at death days (complete period of 24 hours) hours

Place of death

Place of birth

Last seen alive by me day of

1 The certified cause of death has been confirmed by post-mortem.

2 Information from post-mortem may be available later.

3 Post-mortem not being held.

4 I have reported this death to the Coroner for further action. [See overleaf]

Please ring appropriate digit and letter.

a Seen after death by me.

b Seen after death by another medical practitioner but not by me.

c Not seen after death by a medical practitioner.

CAUSE OF DEATH

a. Main diseases or conditions in infant

b. Other diseases or conditions in infant

c. Main maternal diseases or conditions affecting infant

d. Other maternal diseases or conditions affecting infant

e. Other relevant causes

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature

Address

Qualifications as registered by General Medical Council

Date

For deaths in hospital: Please give the name of the consultant responsible for the above-named as a patient

Appendix XI Cancer registration abstract card

Office of Population Censuses and Surveys Titchfield Hants		Cancer Abstract Card 1984		Region 2-5	Registration number 6-12 84 -			
Please complete in black ink and BLOCK LETTERS		Hospital case number	Hospital	Treated at this hospital		Sex	13	
NHS number 63-73				Yes	No	M F		
Surname 74-		Hospital referred from	Hospital referred to		Date of birth			
					DAY	MONTH	YEAR	
					14-15	16-17	18-19	
Forenames		Occupation	Industry		Area 20-23			
		of patient			POB 24-27			
Maiden name of married woman -133		of husband, if married or name of wife, if widow			Occ-Patient 28-34			
		Site of origin			Occ-Hub/Fa 35-41			
Full home address 134-173		OR main presenting secondary if primary unknown			Site 42-45			
		Type of growth			Type			
Postcode 173-179					Yes	No	Don't know	
Place of birth			Microscopically confirmed (Tick box)					
		Anniversary Date	DAY	MONTH	YEAR	Date of Death		
						DAY	MONTH	YEAR
NOTES								
CR(T)62 7/82								

SPECIMEN

(c) Form CR375 – Record of Enlistment

CR 375

To NHS Central Register, Smedley Hydro, Southport,
Merseyside PR8 2HH

Surname Any former surname

Forename(s)

Date of birth Place of birth

Mother's maiden name

Date of last
enlistment Service number

Usual address prior to enlistment
.....

Please supply the NHS number of the above-named person

Record Office Date

For use at NHSCR

To the Officer i/c Records

1. NHS number is
2. NHS number not traced

Initials Date

(d) Form CR237(j) – Record of embarkation

C.R.237(j) (Rev.) Part 2

C.R.237(j) (Rev.) Part 1

NOTIFICATION OF EMBARKATION

NATIONAL HEALTH SERVICE

DETAILS RELATING TO YOURSELF

Surname _____ Forename(s) _____

If you are a woman who is married, widowed or divorced please also enter your maiden surname)

Your date) (Day) (Month) (Year))
of birth)

Your National Health)
Service number)

Your address when you were)
last registered with a)
National Health Service doctor)

The name and address)
of your last doctor)

Your proposed date of departure _____

NOTICE TO PERSONS WHO INTEND LEAVING THE UNITED KINGDOM FOR A PERIOD OF MORE THAN 3 MONTHS

If you are going abroad, or to the Channel Islands, for more than 3 months, it is important that you and any dependants or other persons accompanying you surrender your National Health Service medical card(s) either by:-

- i. handing it (them) to the Immigration Officer at your point of departure, or
- ii. sending the card(s) to the National Health Service Central Register in the envelope provided, which does not require a stamp.

If you are unable to find your medical card(s), would you please complete Part 2 of this form in respect of each person whose medical card has been lost or mislaid, detach it and send it to the N.H.S. Central Register in the envelope provided.

Should you be preceding your family or other persons who will eventually join you, their details should not be entered on Part 2. Instead their medical cards should be surrendered by one of the methods listed above before they leave the United Kingdom.

You should notify your local Family Practitioner Committee at once if for any reason you find it necessary to postpone or cancel your travel arrangements.

If you subsequently return to this country it will be necessary for you to re-register with a doctor.

TEAR OFF

DETAILS OF DEPENDANTS OR OTHER PERSONS ACCOMPANYING YOU FOR WHOM MEDICAL CARDS ARE LOST OR MISLAID

Your wife	Forename(s)	Maiden Surname	Date of birth			National Health Service number
	(Day) (Month) (Year)	National Health Service number)	Day	Month	Year	
Your child(ren)	Forename(s)	Date of birth	National Health Service number			
	1.					
	2.					
	3.					
	4.					
	5.					
Any other persons who will accompany you	Surname and Forename(s)	Date of birth	National Health Service number			
		Day Month Year				

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(e) Form CR378 – Record of entry to Long-stay Psychiatric Hospital

PART 1

CR378

To NHS CENTRAL REGISTER, SMEDLEY HYDRO, SOUTHPORT, MERSEYSIDE PR8 2HH

Name or Serial No. of Hospital

Date of admission NHS number

Surname (Mr, Mrs, Miss)
(In BLOCK LETTERS)

Forename(s)

Former name (if any)

Date of birth, and place if known

Home and other addresses

.....

.....

Name of doctor (prior to admission)

PART 2

To FPC

The above-named has been a patient in a Psychiatric Hospital for more than two years.
Will you please have a search made in your records and, if an acceptance is found,
cancel the registration.

If the NHS NUMBER IS ALREADY ENTERED ABOVE, DO NOT RETURN THIS FORM.

If the NHS NUMBER IS NOT ENTERED ABOVE, PLEASE)
INSERT IT AT A BELOW.) AND RETURN THIS FORM
) TO NHSCR
IF NO TRACE, PLEASE TICK BELOW)

Initials Date
NHSCR

PART 3

REPLY (If necessary)

A. Registration now cancelled. NHS No. is

B. No Trace

Initials FPC Date