

Application to Local Registrar for Copy of Birth Record

CERTIFICATE INFORMATION

Name First Middle Last	Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M M D D Y Y Y Y	
Place of Birth Hospital (If not hospital, give street & number)	(Village, Town or City)	County
Father First Middle Last	Maiden Name First Middle Last of Mother	
Number of Copies Requested	Enter Birth No. if Known	Enter Local Registration No. if Known

Purpose for Which Record is Required (Check One)

- | | | |
|---|---|---|
| <input type="checkbox"/> Passport | <input type="checkbox"/> Working Papers | <input type="checkbox"/> Welfare Assistance |
| <input type="checkbox"/> Social Security-Retirement | <input type="checkbox"/> School Entrance | <input type="checkbox"/> Veteran's Benefits |
| <input type="checkbox"/> Social Security-SSI | <input type="checkbox"/> Driver's License | <input type="checkbox"/> Court Proceeding |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Marriage License | <input type="checkbox"/> Entrance into Armed Forces |
| <input type="checkbox"/> Employment | | |
| <input type="checkbox"/> Other (Specify) _____ | | |

APPLICANT INFORMATION

NAME FIRST MIDDLE LAST What is your relationship to person whose record is required? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other, specify _____ Telephone No. (____) _____ Social Security No. _____ Signature of Applicant _____ Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YY Address of Applicant Street _____ City _____ State _____ Zip Code _____	If attorney, give name and relationship of your client to person whose record is required <table style="width:100%; border: 1px solid black;"> <tr> <td style="width:50%; height: 30px;"></td> <td style="width:50%; height: 30px;"></td> </tr> <tr> <td style="text-align: center;">(name of client)</td> <td style="text-align: center;">(relationship)</td> </tr> </table> <div style="background-color: #e0e0e0; padding: 5px;"> FOR REGISTRAR'S USE ONLY (Photocopy ID and attach to application form) TYPE OF ID <input type="checkbox"/> Driver's License State _____ No. _____ <input type="checkbox"/> Other ID, specify _____ No. _____ </div>			(name of client)	(relationship)
(name of client)	(relationship)				

Application to Local Registrar for Copy of Death Record

PLEASE COMPLETE FORM AND ENCLOSE FEE

FEE: \$10.00 per copy or No Record Certification. Please do not send cash or stamps.

PLEASE PRINT OR TYPE

Name of Deceased			Date of Death or Period to be Covered by Search		
First	Middle	Last			
Name of Father of Deceased			Social Security Number of Deceased		
First	Middle	Last			
Maiden Name of Mother of Deceased			Date of Birth of Deceased		Age at Death
First	Middle	Last	Month	Day	Year
Place of Death					
Name of Hospital or Street Address			Village, Town or City		County
Purpose for Which Record is Required					
What was your relationship to the deceased? _____					
In what capacity are you acting? _____					
If attorney, name and relationship of your client to deceased _____					
Signature of Applicant _____			Date _____		
Address of Applicant _____					

COMPLETE FOR DEATHS OCCURRING AS OF JANUARY 1, 1988

_____ Number of copies requested with confidential cause of death
 _____ Number of copies requested without confidential cause of death

PLEASE PRINT NAME AND ADDRESS WHERE RECORD SHOULD BE SENT

Name _____
 Address _____
 City _____ State _____ Zip Code _____