

Application to Local Registrar for Copy of Birth Record

CERTIFICATE INFORMATION

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--------------------------------|---------------|------|--------|---|---|--|-------|--------|------|-----------------------|--|--|--|--|---|---|---|---|---|---|---|---|
| <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">First</td> <td style="width: 33%; text-align: center;">Middle</td> <td style="width: 33%; text-align: center;">Last</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Name</td> </tr> </table> | First | Middle | Last | Name | | | <p>Date of Birth</p> <table style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> | | | | | | | | | M | M | D | D | Y | Y | Y | Y |
| First | Middle | Last | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| M | M | D | D | Y | Y | Y | Y | | | | | | | | | | | | | | | | |
| <p>Place of Birth</p> <p style="font-size: small;">Hospital (If not hospital, give street & number)</p> | <p>(Village, Town or City)</p> | <p>County</p> | | | | | | | | | | | | | | | | | | | | | |
| <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">First</td> <td style="width: 33%; text-align: center;">Middle</td> <td style="width: 33%; text-align: center;">Last</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Father</td> </tr> </table> | First | Middle | Last | Father | | | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">First</td> <td style="width: 33%; text-align: center;">Middle</td> <td style="width: 33%; text-align: center;">Last</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Maiden Name of Mother</td> </tr> </table> | First | Middle | Last | Maiden Name of Mother | | | | | | | | | | | | |
| First | Middle | Last | | | | | | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | | | | | | | | |
| First | Middle | Last | | | | | | | | | | | | | | | | | | | | | |
| Maiden Name of Mother | | | | | | | | | | | | | | | | | | | | | | | |

| | | |
|-----------------------------------|---------------------------------|--|
| <p>Number of Copies Requested</p> | <p>Enter Birth No. if Known</p> | <p>Enter Local Registration No. if Known</p> |
|-----------------------------------|---------------------------------|--|

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

| | | | | | | | | | | | | | |
|--|----------------|--------|------|---|--|--|------------------|----------------|----|--|--|--|--|
| <p>NAME</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center; font-size: small;">FIRST</td> <td style="width: 33%; text-align: center; font-size: small;">MIDDLE</td> <td style="width: 33%; text-align: center; font-size: small;">LAST</td> </tr> </table> <p>What is your relationship to person whose record is required?</p> <p><input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other, specify _____</p> <p>Telephone No. (____) _____-_____</p> <p>Social Security No. _____-____-_____</p> | FIRST | MIDDLE | LAST | <p>If attorney, give name and relationship of your client to person whose record is required</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 70%; height: 30px;"></td> <td style="border: 1px solid black; width: 30%; height: 30px;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">(name of client)</td> <td style="text-align: center; font-size: small;">(relationship)</td> </tr> </table> | | | (name of client) | (relationship) | | | | | |
| FIRST | MIDDLE | LAST | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| (name of client) | (relationship) | | | | | | | | | | | | |
| <p>Signature of Applicant</p> <p style="text-align: right;">Date</p> <table style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> <tr> <td>MM</td><td>DD</td><td>YY</td><td colspan="3"></td> </tr> </table> | | | | | | | MM | DD | YY | | | | <p style="text-align: center;">FOR REGISTRAR'S USE ONLY</p> <p style="font-size: x-small;">(Photocopy ID and attach to application form)</p> <p>TYPE OF ID</p> <p><input type="checkbox"/> Driver's License</p> <p style="margin-left: 20px;">State _____ No. _____</p> <p><input type="checkbox"/> Other ID, specify _____</p> <p style="margin-left: 20px;">No. _____</p> |
| | | | | | | | | | | | | | |
| MM | DD | YY | | | | | | | | | | | |
| <p>Address of Applicant</p> <p>Street _____</p> <p>City _____ State _____ Zip Code _____</p> | | | | | | | | | | | | | |

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 First Middle Last | | | Date of Death or Period to be Covered by Search | | |
| Name of Father of Deceased First Middle Last | | | Social Security Number of Deceased | | |
| Maiden Name of Mother of Deceased First Middle Last | | | Date of Birth of Deceased Month Day Year | | Age at Death |
| 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 _____