



NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

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 _____					
Under penalty of perjury, I do hereby swear or affirm that the statements made herein are true and correct to the best of my knowledge and belief.					
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	State of _____ County of _____
_____ Number of copies requested without confidential cause of death	Subscribed and sworn to (affirmed) before me this _____ day of _____ by _____
	Notary Public ► _____

PLEASE PRINT NAME AND ADDRESS WHERE RECORD SHOULD BE SENT

Name _____		
Address _____		
City _____	State _____	Zip Code _____