MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF VITAL RECORDS
APPLICATION FOR A VITAL RECORD

SULLIVAN COUNTY HEALTH DEPARTMENT
PO BOX 129 101 HAWTHORNE DRIVE
MILAN MO 63556

Beginning March 1, 2011, applicants must show identification when requesting certified copies of a vital record at the state health department. **Mail-in requests must be notarized by an acceptable notary public.**

Missouri law requires a non-refundable search fee for each five-year search of the files. If eligibility requirements are met and a record is found, applicant is entitled to certified copies. A statement will be issued if no record is found. **FEE MUST ACCOMPANY APPLICATION**. FEES ARE VALID FOR ONE YEAR. Check or money order payable to: **SULLIVAN COUNTY HEALTH DEPARTMENT. DEATHS PRIOR TO 1980 AND BIRTHS PRIOR TO 1920 HAVE TO APPLY THROUGH THE STATE OF MO.**
State recording of birth and death records began January 1, 1910.

☐ **BIRTH** ☐ **FETAL DEATH REPORT** ☐ **STILLBIRTH**

NUMBER OF COPIES __________ (FIRST COPY ISSUED $15; EACH ADDITIONAL COPY $15)

FULL NAME ON CERTIFICATE ____________________

ALSO KNOWN AS (INDICATE IF BIRTH COULD BE RECORDED UNDER ANOTHER NAME) ____________________

DATE OF BIRTH ________________ PLACE OF BIRTH (CITY, COUNTY, STATE) ____________________

HOSPITAL ____________________ SEX FEMALE ☐ MALE ☐ RACE ____________________

FULL NAME OF FATHER ____________________

FULL MAIDEN NAME OF MOTHER ____________________

DEATH

NUMBER OF COPIES _________ (FIRST COPY ISSUED $13; EACH ADDITIONAL COPY OF THE SAME RECORD ORDERED AT THE SAME TIME $10)

FULL NAME ON CERTIFICATE ____________________

DATE OF BIRTH ____________________ SEX FEMALE ☐ MALE ☐ RACE ____________________

DATE OF DEATH ________________ PLACE OF DEATH (CITY, COUNTY, STATE) ____________________

FULL NAME OF SPOUSE ____________________

FULL NAME OF FATHER ____________________

FULL MAIDEN NAME OF MOTHER ____________________

PLEASE ENCLOSE A SELF ADDRESSED STAMPED ENVELOPE WITH YOUR REQUEST (PRINT THE FOLLOWING INFORMATION)

APPLICANT'S NAME____________________

____________________ PHONE NUMBER ____________________

APPLICANT'S STREET ADDRESS ____________________

APPLICANT'S CITY/TOWN ____________________ STATE ________________ ZIP ____________________

PURPOSE FOR CERTIFICATE REQUEST

YOUR RELATIONSHIP TO PERSON NAMED ON RECORD (IF LEGAL GUARDIAN, MUST PROVIDE GUARDIANSHIP PAPERS). IF LEGAL REPRESENTATIVE, INDICATE LEGAL RELATIONSHIP. ____________________

- **MAIL-IN REQUESTS MUST BE NOTARIZED. ALL APPLICATIONS MUST BE SIGNED.**

I ____________________ SUBJECT TO THE PENALTY OF PERJURY, DO SOLEMNLY DECLARE AND AFFIRM THAT I AM ELIGIBLE TO RECEIVE A CERTIFIED COPY OF THE VITAL RECORD(S) REQUESTED ABOVE AND THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

- APPLICANT'S SIGNATURE ____________________ **DATE** ____________________

NOTARY PUBLIC EMBOSSER SEAL	STATE		COUNTY
	SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME , THIS ____________ DAY OF ________________ , 20 ______		**USE RUBBER STAMP IN CLEAR AREA BELOW**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

WARNING: False application for a certified copy of a vital record is a crime.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF VITAL RECORDS

APPLICATION FOR A VITAL RECORD

SULLIVAN COUNTY HEALTH DEPARTMENT
PO BOX 129 101 HAWTHORNE DRIVE
MILAN MO 63556

WARNING: False application for a certified copy of a vital record is a crime.