



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 STILLBIRTH **NUMBER OF COPIES** _____ (FIRST COPY ISSUED \$15; EACH ADDITIONAL COPY \$15)

REPORT
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 \$14; EACH ADDITIONAL COPY OF THE SAME RECORD ORDERED AT THE SAME TIME \$11)

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 EMBOSSEER SEAL	STATE _____	COUNTY _____
	SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME ,	
	THIS _____ DAY OF _____ , 20 _____	
	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.