



JACKSON COUNTY HEALTH DEPARTMENT
 313 SOUTH LIBERTY, INDEPENDENCE, MO 64050
APPLICATION FOR A VITAL RECORD

HOURS: MONDAY – FRIDAY 8:00 AM – 4:00 PM
 PHONE: (816) 404-6419

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

If eligibility requirements are met and a record is found, applicant is entitled to certified copies. **FEE MUST ACCOMPANY APPLICATION.** FEES ARE VALID FOR ONE YEAR. Check or money order payable to: **Jackson County Health Department.** Birth records from 1920 to the present. Death records from 1980 to the present.

I would like to make a \$1.00 donation to support homeless families & provide financial assistance to organizations addressing homelessness in Jackson County.

BIRTH 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 DEATH _____ SEX FEMALE MALE RACE _____
 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 _____ 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 IS TRUE UNDER THE PAINS AND PENALTIES OF PERJURY.

➤ **APPLICANT'S SIGNATURE** _____ **DATE** _____

NOTARY PUBLIC EMBOSSER 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) _____	
USE RUBBER STAMP IN CLEAR AREA BELOW		

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