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