**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**

<table>
<thead>
<tr>
<th>Name of Deceased</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Date of Death or period to be Covered by Search</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Father of Deceased</td>
<td>First</td>
<td>Middle</td>
<td>Last</td>
<td>Social Security Number of Deceased</td>
</tr>
<tr>
<td>Name of Mother of Deceased</td>
<td>First</td>
<td>Middle</td>
<td>Last</td>
<td>Date of Birth of Deceased</td>
</tr>
<tr>
<td>Place of Death</td>
<td></td>
<td></td>
<td></td>
<td>Name of Hospital or Street Address</td>
</tr>
<tr>
<td>Village, Town or City</td>
<td></td>
<td></td>
<td></td>
<td>County</td>
</tr>
</tbody>
</table>

**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 _________________________________________________________________________________

**PLEASE PRINT NAME AND ADDRESS WHERE RECORD SHOULD BE SENT**

Name ____________________________________________________________________________________________

Address __________________________________________________________________________________________

City __________________________________ State ______________________ Zip Code ________________________

DOH-294A (7/92)  
VS-34D