



Missouri Department of Health & Senior Services
Bureau of Vital Records

Cert # _____

Processor _____

Application for Certified Copy of Death Certification Date _____

Payment: Cash Check # _____

INSTRUCTIONS	COPIES REQUESTED
A \$13.00 search fee is required when requesting a death record. For additional copies of the same record requested at the same time for the same person, the fee is \$10.00. <u>FEE MUST ACCOMPANY APPLICATION.</u> No cash by mail.	Death Certification (Certification of facts of death contained in original record)
MAKE CHECK OR MONEY ORDER PAYABLE TO: LINCOLN COUNTY HEALTH DEPARTMENT	How Many <div style="border: 1px solid black; width: 40px; height: 40px; display: inline-block; vertical-align: middle;"></div>
MAKE THIS APPLICATION TO: LINCOLN COUNTY HEALTH DEPARTMENT # 5 HEALTH DEPARTMENT DRIVE TROY, MISSOURI 63379	\$13 1st copy and \$10 for additional
Phone: 636-528-6117	AMOUNT OF MONEY ENCLOSED \$ _____
Office hours--8:00 a.m.—4:30 p.m. Monday thru Friday	<small>RECORDS ARE FILED BY YEAR OF DEATH AND ALPHABETICALLY BY THE NAME OF THE DECEASED AT THE TIME OF DEATH. THEREFORE, AT LEAST THE APPROXIMATE YEAR OF DEATH OR LAST YEAR IN WHICH THE DECEASED WAS KNOWN TO BE ALIVE MUST BE GIVEN.</small>

INFORMATION ABOUT PERSON WHOSE DEATH CERTIFICATE IS REQUESTED (TYPE or PRINT all items EXCEPT						
1. FULL NAME OF DECEASED						
FIRST NAME		MIDDLE NAME		LAST NAME (AT TIME OF DEATH)		
2. DATE OF DEATH			3. SEX, RACE AGE			
MONTH	DAY	YEAR	SEX	RACE	AGE	
4. PLACE OF DEATH						
CITY OR TOWN		COUNTY		STATE		
5. FULL NAME OF SPOUSE						
FIRST NAME		MIDDLE NAME		LAST NAME		
6. FULL NAME OF FATHER						
FIRST NAME		MIDDLE NAME		LAST NAME		
7. FULL NAME OF MOTHER						
FIRST NAME		MIDDLE NAME		LAST NAME (MAIDEN)		

PERSON REQUESTING CERTIFIED COPY OF DEATH RECORD

8. PURPOSE FOR WHICH CERTIFIED COPY IS TO BE USED (PLEASE CHECK)	9. RELATIONSHIP TO REGISTRANT OR INTEREST OF PERSON REQUESTING CERTIFICATION
<input type="checkbox"/> INSURANCE CLAIM ON POLICY ISSUED WITHIN 2 YEARS OF DEATH <small>(A CERTIFIED COPY OF THE ORIGINAL WILL BE REQUIRED)</small> <input type="checkbox"/> OTHER INSURANCE CLAIMS <input type="checkbox"/> OTHER (SPECIFY): _____	

10. SIGNATURE OF APPLICANT

DATE SIGNED

11. NAME AND ADDRESS OF APPLICANT

NAME & ADDRESS OF FUNERAL HOME OR APPLICANT

NAME OF INDIVIDUAL TO RECEIVE COPIES	STREET ADDRESS
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CITY OR TOWN	STATE	ZIP CODE
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PLEASE PRINT OR TYPE THE NAME AND ADDRESS OF THE PERSON TO WHOM THE RECORD IS TO BE RETURNED. COMPLETE ONLY IF CERTIFICATIONS ARE TO BE MAILED.	NAME
	ADDRESS
	CITY, STATE, ZIP CODE