NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

Application to Local Registrar for Copy of Death Record

PLEASE COMPLETE FORM AND ENCLOSE FEE

PLEASE PRINT OR TYPE

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